Getting Quality Clinical and Coded Data: How UMHS's CDIP Improved Clinical Coded Data and Clinical Staff Relationships

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Obtaining codeable clinical documentation at the point of care in a large teaching facility can be challenging. However, the HIM department at the University of Michigan Health System (UMHS) in Ann Arbor, MI, took on the task, implementing a clinical documentation improvement program (CDIP). As a result of UMHS's successful CDIP implementation, HIM staff and clinicians are well positioned to effectively code under the new MS-DRG system and capture present on admission reporting indicators.

This article details UMHS's program and how it has improved the organization's coding and reimbursement.

Improving the Bottom Line

UMHS decided to implement the program to improve its bottom line. Organizational leaders wanted to accurately capture inpatient facility reimbursement. The program also provided UMHS the opportunity to re-assess internal coding operations.

UMHS identified four areas for improvement as part of its CDIP implementation:

- Improve the post-discharge query process
- Implement real-time clinician education
- Obtain complete clinical documentation at the point of care
- Ensure documentation reflects the complexity and severity of patients treated

Prior to implementation UMHS experienced many of the same inefficiencies in its coding functions that other hospitals experience. There was a lack of HIM staff visibility on the inpatient units. Oftentimes, the only interaction coding professionals had with physicians was through an inefficient and delayed post-discharge query process.

Although documentation is done by attending physicians, fellows, residents, nurse practitioners, and physician assistants, the query process was geared toward attending physicians instead of documenting clinicians. Most important, UMHS felt that it was missing valuable educational opportunities for clinicians.

Program Implementation

With the support and strategic leadership of the chief administrator for HIM, a work group formed to identify a consultancy to develop and implement the program. UMHS used the consultancy to assess its internal coding operations and to identify opportunities for capturing information to drive appropriate DRG assignment for facility reimbursement.

The consultancy and the coding manager worked together to develop a framework for the CDIP. They rounded with clinical services to understand the documentation workflow process. They then reorganized the coding unit structure to create three clinical service teams, created a new job description for clinical documentation specialists (CDSs), and developed a new salary scale.

CDIPs often use nursing staff to capture clinical documentation at the point of care because of their clinical background, but UMHS decided to employ key coding staff (registered health information technicians) in the CDS role. This approach not only allows coders to obtain the documentation needed for coding and reimbursement, it also helps develop positive working relationships with medical staff.

The clinical information decision support services unit assisted the HIM department in identifying clinical services for potential documentation opportunities based on DRGs without complications/comorbidities (CCs).

UMHS used the plan-do-check-act quality improvement process to identify the problems, root causes, and improvement goals. The problems included incomplete or contradictory clinical documentation that did not consistently support facility reimbursement, the severity and complexity of the patient mix, or treatment rendered. The root causes were found to be a lack of clinician education regarding nonspecific documentation and a post-discharge query process that resulted in missed opportunities for clinician interaction and education.

UMHS set the following improvement goals:

- Capture clinical documentation at the point of care
- Improve facility reimbursement and case mix
- Improve clinician communication
- Decrease reimbursement denials
- Retain UMHS's reputation as a high-ranking hospital

The CDIP Process

The coding manager and CDS staff presented the improvement program to clinical departments and identified who performed documentation for each service (e.g., residents, physician assistants, or nurse practitioners). They also identified a contact for the clinical service resident rotation schedules and set up rounding times.

The CDSs use wireless laptops to capture clinical data at the point of care, and all online clinical information systems on the inpatient units facilitate baseline and working DRG assignment to determine if there are query opportunities.

A CDS admission work list was created for each clinical service team. The CDS performs a case review 24 to 48 hours after admission to obtain the baseline DRG. The CDS then selects cases for intervention. For example, if the documentation states "troponin leak," the CDS will contact the documenting clinician (resident, physician assistant, nurse practitioner, or attending) by e-mail, page, or face-to-face conversation to ask whether the patient also had a myocardial infarction. If the patient did, the CDS would then request the clinician document the diagnosis in a progress note and the discharge summary.

The CDS will continue to review the case to check for a clinician response. If no response is received, the CDS will continue to contact the clinician up to discharge. When the chart is coded, the coder has access to the CDS's notes in the abstract to alert the coder to look for documentation of a clinician response in the record.

UMHS modified the abstract to capture a baseline DRG and any potential working DRGs, the questions asked, and whether the clinician responded. If the clinician did respond, the CDS notes in the abstract if the requested information was documented in the chart. If the query resulted in a DRG change, the reimbursement difference between the baseline and working DRG is calculated.

The CDS staff rounds with each of their clinical services at least once a week. The rounding process allows the CDS to interact with the clinicians, gain a basic understanding of the treatment plans, and make themselves visible to the clinical teams. The CDSs also have been asked by clinical services to assist with the creation of online documentation templates.

In order to facilitate documentation for clinicians, pocket cards with documentation tips were developed, including commonly missed CCs and other documentation hints specific to the clinician's service. In addition, space on the back of the cards was dedicated for clinician requests, such as directions on how to use the dictation system and core measures information for the cardiology tip cards.

Reaping the Benefits

The CDIP team periodically presents the results of the program to each clinical service. The presentations outline the high-complexity DRGs and identify opportunities for improving clinician documentation. The team also provides case examples of DRGs with and without CCs to show the financial impact of accurate and complete documentation. The clinicians are

presented with their query response rates. The CDS staff has also been asked to present the program's results at various department meetings.

UMHS has found that clinicians are very receptive to the front-end query process. There has also been greater collaboration between clinicians and the CDS staff.

Using RHITs in the CDS role has created positive communication between coders and the CDS staff. The coding team has benefited from documentation being available at the time of coding. UMHS has seen great improvement in clinical documentation with the implementation of the CDIP.

The physician query response rate is 82 percent. The CDIP team feels it is truly higher than this, as physicians will add documentation at discharge and the current process reports the rate while patients are still in-house. The post-discharge query process has decreased significantly from 819 queries in 2003 to 380 in 2006. The potential reimbursement identified through the physician query process from the point of the admitting DRG to the working DRG to date is more than $13 million.

Next Steps

Given the success of the program, UMHS plans to create additional CDS positions to cover the remaining clinical services. The organization will continue to monitor CDIP outcomes to make improvements to the program.

UMHS plans to continue to trend pre- and post-CDIP data and review documentation for present on admission indicators and MS-DRGs as part of its improvement goals. The CDIP team also will continue to work with clinicians on improving documentation, creating documentation templates, producing newsletters, and a CDIP Web site, and presenting at resident grand rounds.

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