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Insights and actions for successful results

# Revenue Cycle Strategist

## **Clinical Documentation Improvement: Preparing for Payment Changes**

By Colleen Garry and Susan Pletcher

Improving clinical documentation is a win-win undertaking.

Improving its clinical documentation helped the Medical University of South Carolina (MUSC) better position itself for the upcoming changes in the inpatient prospective payment system. MUSC implemented a clinical documentation improvement (CDI) program in January 2005. The program has enabled MUSC to increase/sustain the case mix index from 1.73 (at the inception) to 1.80+ for FY06 and FY07. The "all patient refined" diagnosis-related groups (APR-DRGs), which takes into account risk of mortality and severity of illness, increased from 1.70 initially to 1.90+ for FY06 and FY07.

MUSC employed consultants to assist with the development, training, and roll-out of the program. Using the consulting group allowed MUSC to build a strong foundation and increase its understanding and comfort level with the documentation improvement process.

### **Lessons Learned from CDI**

Some of the lessons learned from implementing the CDI program at MUSC may help others as they look at undertaking a similar quest. The following are "must haves" for a successful CDI program.

*Ensure visible support from administration and medical director.* This leadership support will prevent roadblocks.

*Align CDI program with organizational goals.* Create a win-win situation. For example, MUSC has organizational goals pertaining to service, people, quality, finance, and growth. One of the quality goals is to decrease the mortality index. The mortality index is determined by data derived from documentation in the medical record. Creating awareness of shared goals allows for increased participation/cooperation.



*Hire the right staff.* MUSC hired registered nurses as clinical documentation specialists. This decision was based on the feeling that a nurse could acquire coding knowledge faster than a coder could be trained clinically. Nurses are experienced and comfortable communicating with physicians. As an added bonus, nurses may be better equipped to assist in the Centers for Medicare and Medicaid Services' (CMS) future quality initiatives anticipated to potentially affect finances.

*Maintain flexibility.* The staff does not have permanent floor/service assignments; rather, they rotate services. We believe this rotation has been beneficial in providing accountability for results and flexibility with coverage, while increasing employee satisfaction.

*Dedicate resources.* If the nurse reviewer role was incorporated into another existing job (for example, utilization review or case management), the documentation improvement tasks would take a secondary role to any patient care issues. The CDI program must have a committed role within the institution. Concurrent chart reviews need to be the priority. Colleagues have indicated that combining roles leads to suboptimal results and staff frustration.

*Foster an atmosphere of teamwork.* Develop professionally respectful relationships with the coding, compliance, and outcomes departments.

*Involve physicians.* Ask the physicians for input and feedback. Round with physicians, and invite the coders to join in. Provide benchmark comparatives to clinicians, and discuss the impacts of reported/coded data, such as data from the Medicare Provider Analysis and Review (MEDPAR), HealthGrades, and the Program for Evaluating Payment Patterns Electronic Report (PEPPER). Develop templates, query forms, and educational pocket guides for physicians to make compliance easier.

*Set quarterly goals.* Make sure the team is aware of/supports the goal. One example might be to have the outcome focused on benchmark data; another might be to audit high-volume opportunities or perhaps targeted DRGs. Measurement and reporting timely results are necessary to keep the momentum going. Develop data-driven goals.

*Plan ongoing collaborative education.* Schedule "lunch and learn" seminars to discuss CMS updates, query opportunities, and quarterly reports. Invite clinicians to speak on clinical topics. Engage staff members to facilitate meetings.

*Conduct quality audits (concurrent and retrospective).* Establish criteria for automatic reviews; for example, audit all intensive care unit patients or decedent patients with a severity of illness or APR score of less than 3 (severe), or all patients with a length of stay of more than X number of days. Work with physician champions to prioritize your qualifiers.



Quality audits and financial variance audits are integral pieces to any successful CDI program.

*Network with managers from other CDI programs.* Become involved. Participate in work groups. Join professional organizations, such as the Association for Clinical Documentation Improvement Specialists. Take your program to the next level.

*Conduct quarterly meetings with key personnel (administrators, medical director, coding manager, compliance manager, physician champions, CDI manager, and director).* Provide accurate outcomes and financial data. Reports should be shared with coding and CDI staff. Accountability is essential. Foster a “how can we perform better” attitude. Once the program is well established, the meetings may be held less frequently. Electronic quarterly reports may then become the primary method of communication.

*Have a pioneer spirit, enjoy the process, and be positive, flexible, and ethical.* CDI improvement is a new role in health care, merging clinical expertise with business application. No longer can the two exist separately.

### **Benefits of CDI**

MUSC's CDI program has improved the case mix index and revenue as a result of more complete documentation. The role of the documentation specialist is key to ensuring correct coding and continuity of care through documentation of patient conditions. The leading CDI programs will continue to be flexible in structure, allowing for redirection based on CMS guidelines and quality of care issues.

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