The future of clinical documentation improvement

Data and analytics will drive CDI and support population health management

By Angela Hunt, RN, senior consulting director; Aman Sabharwal, MD, senior principal; and Jim Tamburini, consulting director, clinical consulting, Vizient

As health care continues to move toward value-based care and pay-for-performance models, successful organizations know the importance of having accurate and complete clinical documentation to reflect medical decision-making and better patient care.

Traditional clinical documentation improvement (CDI) is inherently limited because it is based on subjective data rather than empirical data. A more effective and accurate, data-driven approach is now emerging. In this new paradigm, CDI teams compare discharge data with benchmark data to pinpoint where they need to concentrate their efforts.

At the same time, CDI professionals work more closely with quality, case management and safety teams to reduce care variations, manage length of stay, contain costs, provide insights into service line development and improve population health. In short, clinical documentation becomes a means to identify and prioritize performance improvement efforts.

To achieve these goals, CDI professionals must be able to compare individual provider and service line-specific discharge data to similar information from other peer institutions. This requires access to publicly reported Medicare Provider and Analysis Review (MedPAR) data and/or a database that includes length of stay, case mix index and other quality data from the members of a specialized documentation performance program.
Working with quality teams, clinical documentation improvement professionals can use the same comparative databases and analytics to better understand how their providers and their hospitals differ from higher- and lower-performing organizations. With this information in hand, they can help the hospital correctly capture diagnoses related to HAC scores, expected mortality and readmissions, and, in turn, potentially avoid penalties. Data gives the organization insight to capture missed potential opportunities per service line or per physician to achieve better outcomes. This data results in actionable items for the CDI team to address on a concurrent basis and is based on the day-to-day documentation in the patient’s medical record. But none of these goals can be realized until documentation improves.

Understanding the challenge

Many hospitals are unaware that they have potential to improve their documentation. Even if they do recognize this opportunity, they may not know how to address it. Here are a few of the ways health care organizations can overcome common challenges of clinical documentation.

Get specific

Physicians are rightly focused on providing high-quality patient care and improving patient outcomes. As a result, busy doctors may take the path of least resistance and document an unspecified diagnosis. For example, they may document “respiratory failure,” although the patient actually has acute and chronic respiratory failure with hypoxia. This kind of choice often results in the medical record being assigned an incorrect MS-DRG that reflects a reduced severity of illness.

If a high percentage of a hospital’s diagnostic codes are unspecified, rather than specific to the diagnosis, the facility is missing opportunities to document clinical quality and achieve accurate reimbursement because the severity of their patients’ conditions is not being appropriately described in medical records. An indication of this lack of specificity is that the hospital’s average length of stay is longer than expected, when compared with its case mix index. One explanation for this discrepancy is poor documentation, which does not reflect the complexity and severity of the patient population. But it is also possible that the disparity may be related to poor care coordination, operational inefficiencies or other issues. It can be difficult for a hospital to tell which factor is responsible.

With the help of a specialized external database, the hospital can analyze its data and compare itself to other peer institutions to find out whether there is an opportunity to improve documentation. For example, a hospital with an unusually long average length of stay may have a large number of principal diagnoses that have no secondary diagnoses that reflect the severity of illness or risk of mortality associated with them.
When that hospital is compared with other like-sized facilities within a particular service line, it may turn out that its case mix index is consistently lower than that of other hospitals in its cohort. This could indicate that its physicians are missing documentation opportunities.

This kind of data directs hospital administrators towards a service line or specific physician who needs education and focused clinical documentation reviews. When a service line or physician is targeted, the same data tracking provides information on the effectiveness of interventions to improve documentation.

Encourage peer-to-peer comparisons

Busy physicians may resent the need to devote hours to data entry instead of patient care. They may practice at multiple facilities that have different electronic health records (EHRs), making it difficult for them to document properly in each of these records. Because most hospitals customize their systems, even dealing with the differences in the same EHR used by different hospitals can be challenging. As a result, doctors may inadvertently neglect to enter important data or enter it into the wrong fields in the EHR. Reducing variation in EHRs across a system—including standardizing documentation templates and updating the menus from which diagnoses can be selected—will assist in accurate data capture. Standardization, maintenance and maximization initiatives can often be handled by partnering with the EHR task force in your hospital.

One way to persuade physicians to focus more on documentation is to appeal to their desire to succeed by using proven methodologies supported by empirical data. Showing physicians how their documentation compares with that of other doctors within their hospital can motivate them to improve. Reviewing like service lines from competitors provides insight on the complexity of the patient population. This is another benefit of using reports derived from databases that involve numerous health care organizations: The data on many other physicians in the same specialty helps identify potential documentation gaps.
Offer and emphasize continuing education

As the coding system continues to evolve in both breadth and complexity, continuing education is more important than ever. The move from the ICD-9 to the ICD-10 diagnostic and procedural coding system has greatly increased the documentation challenge for physicians. The newer coding system has nearly five times as many codes as the older one, and they are much more granular than the ICD-9 codes. Most physicians have received differing degrees of training in ICD-10, but the extent of their familiarity with the system varies.

CDI professionals have found that the best way to improve physicians’ documentation is to provide continuing education at routine intervals. The more that physicians understand about what’s required, the more likely they are to make the necessary changes to their documentation.

The health IT department of a hospital can also customize the menus related to diagnostic coding to make it easier for physicians to pick the right codes. Most EHRs provide fairly short lists of diagnostic options in drop-down menus. Physicians are unlikely to scroll down through long lists to pick the right diagnostic code. But the menus can be customized so that reminders or alerts appear when a physician documents an unspecified code for a patient with certain clinical indicators.

Align with quality and safety teams

While helping physicians improve documentation, CDI professionals also should work closely with hospital quality and safety teams to ensure that patient care is documented, present-on-admission status is clearly indicated, and the final coding summary correctly reflects the care provided. Because of government regulations, these goals have financial and reputational implications. For example, in 2017, 751 hospitals lost 1 percent of their Medicare payments because of their high rates of hospital-acquired conditions.¹

Documentation also plays an important role in the hospital quality scores that the Centers for Medicare & Medicaid Services (CMS) reports on its Hospital Compare site. To the extent that consumers use the Hospital Compare data in selecting a hospital, it can affect the hospital’s patient volume. In addition, quality measures for individual providers—part of CMS’s Merit-based Incentive Payment System (MIPS)—can impact the Medicare reimbursement of the physicians on the hospital staff.²

Shortcuts that impede CDI

How physicians document may explain why their documentation is sometimes inadequate or contains inaccuracies. Some of these problems arise from EHR shortcuts such as:

- **Copying and pasting.** Doctors pull in parts of previous notes but may not remove data that no longer applies, such as discontinued medications or inactive problems. The copied portions are often from an earlier part of the stay, when documentation is less specific and diagnoses may not have been established yet. As the stay progresses, greater diagnostic specificity is often obtained but not reflected in the documentation that was copied and pasted from earlier in the stay.

- **Using smart phrases or smart links.** These macro functions enable physicians to create notes more quickly by pressing keys or buttons that populate fields and launch preprogrammed phrases or sentences. However, the resultant notes can bury relevant data in long sections of repetitive verbiage. This “note bloat” reduces the usefulness of the notes to the physician and to other clinicians who care for the same patient.³

- **Using voice recognition.** Some physicians use voice recognition to speed documentation. However, the accuracy of voice recognition is limited, so doctors must review their notes to correct mistakes.⁴ In addition, voice recognition, like transcription, creates free text that makes it difficult to search for terms that support diagnostic codes.
If physicians enter detailed and accurate information about
the services they deliver in the proper fields in the EHR, it
is easier for hospital quality teams to find the data their
facilities need to show how well they are performing on the
quality measures—and for the doctors to do the same on
the metrics that apply to them individually.

**Capture present-on-admission conditions**

CDI and patient safety professionals also search records
for particular conditions that can affect hospital
reimbursement. For example, if a patient comes into the
hospital with a pressure ulcer that is not documented
as present on admission, it may be assumed that the
patient developed the ulcer during his or her inpatient
stay, resulting in documentation that supports reporting
of a hospital-acquired condition, a key quality metric
reported to CMS. Similarly, the quality team might notice
that there is an unusually high rate of catheter-associated
urinary tract infections at the hospital. They might ask the
CDI team to check the records to see how many of those
conditions were truly present on admission. In many cases,
ambiguous, unclear or conflicting documentation may
lead to a hospital displaying inflated scores in key quality
metrics such as these.

CDI professionals should also look for potential diagnoses
that exclude a case from being counted in the patient
safety indicator (PSI) score. For example, a patient with
a history of cancer who is receiving chemotherapy may
develop a condition called thrombocytopenia, which may be
noted in the lab work but never documented. The addition
of this diagnosis to the documentation may exclude a case
from being counted in the complication measures, such as
perioperative hemorrhage or hematoma. If this condition
is assessed and treated, the CDI team should make sure
that provider documentation includes thrombocytopenia,
because it accurately reflects the patient’s health status
and the resource intensity in providing care, which
represents the true severity of the case. They should also
ensure that the condition is recorded and carried over to
the final coding summary.

**The future of CDI is data**

To decide if they have a documentation problem, hospitals
need data analytics to show how their care processes and
documentation compare with those of similar facilities.
Statistically valid data on diagnostic coding can also
persuade physicians to improve their documentation if
they’re shown how they compare with their peers.

Not only can better documentation improve reimbursement,
quality and safety, but it can also help hospitals manage
length of stay. Looking more closely at care variations, as
reflected in documentation, can also help hospitals contain
costs. If they are able to improve costs and quality, they are
likely to do well in the value-based environment.

**As the coding system continues to evolve in both breadth and complexity, continuing education is more important than ever.**
About the authors

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Angela Hunt brings more than 23 years of experience in the health care industry as a registered nurse. Prior to joining Vizient®, Hunt spent five years consulting with acute care hospitals, pediatric hospitals and academic hospital systems to improve their documentation, increase case mix index, improve severity of illness and risk of mortality scores and provide continuing education of CDI staff and health care providers. In prior years, she started, staffed and managed the CDI program at a local hospital in Missouri.

Hunt received her Bachelor of Arts in Psychology from the University of Arkansas, her diploma in nursing from the Baptist School of Nursing and her Master of Business Administration focusing on finance.

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Aman Sabharwal has more than 20 years of health care experience and is a board-certified internal medicine hospitalist. Prior to joining Vizient, Sabharwal served as the chief utilization officer and corporate medical director of the Jackson Health System in Miami. Prior to this role, Sabharwal started and operated the first hospitalist group at Jackson Health System.

Sabharwal received his medical and undergraduate degrees from the University of Missouri in Kansas City, Missouri along with a master’s of health administration from the University of North Carolina in Chapel Hill, North Carolina. He currently serves as a clinical assistant professor of Medicine at Florida International University College of Medicine and as an assistant professor of anesthesiology and perioperative medicine at the University of Miami—Miller School of Medicine.

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Jim Tamburini brings more than 20 years of experience in the health care industry, including an extensive background in acute care inpatient and outpatient coding, health information and coding department management, clinical documentation improvement and consulting. He has an in-depth knowledge of ICD-9-CM, ICD-10-CM/PCS and CPT-4 coding guidelines and compliance regulations, MS-DRG and APR-DRG reimbursement methodologies, and severity of illness and risk of mortality scores, and has implemented successful clinical documentation improvement programs in adult and children’s acute care hospitals across the U.S.

Tamburini received an associate’s degree in health information technology from Weber State University and a bachelor’s degree in health policy and administration with minors in gerontology and human development and family studies from Penn State University.

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