

# LEADING THE DOCUMENTATION JOURNEY: A REPORT FROM THE AHIMA 2014 CLINICAL DOCUMENTATION IMPROVEMENT SUMMIT

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## **Abstract**

The American Health Information Management Association (AHIMA) convened its annual Clinical Documentation Integrity (CDI) Summit in August 2014 in Washington, DC. The summit is committed to presenting interactive sessions, showcasing real-world examples, advancing networking opportunities, and providing critical insights to move CDI programs forward.

Current healthcare industry pressures demand change. AHIMA believes hospitals and providers, in all settings, must improve clinical documentation in preparation for the expanded scope of clinical data beyond a single patient encounter to a comprehensive data set across the continuum of care. The 2014 Summit took place in the aftermath of a Congressional action that delayed the implementation of ICD-10-CM/PCS code sets until October 2015. In recent months following the delay, AHIMA has heard conclusively that readiness and momentum towards the new code sets must continue and that CDI is an immediate opportunity.

Accurate clinical documentation is no longer a low-level priority for organizations today. It is a vital component to patient care, physician satisfaction, and revenue cycle strategies. CDI specialists, along with clinical care providers and senior management, must contribute to organizational success and ensure the right information is available at the right time. This paper presents findings and discussion from the 2014 summit and includes opportunities, challenges, and risks related to clinical documentation today. It also includes findings and AHIMA's recommendations for actions to develop and maintain accurate and timely documentation.

## **Introduction**

Since 1928, AHIMA has recognized that clinical data and information is a critical resource needed for efficacious healthcare. HIM professionals strive to ensure health information used in patient care is valid, accurate, complete, trustworthy, and timely. But current healthcare industry pressures are demanding change. AHIMA believes that hospitals and providers must improve clinical documentation in preparation for the expanded scope of clinical data beyond a single patient encounter to a comprehensive data set comprising the entire continuum of care.

AHIMA developed the CDI Summit to assist the industry lead the documentation journey and gain strategic advantage from implementing and maintaining accurate clinical documentation. This event provides a forum for thought leaders from all segments of the industry to engage in open discussion to better understand the perspectives of other stakeholder groups and develop opportunities to share best practices and lessons learned.

The goals of the 2014 CDI Summit were to:

- Provide information to refine implementation strategies by leveraging opportunities and best practices
- Move accurate documentation from a low-level priority to a strategic initiative
- Demonstrate the connection between CDI and revenue cycle management, physician satisfaction, and patient care

The meeting convened on August 4-5, 2014, in Washington, DC. Plenary sessions provided context for the discussions and assisted participants in focusing on key issues surrounding the need for accurate clinical documentation. Speakers included representatives from the American Hospital Association, eHealth Initiative, Precyse Solutions, Equifax Identity and Fraud Solutions, Verisys, National White Collar Crime Center, ChartWise Medical Systems, Inc., and J.A. Thomas and Associates (a Nuance company). Plenary sessions were followed by breakout sessions on topics including technology, success metrics, ICD-10-CM/PCS, and innovation.

This report presents findings and discussions from the 2014 summit and highlights short-term issues related to content discussed.

## **Background and Significance**

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was enacted, which prohibited the Secretary of HHS from adopting the ICD-10 code sets as the standard for code sets prior to October 1, 2015. In effect, Congress unexpectedly delayed the mandatory implementation of ICD-10-CM/PCS for at least one year. Subsequently, the Centers for Medicare and Medicaid Services (CMS) announced that a forthcoming final rule would set the new compliance date as October 1, 2015.

The announcement from CMS likely came as a relief to healthcare stakeholders, who were living in limbo trying to figure out how to proceed with ICD-10 implementation. In the aftermath of the delay, CDI programs emerged in the spotlight as a way to continue to move during the interim toward a smooth transition.

CDI is a process used in a variety of settings by employees who review clinical documentation and provide feedback to physicians regarding ambiguous information. The feedback is designed to fill in gaps in documentation so that clear and concise information is available for code assignment, quality measures, and overall patient care.

The impact of CDI is not limited to the code set change. Some organizations are choosing to implement CDI now to assist with technology advances and to track key metrics for success and innovation. A paper feedback loop is increasingly labor intensive, and many organizations are choosing to automate this process. Technology and innovative opportunities such as computer-assisted coding (CAC) and natural language processing (NLP) are opportunities to accomplish automation. It is also important to identify key metrics and understand what makes a CDI program successful. Without key metrics, the program's overall success cannot be measured.

## Opportunities

Information capture in healthcare today is very complex. Traditional mechanisms such as pen and paper and dictation are still in use. These methods are now joined by newer methodologies such as direct data entry, use of templates, and speech recognition. Anticipated benefits of a robust CDI program include:

- Quality measurement
  - Better data for evaluating and improving quality of care
  - Greater ability to ascertain disease severity for risk and severity adjustment
  - Greater ability to manage chronic diseases
  - Identification and reduction of medical errors
- Public health
  - Enhanced public health surveillance
- Research
  - Greater detail offers the ability to discover previously unrecognized relationships or uncover phenomenon such as incipient epidemics early
  - Expanded injury research and successful injury prevention strategies
- Organizational monitoring and performance
  - Administrative efficiencies
  - Cost containment
  - More accurate trend and cost analysis
  - Improved ability to analyze trend and cost data
  - More effective monitoring of resource and service utilization
- Reimbursement
  - Better justification of medical necessity
  - Fewer erroneous and rejected claims
  - Defense against audits
- Health information technology
  - Expanded computer-assisted coding technologies
  - Expanded use of natural language processing
  - Expanded use of speech recognition

## Challenges and Risks

There are many factors driving organizations and providers towards CDI, but efforts that focus strictly on maximizing reimbursement may expose risks of penalties and paybacks when audited. At the same time, some organizations feel challenged to obtain the reimbursement they have earned

while navigating the implied threat of upcoding.

Obtaining accurate, timely physician documentation is not always an easy task. However, physicians are key stakeholders in clinical documentation today. Who better to tell the patient story than the person responsible for writing it? Understanding clinical documentation from the physician's point of view is a key step in moving a CDI program forward.

There is some risk associated with the use of new technologies. For example, there are limitations when using NLP in a hybrid record environment. It's important to properly investigate whether NLP can truly be beneficial to the organization to ensure that the appropriate technology is implemented. Technologies such as speech recognition, NLP, and CAC can only be effective and efficient if the documentation being captured and analyzed is of good quality.

A thorough overview of the concept of forms management is required. Organizations that lack forms and data field management can expect a negative impact on reporting and analytics. Healthcare organizations have a daunting task to take inventory of all paper and electronic capture methods so that they can identify areas of inefficiency, duplication of effort, and common points where errors can be introduced.

There is a strong risk that the ICD-10 implementation delay will cause organizations and providers to lose momentum in implementation efforts. Every organization and provider should use the added implementation time wisely and perform a gap analysis of current patient care documentation. In addition, ICD-10-PCS will bring new documentation requirements due to its increased granularity and specificity. CDI specialists need to remember that all components of the procedure code must be identified or the procedure code cannot be applied. ICD-10-PCS guideline A11 states that it is the coder's responsibility to determine what the provider documentation equates to in ICD-10-PCS definition.<sup>1</sup> It is inappropriate to query a physician when the correlation between the documentation and the defined ICD-10-PCS term is clear.

There are a variety of reasons organizations choose to implement CDI programs, such as improving quality measures and patient care. Although reimbursement is a piece of a CDI program, organizations that implement CDI strictly as a means for increased reimbursement run the risk of alienating their providers. Accurate clinical documentation is a must to ensure the quality of patient care. This is true for any organization or setting implementing CDI. If the health record documentation is accurate and timely, then the need for queries will decrease and appropriate reimbursement will follow. Focusing solely on reimbursement will result in the decreased capture of quality measures, patient safety activities, and research needs.

Finally, the risk for fraud and abuse activities is a focus of the healthcare industry. Identity theft is the fastest-growing white collar crime in the US today, with up to 31 percent of individuals stating that a family member has stolen their healthcare insurance cards with their full knowledge.<sup>2</sup> In addition, the

healthcare industry has a tremendous problem with wasteful practices such as bad billing, increases in duplicative tests, and lack of ability to meet payer contracts that contribute to the cost of healthcare today. Clear documentation can help organizations combat fraud and abuse, while accurate and timely documentation can eliminate wasteful practices.

## **General Discussions and Findings**

Participants at the summit were given the opportunity to participate in audience polls. The aim of the polls was to better understand the operational nature of the audience's CDI programs. The questions and results are listed below.

*In what setting does your organization perform CDI?*

Inpatient only: 88%

Outpatient only: 0%

Both: 12%

*What insurance types does your organization review?*

Medicare: 16%

Medicaid: 0%

Other third-party payers: 4%

Mix of all payers: 80%

*What level of education do your CDI specialists have?*

Associate degree: 45% (includes RNs with no bachelor's degree)

Bachelor's degree: 31%

Master's degree: 17%

PhD or MD: 7%

*Does your organization document verbal queries?*

Yes: 35%

No: 65%

The survey results were conducted to obtain a basic understanding of how organizations are using CDI programs today. The audience was not surprised to see that the majority of organizations (88 percent) doing so were in the inpatient setting, and most (65 percent) agreed that documenting verbal queries was not warranted. The level of education for CDI specialists was predominantly associate's (45 percent) and bachelor's (31 percent) degrees. Registered nurses (RNs) with no bachelor's degree were captured at the associate's degree level.

It may have been somewhat surprising to see that the majority of organizations (80 percent) used

the CDI program across a mix of all payers. This could indicate that CDI programs are progressing past a reimbursement-driven program toward a documentation program geared to greater rewards in quality measures and patient safety.

Based on the content of summit presentations and commentary from audience members, a number of conclusions, observations, and key findings can be drawn.

General:

- Documentation is the beginning, not the end
- Better data will lead to better insights about health conditions and care management
- Technologies must be implemented correctly to achieve their full benefits
- CDI ties to information governance by ensuring that HIM and HIT work together to protect patients, providers, and organizations
- Use the ICD-10 delay to improve documentation
- The HIM, CDI, and quality areas must increase their knowledge of secondary data uses
- The role of CDI can apply to multiple settings such as acute care, physician practice, rehabilitation and long-term care
- Physicians must be taught the concepts of CDI in order to understand the return on investment of the program
- Physicians, coders and CDI specialists, and healthcare documentation specialists can unite around clinical documentation
- Fraud is rampant across all healthcare stakeholders
- Most people who commit healthcare fraud have already been involved in and committed credit card fraud<sup>3</sup>

Document Creation:

- If it isn't documented, it did not happen
- If it is documented, it's important to ask "is it also correct?"
- Appropriate forms management can positively impact documentation capture
- Focus on quality documentation
- Know the functionality of the electronic health record and how documentation capture occurs (e.g. pick list, drop down menu)

Technology:

- Do not rely on the electronic health record to perform queries by itself
- NLP technologies can facilitate the CDI process by pulling out key words
- Structured data will power analytics
- Use data analytics to determine risks, challenges, and highly volatile areas

- Develop a QA program for healthcare documentation to address broader quality issues separate from (but in collaboration with) the CDI program

#### Best Practices:

- Use the CDI program to capture accurate and timely patient safety indicators and quality management
- It is important to make sure the right people, processes, and technologies are utilized
- CDI should be consistent across the organization
- Key metrics for success include:
  - Query rate
  - Query quality
  - CC/MCC capture rates
  - CDI productivity
  - Physician specific query rate
- Involve the DRG coordinator to review for hospital-acquired conditions and patient severity
- Focus physician training on high-impact or high-performing physicians
- Provide physician-to-physician guidance

#### Conclusion

In order for the healthcare industry to prepare for new initiatives such as accountable care organizations, pay-for-performance, meaningful use, and a variety of other initiatives, clinical documentation must improve. It is imperative for organizations and providers to continue to seek clarification and guidance on documentation requirements. Top priorities during the next 12 months include identifying documentation gaps, achieving documentation excellence, and providing ongoing education to clinical providers.

Accurate documentation of patient encounters is the foundation for telling the patient's story, appropriate reimbursement, and quality reporting. As healthcare reform moves quickly towards quality-driven reimbursement, organizations and providers will have to continue to justify care plans and treatment options as well as successfully demonstrate quality outcomes and patient safety. Consistent, complete, and accurate documentation is the key to the economic health of the organization and a key indicator of physician quality. Organizations and providers need to be able to use automated, intuitive tools to successfully implement new technology, new federal requirements, and specific strategic initiatives without compromising patient care.

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