Investigative Approach: How Clinical Documentation Teams Improve Communication, Documentation Outcomes and Patient Care

By Steven Robinson, MS, PA, RN, CDIP

Clinical documentation programs' success is a result of the healthcare team keeping a constant vigil on communication while operationalizing outcomes and instilling provider support. Patient care is largely dependent on accurate communication among the healthcare provider team. In a moment's notice, the patient's condition can abruptly change. Without the ability to communicate and document changes and corresponding responses, a crucial misstep could ensue. Accurate, timely and complete documentation is critical to integrated healthcare delivery and ensuring data integrity.

As the long-time guardians of documentation, clinical documentation specialists (CDSs) have said: If it was not documented, it was not done. Today's value-based regulations demand an even deeper dive into evidences of mandated quality measures: Failure to document properly can subject the patient to being:

- *Overcharged or not covered for treatment* that may have been unnecessary—no diagnosis that corresponds to the treatment plan
- *Categorized inaccurately* as being less sick than was the case—aggregated diagnoses that do not reflect severity of illness
- *At higher risk* of developing a complication of care—acuity of diagnosis not described, thus at higher risk of complications
- *More likely to be readmitted* after discharge—appropriate treatment plan cut short due to allocated length of stay, or weekend follow-through lapsed due to short staffing

As advocates for ongoing improvement, the healthcare team must be good stewards of collecting and measuring pertinent and actionable outcomes derived from our clinical documentation efforts. Compilation of superficial metrics—such as volume of review, volume of physician responses, time required for concurrent review—is necessary for process and staffing purposes but these metrics do not directly drive patient care results.

Deeper Inquiry Spurs Actionable Outcomes

I would challenge clinical documentation programs to delve deeper into what, where, when, how and why outcomes are collected, monitored, and measured. Are they operational metrics or actionable outcomes that can be used to improve communication, documentation, and patient care?

One aspect of clinical documentation that can spur actionable outcomes is the physician query process. Suppose your clinical documentation improvement (CDI) team finds 43 percent unanswered queries in one month. From this metric, can you further investigate to identify root causes? Here are 12 "drill-down" questions to consider:

- How many specialties participated in the 43 percent?
- What were the specialties?
- Which were the largest specialty contributors?
- Which physicians within the specialties participated most?
- Why did they not answer the query—did they disagree or ignore?
- Was there a trend among the types of queries not answered?
- Did a trend point to one or two CDSs—due primarily to unclear/poor wording on the template?
- Were there attempts to approach the providers that disagreed?

- Was the escalation process or provider approach appropriate?
- Were there plans to address with physician, CDS, and/or coding professional?
- Was it determined that an education plan was needed?
- Was ongoing monitoring of the operational and actionable metrics amended?

Automated Root Cause Analysis Capability Directs Educational Initiatives and Improves Data Integrity

Answers to deeper questions promote a better approach to decreasing the percentage of unanswered queries while improving overall clinical data integrity and increasing confidence in results from the clinical documentation process.

Finding and addressing root causes, even when a base problem is recognized, can be time consuming and convoluted if there is not a consistent automated drill-down process/tool availability. Investigation into operational deep-dive metrics can be accomplished for many using current IT systems' analytics capabilities. The ability to address the 12 example questions quickly using your clinical documentation analytical tools is a necessary component to provide support for physicians, coding professionals, and CDSs. For organizations with minimal analytics capabilities, drill-down inquiry can become an arduous task on a monthly or quarterly basis.

Progressive inpatient and outpatient clinical documentation outcomes are dependent upon altering learned behaviors through education and succinct ongoing educational support. Identifying pointed deficiency trends and recalibrating those focused areas of concern are much more efficient with the capability to quickly understand the base cause. All—the patient, physician profiles, facility outcomes, and more—will benefit from these studies.

Steven Robinson is vice president of clinical revenue integrity at RecordsOne. Robinson holds advanced degrees and a unique understanding of the complete clinical documentation processes and its impact on healthcare facility revenue cycle. His experience includes clinical documentation and quality leadership for over 250 healthcare facilities nationwide managing process improvement, throughput, and clinical documentation consulting engagements.

Original source:
Robinson, Steven. "Investigative Approach: How Clinical Documentation Teams Improve Communication, Documentation Outcomes and Patient Care" (Journal of AHIMA website), December 29, 2016.
