Clinical Documentation Integrity's Quality and Cost Implications

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Healthcare analysts and industry experts are forecasting that operating margins will remain depressed for the remainder of 2021. In fact, the number of healthcare systems currently experiencing negative margins will most likely continue increasing, and the financial stability of all hospitals nationwide (especially rural and critical-access hospitals) will feel significant effects from the pandemic.[1]

Elective surgeries are once again being placed on hold as available physical space within the hospital walls is limited, and longstanding staff shortages continue and likely will increase through 2030. Knowing this, health system executives are seeking ways to buoy the financial stability of their organizations. And one of the possibilities that would support their journey to operational excellence? **Clinical documentation integrity.**

Our front-line leaders have been battling the pandemic for more than 18 months. They are overwhelmed with the day-to-day pressures of providing exceptional patient care amid chronic staffing difficulties and meeting the threshold for minimal documentation requirements for professional and hospital billing. Clinicians strive to ensure critical elements of documentation are recorded, but this can prove difficult. Sometimes their efforts will fall short given the increasing complexity of patient care.

Partnering with clinical documentation experts will safeguard patient documentation and confirm that the medical record accurately reflects and essentially paints the precise picture of a patient's illness including diagnoses, clinical indicators, and procedures.

Clinical Documentation Integrity Overview

The clinical documentation integrity (CDI) process incorporates diagnoses and procedures into the medical record, supported by precise and appropriate clinical indicators, including appropriate ICD-10-CM and ICD-10-PCS codes.[2,3]

Today, over 72,700 ICD-10-CM diagnosis codes and 78,200 ICD-10-CM procedure codes are used to accurately reflect clinician documentation.[4] Every one of these codes is correlated with the documentation gleaned from patient medical records, which is then conveyed to numerous health insurance payers and plans, the Centers for Medicare & Medicaid Services (CMS), Leapfrog Group, Healthgrades, and more.[1,5]

Clinical documentation contained in a patient's medical record should reflect the care provided as well as the time and resources expended in the provision of care. More importantly, inaccurate documentation of patient symptoms and corresponding diagnoses can result in a diminished reflection of actual patient acuity and essential care provided. An inadequate representation poses greater potential for a less precise diagnosis related group (DRG) classification and resultant reduced reimbursement for your healthcare organization.
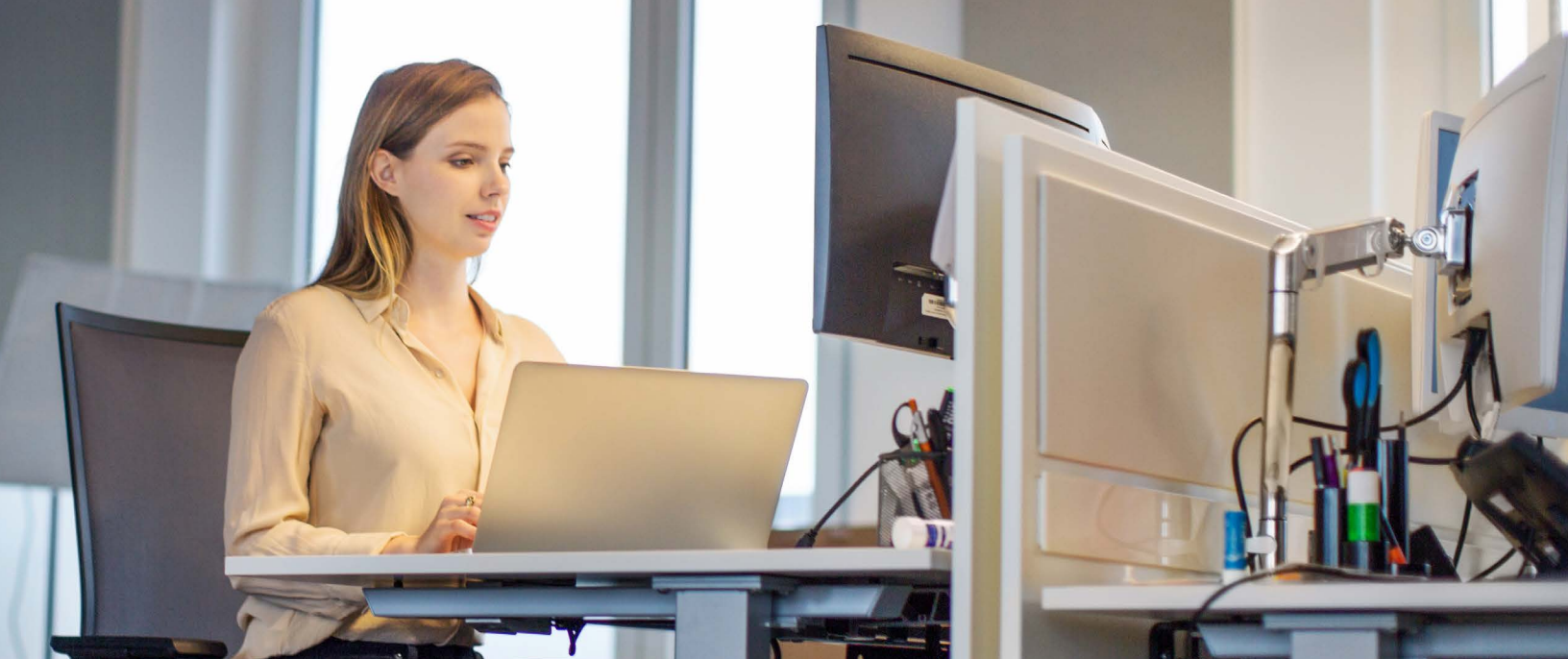
An essential responsibility for CDI teams is to closely evaluate patient medical records and search for opportunities to further clarify documentation. When an opportunity is identified, a query is then presented to the provider to ensure that the patient's severity of illness and risk of mortality is reflected in the medical record. From these conversations, the most accurate codes are then conveyed to the appropriate audience.

In addition to reviewing records, CDI teams craft and facilitate education to broaden the foundational knowledge for providers in all service lines. With the understanding that codes and subsequent coding guidance from CMS most likely will change from year to year, **CDI teams proactively broaden their own knowledge and understanding to ensure that required documentation updates are included in additional provider training and that no unintended gaps in documentation occur.[4]**

Clinical documentation integrity departments play an important role, not only in supporting providers, but also in ensuring that their health system's performance is accurately represented, as they will be compared to competitors in their immediate and surrounding communities and as on the regional and national level.[6] The trained CDI specialist closely interprets patient medical records recorded by providers to validate that the documentation is both accurate and complete. In addition, clinical documentation integrity specialists perform comprehensive analyses and verification of corresponding codes, ensuring that health systems are afforded the largest and most accurate reimbursements.

CDI specialists can recognize and appreciate that clinical documentation from the medical record is the foundation for data capture and ultimately used in reporting for patient safety indicators (PSI), hospital-acquired conditions (HAC), hierarchical conditions (HCC), quality measures (QM), hospital mortality ratios (observed and expected mortality calculations), accurate lengths of stay (LOS), diagnosis related grouper (DRG) assignments, and overall standings as compared to competitors.[5,6,7,8] HACs and PSIs are reported according to documentation as found in the medical record.

On the occasion a HAC or PSI occurs, reimbursement and quality scores can be significantly impacted. In fact, CMS will adjust or reduce reimbursements for healthcare organizations because of their sub-optimal quality outcomes.[9, 10]

However, CDI specialists are acutely aware of and are trained to recognize specific exclusions to patient safety indicators and hospital-acquired conditions. They can subsequently query providers about potential exclusions when these opportunities are identified.[11]

Challenges of Implementing Clinical Documentation Support

As already detailed, health systems realize numerous substantial advantages when establishing a CDI program. Specifically, hospitals can see benefits such as improved standing or ranking among their competitors and, perhaps most significant considering the enduring pandemic, stronger financial stability and security. While considerable positive impacts can be realized, any program can encounter challenges when beginning the journey to successful implementation.
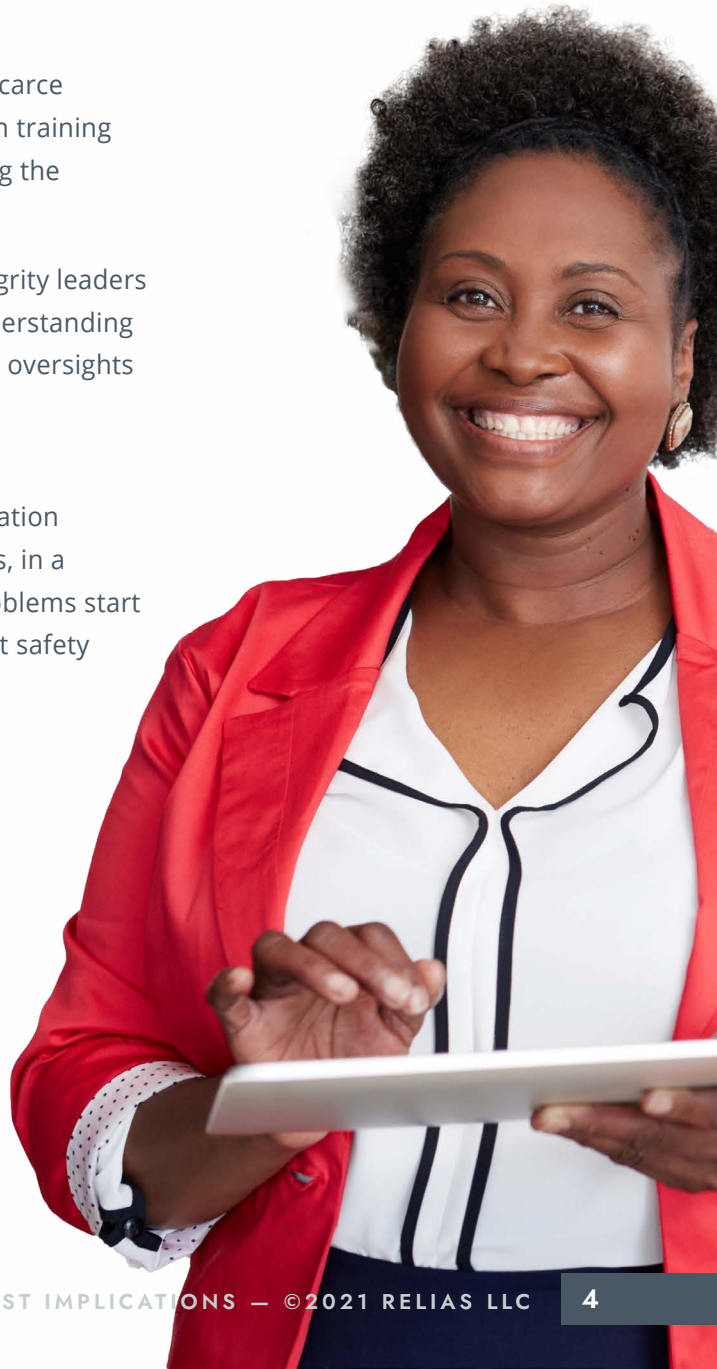
A nationwide survey in 2015 revealed that 98.5% of CDI programs identified providers that could benefit from improvements in documentation practices.[12] These findings are critical for health systems to understand, as active provider participation and engagement are key factors in realizing a productive and effective CDI program.

Additionally, lack of provider engagement can be associated with scarce buy-in or support from hospital leaders, minimal ongoing physician training regarding documentation requirements, and gaps in understanding the ramifications caused by imprecise documentation.[12]

While these factors might seem minor, clinical documentation integrity leaders with foundational knowledge of the revenue cycle have a solid understanding of the potential consequences of inadequate documentation. Such oversights can bring significant negative repercussions for health systems.

The overall ramifications of poor documentation are far reaching, as noted by Gina Stewart, BSN, RN, CCS, CCDS, a clinical documentation improvement practice director and senior consultant at e4 Services, in a 2016 interview with *For The Record*.[13] She pointed out that these problems start at the front line, and most importantly, can be correlated to patient safety issues. Additionally, these missed opportunities tend to persist and can bring undesirable effects on a hospital's financial health.

In the end, the results of poor documentation can feed a negative cycle.[13] Combined with time constraints and strained resources, these challenges can worsen provider burnout, which will eventually bring inconsistent and unclear documentation that fails to accurately reflect care delivered and appropriate DRG assignments. Given all of this, once successful in securing leadership buy-in and provider collaboration, consider strategies for validating the return on investment (ROI) in your CDI program.

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The complexity and ever-changing electronic health record also poses a challenge for frontline providers and clinical documentation teams. The adoption of the HITECH Act in 2009, which encouraged healthcare facilities to adopt electronic health records (EHRs) to improve privacy and security of healthcare data, has added to provider stress.[14,15] Some physicians have stated that EHRs turn a patient encounter into a test of physician data entry and can limit their ability to expand on their comments within the record.

The additional pressure of EHRs, coupled with clinical documentation queries, can pose a barrier to the partnership meant to support, not hinder, providers and the entire hospital system. In 2019, *EHR Intelligence* published an article highlighting research by Philip Kroth, MD, director of biomedical informatics research at the University of New Mexico, which revealed that up to 40% of physician stress is directly related to an electronic medical record.[16] Therefore, designing organizational strategies to alleviate that stress can be valuable. Strong CDI teams can help improve communication among care teams and reduce unnecessary stress related to documentation.

Best Practices for a Successful
Clinical Documentation Integrity Program

A strong CDI program aligns with hospital key performance indicators and supports the achievement of strategic business objectives.

To ensure a successful program that minimizes errors and supports a flourishing partnership with providers, you must have a knowledgeable clinical documentation team. Providing the right educational foundation to your department will instill the confidence in your team to create a trusting relationship with front-line providers.

Education can ensure the competence of the CDI team, promote the accurate reflection of physician documentation and avoid unnecessary over- or under-coding.[6] Choosing the right education platform can be challenging, especially when there are a multitude of options available. When making your choice, be sure to **consider ways to address differing learning styles and the specific goals of your department and the health system. In addition, look for a platform that offers continuing education that continually evolves to align with updated CDI practice guidance.**

A well-trained clinical documentation team will be armed with the knowledge of what to look for in the medical record and close the gaps in clinical documentation that will lead to improved revenue and overall higher documentation quality.[11]

CDI programs are not a one-size-fits-all design. Health system executives are responsible for the management and improvement of several quality measures, and a CDI program should support those commitments. A strong CDI program aligns with hospital key performance indicators and supports the achievement of strategic business objectives.

Without an established CDI program in place, healthcare organizations risk the integrity of their rankings and physician quality profiles, as they may not reflect the true extent of their patients' needs. Inadequate data can therefore harm the organization's financial health and its reputation. Not only are hospitals at risk, physician groups are also in danger of falling short on the integrity of their medical records.

All this underscores how the accuracy of delivered and documented care can intensely reflect on patients' well-being and the organization's financial health and stability. Understanding this, the clinical documentation department leaders should meet regularly with hospital executives to ensure that mutual goals still align, and improvements are being achieved with the current design.[17] As the CDI program evolves, so do the requirements for documentation. Programs must keep up to date on their education so they can provide accurate and timely information to providers, validate medical record completeness, ensure accurate reimbursements, and enhance the organization's financial stability.

Once hospital leaders and CDI teams are aligned with the same business objectives, the next step is expanding the partnership to frontline providers. However, this step can bring its own hurdles to overcome. In addition to providing excellent patient care, providers have the challenge of grasping an understanding of the many regulations for medical record documentation — not only for professional billing, but also for overall hospital billing. Providing efficient education options for providers and other members of the CDI team can help address this issue.

CDI specialists will work with physicians to ensure that their documentation is reflective of both the clinical perspective and evidence-based practices. Progress notes are becoming more extensive, queries are mounting, and understanding the "why" could very well be the key to strengthening provider compliance with queries and lessening provider angst.

Additionally, not fully grasping the impact of inadequate documentation is a huge barrier. The CDI team should be alerting providers how care quality is increasingly tied to revenue through accurate documentation in the medical record and incomplete or inaccurate documentation can result in lower reimbursements. Once providers understand the importance of documentation, they will be more willing to master important elements of the task.

CDI specialists are trained to not only query providers but to also create education that makes the ever-changing world of coding easier to navigate. The partnership between clinical documentation specialists and frontline providers is essential for a successful outcome.

Being able to show the ROI of the clinical documentation program is of the utmost importance, but it can also be difficult to accurately depict. Measuring the impact of your program can be challenging since data from outside sources is not provided in real time. In fact, many elements are delayed by months or even years. For more timely data, many coding

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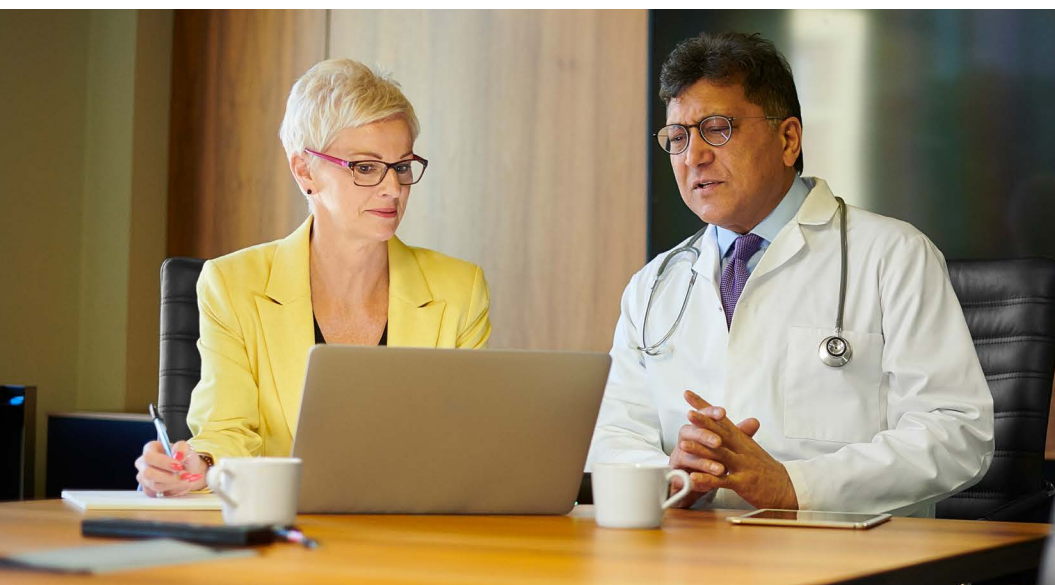
applications offer reporting that will report the change in DRG, SOI, and ROM based on clinical documentation queries. The data compiled by the application is in real time and can offer information that can not only be used at an institutional level but also in enhancing the knowledge of the CDI team.

This information is vital in revealing what impact your team has on the overall health of your institution. Many organizations want to see the ROI to support or justify the development or expansion of a CDI department. But the tangible impact realized by a CDI team extends beyond merely capturing revenue. Not only should you be showing the DRG, SOI, and ROM movement, but your data should include the HAC, and PSI penalties avoided by CDI queries, which safeguarded your revenue by limiting your risk of seeing payments reduced for these hospital-acquired conditions.

Let's consider the example of clinical documentation recorded as *patient has a stage 3 sacral pressure ulcer*. However, the record has no mention of the ulcer being *present on admission*. The CDI specialist is trained to spot this documentation opportunity and query the provider to clarify whether this instance was indeed a HAC, potentially saving the organization from an unnecessary penalty.

In addition to showing the data from the report to leaders, having a departmental measuring system is also vital to the health of your department. CDI metrics can reflect the success of a program and identify any areas where opportunities reside. The departmental metrics usually include case mix index (CMI) movement, new review rate, re-review rate, query rate, response rate, response time, and quality impact.[17]

Reviewing your departmental metrics can help identify educational needs for your team and in turn improve the overall impact to your institution. In addition, departmental metrics also reveal the success or opportunities for growth of your CDI department's partnership with hospital providers.[11] If your team has a low response rate or lengthy response time, that information reflects a lack of provider engagement. Identifying these factors highlights an opportunity to educate providers and potentially the CDI team regarding building and maintaining relationships with providers.

Implementing and sustaining a successful partnership with CDI teams hinges on unwavering and sustained support from healthcare leaders and the proper education of CDI professionals, who in turn can promote best practices with other team members. Executives have the crucial responsibility of providing

consistent messaging about the importance of cultivating a solid partnership with CDI team members. **A steady and unwavering commitment to education, competency, and collaboration buoys the underlying fundamentals of data accuracy and continued improvements in medical record documentation.**

As your CDI teams continually bolster their expertise, they can be a driving force in promoting awareness of the unforeseen consequences of inaccurate data recording practices. By enhancing your entire care team's competence in this arena through ongoing education, you can secure the safest care environment, ensure optimal patient outcomes, and ultimately strengthen the financial position of the hospital. Given the highly complex and ever-changing regulatory environment, clinical documentation integrity expertise is crucial for the long-term financial health and stability of healthcare organizations.

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