CDI Programs Used to Improve Quality Reporting Accuracy

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A key focus of clinical documentation improvement (CDI) programs is to identify deficiencies in clinical documentation and develop methods to ensure the complete and accurate capture of a patient's clinical encounter. Healthcare records that are inaccurate or incomplete will compromise clinical decision support, accurate reimbursement, and quality of care reporting. CDI programs have focused on improving the accuracy of coding and reimbursement. However, the increased need for interpreting coded data and clinical documentation for quality reviews and reporting is expanding the role of CDI professionals.

Uses of Quality Reporting

The purpose of quality reporting is for organizations to measure the quality of care delivered and identify areas in need of improvement. Since the early 1990s, there has been a steady increase in federal regulations and accreditation agencies requiring healthcare organizations to report quality of care measures to reporting agencies such as the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, and the National Committee for Quality Assurance (NCQA).

For example, hospitals have been reporting quality measures through the Hospital Inpatient Quality Reporting Program since 2004, and that information is publicly available on the Hospital Compare website.

Since July 2002, the Joint Commission, along with CMS, implemented a requirement that accredited hospitals collect and report data on standardized performance measures known as core measures. Health plans have been reporting quality measures to NCQA for the Health Effectiveness Data Information Set program since the early 1990s.

Quality reporting is also a vital component of quality improvement programs and initiatives for financial incentives or penalties. For example, the Affordable Care Act's Value-Based Purchasing initiative increases the CMS reimbursement to hospitals with higher quality measures scores. For physicians, the CMS Physician Quality Reporting System program provides incentives to providers who report quality measures. Additional activities include tracking present on admission (POA) or hospital-acquired conditions (HAC) as a part of the 2005 Deficit Reduction Act, and state-level activities such as California's pay-for-performance program.

Consequently, the importance of detailed, accurate, and complete documentation is imperative for accurate quality reporting. The source of quality reviews are clinical records and the demographic, diagnosis, and procedure codes located on claims data.

For example, the HAC-POA initiative determines the quantity and type of HAC from the diagnosis codes on claims. If a provider overlooks documenting that a patient's condition was POA, it will be considered an HAC-which can result in financial penalties to the hospital.

Other quality measures, such as core measures, rely on claims data to identify the sample medical records to collect for further focused clinical documentation reviews. Consequently, incomplete documentation affects completeness and accuracy of coding, which affects the accurate selection of eligible members for focused clinical quality reviews.

CDI Specialists a Quality Improvement Resource

A CDI program focused on improving the accuracy of quality reviews needs to include CDI specialists, quality improvement managers, health information management professionals, coders, clinicians, ancillary staff, and information technology managers.

CDI specialists must work with quality improvement managers to review and understand the quality of care measures and what documentation must be captured and reported, as well as identify documentation deficiencies that may affect quality measure scores.

Continuous physician education on documentation is necessary, but ancillary departments such as lab, dietary, radiology, respiratory therapy, and pharmacy also need to be educated because complete and accurate documentation from ancillary departments supports better physician documentation.

CDI specialists should understand the connection between clinical documentation and Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT), a standardized clinical classification system incorporated into certified electronic health records (EHRs) to enable the interoperability of clinical systems. This technology enables documentation entered once to be used for multiple purposes including reporting clinical quality measures, which is mandated in the HITECH Act as one of the "meaningful use" EHR Incentive Program requirements of certified EHRs.

Data will be accessible and reportable faster and more efficiently, and data entered once can affect multiple reports. However, the benefits of this technology will be unrealized if clinical documentation is incomplete or inaccurate and the reliability and validity of reports questionable.

CDI Promotes Best Practices

With the increasing demand of clinical quality reporting, CDI specialists are a valuable resource for identifying documentation deficiencies and promoting documentation practices that capture the details of a patient's encounter. These details lead to the quality indicators needed to accurately report quality measures.

References

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