CDI Programs Support Meeting Meaningful Use

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Information quality, better access to health information, and greater information exchange are in store for eligible providers, eligible hospitals, and critical access hospitals expecting to attest to stage 2 of the Centers for Medicare and Medicaid Services' (CMS) "meaningful use" EHR Incentive Program. On the table for eligible hospitals is a potential $2 million base payment for successfully implementing an electronic health record (EHR).

In order to obtain the potential payments, hospitals must be able to demonstrate compliance with key objectives and measures. Stage 1 criteria set the building blocks for hospitals and providers eager to begin demonstrating meaningful use of certified technology. But implementing an EHR alone was not sufficient to meet the requirements of the program, and compliance with stage 1 criteria was never meant to be the end of the story.

Later Stages Increase Quality Metrics

To successfully demonstrate meaningful use, hospitals must continue to meet the expanded criteria of stage 2, released in 2012, and stage 3, to be announced at a later date. Stage 2 criteria add to the measurement complexity, challenging participants to meet higher measures as they advance through the program stages.

Of particular concern to clinical documentation improvement (CDI) specialists may be the clinical quality measures (CQM) defined in stage 1. These measures continue in stage 2, though CQMs have been removed from the core and menu sets. Now facilities must meet CQMs as separate objectives and all providers are required to report on CQMs. This approach will become effective in 2014 when all CQMs must be electronically submitted to CMS.

To demonstrate compliance in 2013 eligible providers will continue to report from 44 measures finalized in stage 1, in the same schema that includes reporting on three core measures, and three additional measures. Eligible hospitals and critical access hospitals will continue to report the 15 measures finalized for stage 1. Of note is that National Quality Forum's (NQF) 0013 measure is a core CQM in the stage 1 final rule. In the 2014 certification criteria NQF 0013 is no longer available, and eligible providers will need to choose an alternative measure to report on. A successful CDI program may be the ideal place for organizations to track these measures and ensure that the appropriate new measure is tracked.

In 2014 and beyond eligible physicians must report on nine of 64 approved CQMs. Eligible hospitals and critical access hospitals must report on 16 of 29 approved CQMs. All three providers must select at least three of the CQMs that are a part of the National Quality Strategy domains. Measures fall within six domains:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

CDI professionals can assist organizations in reviewing the domains and assist organizations in making a determination as to which domains best fit the organization and what initiatives or measures are already captured. And finally, beginning in 2014 all providers beyond their first year of demonstrating meaningful use must electronically report CQM data to CMS. This final requirement will increase the need for accurate and concise documentation at the point of care.

Quality Measures Submitted Electronically

Historically, reporting quality measures may have been a paper-based process for some facilities, thus creating an error-prone system reliant upon human interaction to review the record and report measurements.

Retrospective data mining of billing information is another trouble area. Through this system, facilities routinely reported information via standardized billing documents. Because the review was retrospective, however, the lag time between billing and reporting can often be several months apart.

Under stage 2 the CQM measures are to be electronically submitted to CMS in 2014. This requirement will create added burdens for hospitals that do not have processes in place to ensure clinical documentation is clear and concise at the point of care. A successful CDI program provides the assistance organizations need to ensure documentation is clear, accurate, and reflective of severity of illness. In addition, CDI staff can assist the organization in identifying where the information will be captured, from which system, and ensure that the information can be pulled accurately.

All too often, physicians are unaware of the specific terminology required for proper code assignment. Coders in turn may lack clinical training that allows them to correlate documentation and code assignment. The CDI program and staff are the bridge between physicians, their clinical documentation, and the resulting clinical code assignment made by the coding professional. Through the ongoing education and training of all three groups, organizations can be confident that the coded data needed for electronic quality measure reporting is accurate.

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