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The Importance of Clinical Documentation Improvement

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IMPORTANCE OF CLINICAL DOCUMENTATION IMPROVEMENT

The Importance of Clinical Documentation Improvement

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Abstract

The world of technology in the twenty first century is forever expanding. In the healthcare field, patient data has transformed from paper charts into electronic health records. Electronic health records allow for organized patient information however, an enormous amount of information becomes available. Sometimes the massive amount of information is not always needed but important detail the medical chart is looked for by insurance companies for reimbursement. There is a special department in hospitals called the Clinical Documentation Improvement specialists who are made up of experienced medical coders, registered nurses, mid-level practitioners such as nurse practitioner's s or physician's assistants and physicians. This team focus on the pertinent clinician documentation while the patient is hospitalized looking for accurate information depending on the patients diagnose/s and reducing low quality clinical records. The importance of precise patient information leads to the point of this project to demonstrate the value of clinical documentation improvement.

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Chapter 1- Introduction

Background

The growth of the electronic health record has expanded over years and continue to develop in the healthcare field. The transition of the paper charts to the electronic health records has allowed for structured and systematize patient information. Nevertheless, clinicians have made their daily notes of the patients progress a routine by copying and pasting outdated information. According to the Joint Commission, copying and pasting information can lead to redundant data in the electronic health record that no longer the acute reason as to why the patient is still hospitalized or being treated (Joint Commission, Division of Health Improvement, 2015). There is a team of specialist called the Clinical Documentation Improvement department who focus on the clarification of missing, conflicting or unclear documentation in the medical record. This department reduces irrelevant information in the medical record which decreases the chances of insurance companies sending hospitals denials based on the doctor's documentation.

Clinical documentation improvement has become a survival tactic for acute settings such as hospitals. The Centers of Medicare and Medicaid has implemented policies and procedures that needs a department to close the loop of communication from medical coders and physicians. The medical coders are the individuals who code the diagnoses or procedures that a patient is treated during hospitalized and the doctors are the ones who document. The clinical documentation improvement (CDI) specialist fills in the gaps that are missing in the chart by querying the doctor. CDI's main aspect is to document where insurance companies can easily understand charting by the doctors and allow for optimal reimbursement for treatments.

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Purpose of the study

The purpose of this study is to demonstrate the importance of the clinical documentation improvement team. The study will represent how the CDI department positively impacts hospitals which allows them to keep their doors open to serve the public. CDI continues to struggle with physician engagement. The CDI department queries doctors to answer questions however, physicians are not fully understanding the complete concept of the prominence of clinical documentation improvement. We as clinicians need to enlighten CDI and education on the value.

Significance of the Study

The advantages of having a clinical documentation improvement team in a hospital is to reflect correct reimbursement, increase patient care quality results and help rise ratings of care. CDI does not have direct impact on the scores of a hospital however, if the rates of a hospital is skewed the data behind the patient records tend to inaccurate or incomplete. My study is important to the profession of CDI because we as clinicians need to educate to other health care professionals the definition of CDI and what the team does.

Our problem is to continue to teach and obtain feedback on the importance CDI and what accurate documentation represents. Appropriate documentation includes patient's severity of illness (SOI) and risk of mortality (ROM), as well the accurate reporting of hospital –acquired complications (HACs), patient safety indicators (PSI's) and morality outcomes, all figure into quality measures that not only affect a hospitals' bottom line, but also go into defining where and how hospital allocate resources.

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Conceptual Frame of Reference

This project is based on the work done by the clinical improvement documentation team. A qualitative approach was used by using questionnaires and interviewing clinical documentation specialists; two who is a Registered Nurse and another person who is doctor. In addition, I have interviewed and conducted a questionnaire with two medical coders. One coder has thirty years of experience and other coder has a few months of coding experience. The model I am working with for this study is to demonstrate the importance of CDI and decrease of the frustration of the set back of education of CDI.

Research Questions

This project will attempt to answer the following questions:

Why is CDI important to hospitals?

Why is it valuable for health care professionals to be educated on CDI?

Has the Electronic Health Record impacted CDI?

What is a query? What do queries represent?

Definition of Terms

CDI- facilitates a representation of a patient's clinical status that is transformed into coded information; ensures there are no gaps in communication when it comes to patient documentation.

Query- either a written or verbal clarification used by the CDI team to ensure documentation in the health record is clear.

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Definition of Terms continued

Medical Coding- transformation of patient's diagnoses and procedures into medical alphanumeric coders.

Patient-an individual who is receiving care by a clinician

Clinician- a licensed care professional.

Limitations

There were limitations with conducting this study. The population of interviewees for the questionnaire were a small group. A population with a larger amount of individuals would allow for more information to be obtained however, the world of CDI is limited. There was only one geographic area used and completing the questionnaire was voluntary. Bias is always an issue depending on the outlook of the employee with their relationship with CDI.

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Chapter 2- Review of Literature

A literature search was done in the PubMed database as well as Google with the help of the UTHSC's librarian at phone number 9014485634. All the articles that will be discussed were written before 2013. The main terms used in the search were: Importance, CDI, clinical, documentation, improvement, medical record and notes. There were over two hundred articles available for search, however when clicking on the abstract of the article only half were relevant to the topic in some way. Overall, I found four articles to have relevance of proving the importance of CDI in the medical field.

The article reviewed to have the most relation to the study took place in a hospital setting where trauma surgeons focused on documentation improvement benefits. The article explained the translation gap between doctors who document in the medical record and medical coders who decide the code that are submitted to the insurance companies for reimbursement (Willcutt, Swierczynski, Mazzarelli, Fox, & Elberfeld, 2016). Physicians are not educated on documentation improvement strategies regardless of the fact that their documentation represents reimbursement, revenue and outcome. In this study, all Level 1 trauma center surgeons were mandated for training on documentation improvement. After the training, surgeon's response rate to queries were 100%. Overall, revenue recovery was over million dollars; resulting education is effective method to engage physicians in documentation improvement.

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Chapter 2

Review of Literature continued

Another study demonstrates how CDI helped ease the transition of ICD-10. The world of ICD-10 has had the lives of coders and doctors a bit more complex. For instance, if a patient comes in with a diagnose of asthma, doctors have to specific in their documentation the asthma severity classification scale which indicates if the asthma is intermittent, mild persistent, moderate persistent or severe persistent. Also, another example is if the patient has come in for a diagnose of exacerbation of congestive heart failure, hospitalist or attending doctors have to reveal the ordinarily, is this exacerbation initial or a subsequent visit? This shows without doctor's engagement CDI programs will not be successful.

In contrast, another study was reviewed where organized clinical documentation in the electronic medical record showed improved quality and supported practice-research. The study produced a workflow assessment for patients who were being assessed for epilepsy. Every two weeks, neurosurgeons along with the informatics team at the Northshore Hospital came together and review the outcome. It was not specific in the study, the percentage of improved quality of care through clinical documentation in the EHR but, workflow assessment has helped participation of all parties. There were no studies that directly demonstrated the rates of how important CDI is in the world of the electronic medical record. However, the literature supports the fact in multiple settings improved clinical documentation has increase quality, reimbursement and participation. Moreover, as clinical documentation becomes more imperative in the healthcare field more information will be easily assessable for the public.

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Chapter 3- Methodology

Under the Methodology section, the reader will find out how research was designed, the population used, the facility selected, the information collections utilized to review data and the questionnaire used to obtain the data.

Research Design

The type of research design that has been proposed is the Descriptive method by using a questionnaire. The questionnaire was broken into two parts, the first section focusing on the clinical documentation improvement questions. The second part asked about coding questions. All the questions were open-ended to gain extra insight.

Population and Sample Design

The study was limited to five participants all of whom were once medical coders and now work as clinical documentation improvement specialists in NYU hospital in the New York City. The participants varied in age, gender, years of experience and educational backgrounds. The questionnaire was sent via email to the participants. I had to send follow up emails for responses. Nevertheless, five participants answered back in a timely manner.

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Data Collection Procedures

I sent out my questionnaires via email using open-ended questions. I used a qualitative questions to give participants the ability share their views and opinions based on the question. I had to send follow up emails to two participants to ensure they haven't forgotten about the questionnaire. I sent a brief explanation on the top of the questionnaire explaining to please add if I haven't cover the main points of CDI, please (see figure 1).

Figure-1 Cover letter

Dear Participate,

I am conducting a research paper on the importance of Clinical Documentation Improvement with a qualitative approach. I am currently enrolled at the University of Tennessee at the Health Science in Memphis, TN. The completion of the questionnaire is completely voluntary. I thank you beforehand for filling out the questionnaire below. Please add any questions and answers you think I would benefit for my paper.

Regards,

Amanda S. Baksh

Health Informatics and Information Management Student

516.508.8217

Data Collection Instrument

The survey instrument was focused on six questions on clinical documentation improvement and then three questions based on medical coding.

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Data Collection Instruction Continued

The questionnaire was developed based on the topic of clinical documentation improvement to show the importance of the team in the healthcare team. The clinical documentation specialist included registered nurses and doctors using open-ended questions. See figure 2.

Figure 2- Questionnaire

1. Define Clinical Documentation Improvement in your own words.
2. Has EHR impacted CDI workflow?
3. What is a query? How long does a doctor have to answer to a query? What is the importance of a query? Are the queries at NYU hospital automated?
How long does the provider take to respond/answer to a query?
How are the queries communicated in NYU?
4. How does CDI impact on patient's quality of care?
5. What is the new opportunities in CDI and how to expand?
6. How do CDI department engage physicians as to the benefit of accurate documentation and coding?
7. How EHR implementation impacted coders/ coding?
8. Explain how coders transitioned for ICD 10 implementation
9. Do coders and CDI specialist have to work as a team? If so, why?
10. How many years have you been a CDI specialist or a medical coder?

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Data Analysis

Overall, this area will explain response rate of the questionnaire that was conducted. The research questions should be addressed.

Response rate

There were five participants who answered the questionnaires via email. Three participants answered within the first week, the two individuals needed a follow up email.

Representativeness of Sample

The sample that was chosen was a hospital in New York City called NYU hospital.

Profile or Sample or Population

The population of people were picked based on their profession. The individuals had to be medical coders in the beginning of their career and then had to progress to a clinical documentation improvement specialist.

Summary of the Chapter

The methodology was reviewed along with the evaluation of the study. In addition, the population and sample design was discussed. The collection of information as well as the data instrument and data analysis were assessed.

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Chapter 4 -Results

In chapter four, the final analysis and the results from the questionnaire will be reviewed. The details of the questionnaire that will be discussed are the response rate of the sample population, representativeness of the sample, reliability of the instrument, the research questions and the statistical analysis from the questionnaire instrument.

Response Rate of Sample/Population:

I sent out five emails with questionnaires. Three participants answered within the first week and the other two answered after a follow up email from myself. There was a 100% response rate.

Representativeness of Sample:

The hospital chosen is one of the most recognized organizations in New York City, New York Langone Medical Center. The questionnaire was sent via email to three CDI specialists and two medical coders. These five representatives were chosen to complete the questionnaire because of they're of their position with the medical record documentation quality.

Profile of Sample/Population:

See table 1 for years of experience of CDI specialist and medical coders.

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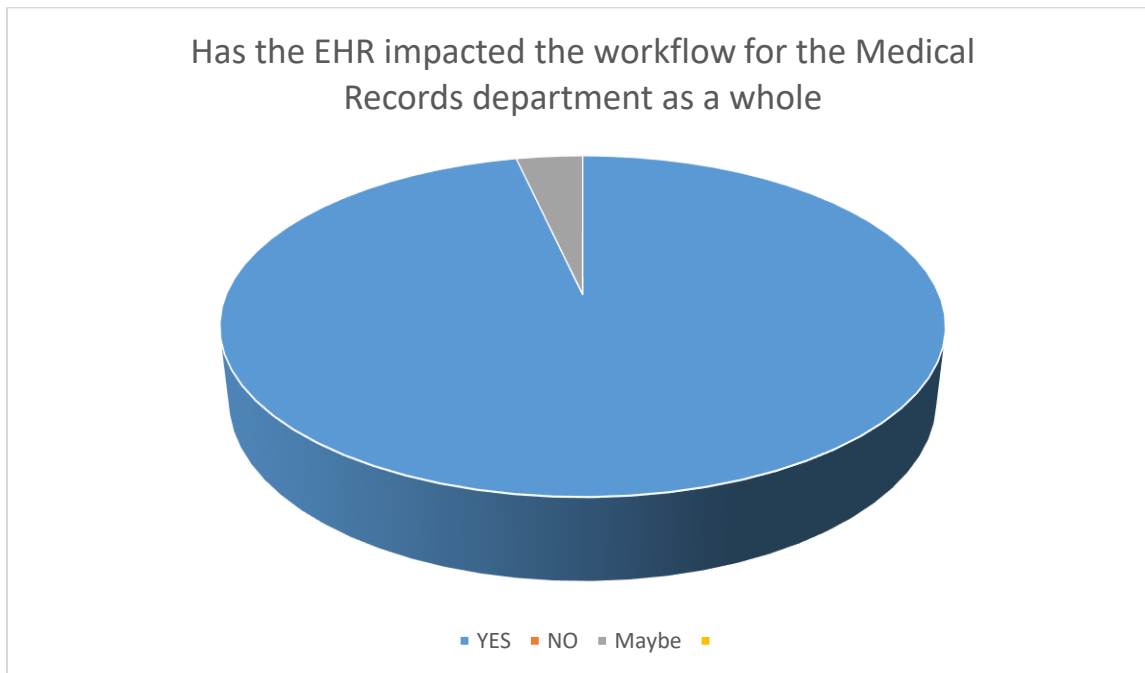
Table 1 - Participants

Participants					
Years of Experience	0-2 years	3-5 years	6-8 years	10-15 years	Over 16 years
Medical Coder	I	I			
CDI specialist			I		
Both Medical Coder and CDI Specialist				II	

5

The data was placed in a spreadsheet and free text comments were noted to allow for open-ended answers.

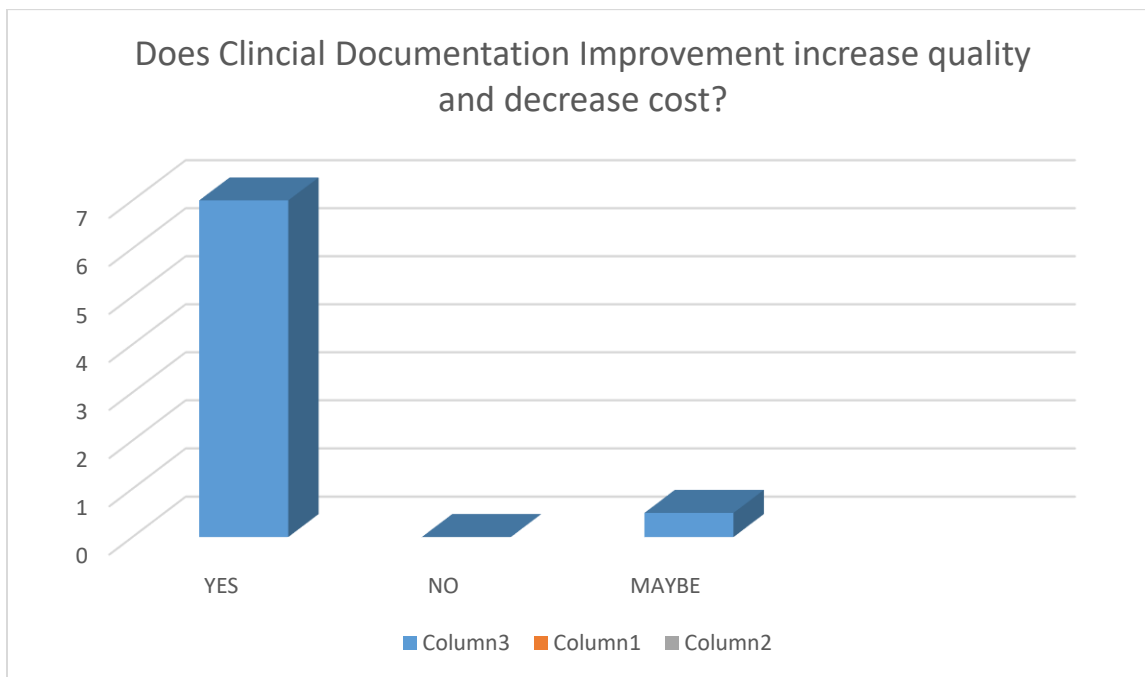
Table 2 – How the Electronic Health Record impacts workflow



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Table 2 demonstrates how CDI specialist and medical coders view how the electronic health record has impacted their workflow.

Table 3- CDI increases quality and decreases cost



Research Question

The overall consensus shows the EHR has affected workflow. In addition, clinical documentation improvement in fact enhances the quality of documentation and patient care in the long term.

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Summary of the Chapter

The results of this chapter demonstrates the results of the questionnaire. The charts above represent the response rate, the representative of the sample and the results of the information pertaining to the questionnaire.

Chapter 5- Conclusion and Recommendations

In chapter five the summary findings, implications of the stud and recommendations regarding clinical documentation improvement will be discussed.

Summary of Findings

Based on the questionnaires answers received, the importance of clinical documentation improvement is important. CDI reflects appropriate reimbursement and correct quality scores. Thanks to the CDI department, there has been a positive change in quality metrics. The rates of mortality and the length of stay has been reduced. However, remember CDI does not change patient care but has paid detailed attention to the documentation. Nevertheless, documentation goes hand and hand with patient care because if mortality rates are decreasing; more patients will want to that particular hospital to be treated.

Conclusion

Hospitals and other healthcare organizations are recognizing the important of CDI. The overall perceptions of the CDI team are to help and increase positively within a company. There may be health care institutions who may identify cost of a CDI department a concern, however when looking at the entire image the outlook of the department remains constructive.

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Implications of Study/Limitations

My results of the questionnaire demonstrate CDI does increase quality and stands to be an important factor within healthcare. The limitations of this study is there was only five individuals who completed the questionnaire. However, I did conduct this study with a large health care practice that deals with inpatient, outpatient and ambulatory services.

Recommendations

This study did consider the individual's profession but did not judge base on gender or age. CDI is a growing department which many health care professionals including physicians have yet to be educated on. This small study may create additional questions for a future study, such as can CDI be outsourced to save on cost? Will CDI be as worthy as the department is when actually located within a health care corporation versus. outsourced?

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Chapter 6

Conclusion

Applicable documentation is important by saving establishments money, however initially that organization may have to invest into a sturdy CDI department. Correct documentation includes patient's information on severity of illness (SOI), risk of mortality (ROM), hospital acquired complications (HACs) such as urinary tract infections or pneumonia developed while hospitalized, patient safety indicators (PSIs), and mortality outcomes all reflect the hospital's score outcome. These scores also define where and how hospitals allocate their resources. This all ties into how CDI reflect reimbursement and quality. Remember, as stated above CDI doesn't have direct contact with patient care however, CDI improves patient care and EMR documentation indirectly. The CDI team is in the back end reviewing and ensuring all the other departments are doing the best job possible.

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