Leading Clinical Documentation Improvement: Three Successful HIM-led Programs

by Chris Dimick

Clinical documentation improvement programs are increasingly common, but who leads them varies. Here's a look at three successful programs led by HIM departments.

Tammy Love knew they were coming. She needed to take action.

It was April 2006, and Love, RHIA, CCS, knew the upcoming MS-DRG and present on admission coding changes would shake up her department at University of Arkansas for Medical Sciences (UAMS) Medical Center in Little Rock, AR. Hoping to get ahead of any problems the changes could create, Love, the HIM coding manager, saw the potential of a clinical documentation improvement program (CDIP) in which specialists concurrently review medical records for incomplete documentation. Better documentation would lead to more complete medical records, which coders could use to apply clearer, more concise codes, she reasoned.

Love took the idea to her HIM director and then to the CFO. Administration agreed to institute the program, and when it came time to decide who would organize and run the CDIP, Love lobbied for HIM to take the reins. After consideration, UAMS agreed.

Just who leads a CDIP varies according to the organization. Clinical areas such as case management may house the programs because their staff's medical knowledge and familiarity with the hospital floor helps them query physicians. Other facilities choose HIM, because in order for clinical documentation specialists (CDSs) to query physicians, they must be able to ask questions from a coding, reimbursement, and clinical standpoint.

"When we [at UAMS] started this program, we were at the point where either HIM was going to teach case management to do this or we were going to do it," Love says. "And it didn't make a lot of sense for us to spend the time to teach somebody else to do it when we already had the people who knew what needed to be done."

Program Structure

UAMS Medical Center started a concurrent coding program along with a CDIP, hiring the first of their CDSs in November 2006. All of UAMS's inpatient coders transitioned to a combined CDS and inpatient coder role, both querying and coding concurrently by early 2007.

Prior to the implementation of the program, five inpatient coders worked from home. But since CDSs work on the units, several of those coders were transitioned back into the hospital. With 11 CDS/inpatient coders, nearly all the facility's service lines are covered by CDSs, except newborns and deliveries and observation cases, Love says.

Eastern Maine Medical Center (EMMC) in Bangor, ME, took a more traditional approach to a CDIP. Like Love, Michelle Fuchs, RHIA, CHP, hoped a CDIP would help her facility get ahead of impending Centers for Medicare and Medicaid Services reimbursement changes.

"We knew that the coders were doing a very good job, but they were under-reporting the severity of how sick our patients were because we weren't getting that level of information from our providers," says Fuchs, director of health information services.

If the hospital was going to use a severity-adjusted reimbursement system where the risk of mortality was a factor, Fuchs knew her facility would do poorly unless the coders could improve their severity report—which comes from better clinical documentation.

EMMC decided between HIM and care management to run its new CDIP in mid-2007. It chose the HIM department because of its combination of coding and clinical knowledge, Fuchs says.

Fuchs feels it was the right decision to call on HIM for the job. "I feel very strongly that it is an HIM responsibility," she says. "I think other departments have other areas of emphasis and would be pulled away." HIM's primary focus has always been on the accuracy and improvement of the medical record, she says.

EMMC's CDSs focus on reviewing the chart and leave the actual coding to the HIM coders. The CDSs and coding staff have weekly meetings to discuss documentation improvement efforts, according to Mandy Storman, RHIT, coding manager at the facility. The meetings foster cross education. The coders educate the CDSs on coding specifics, and the CDSs, who have RN backgrounds, educate the coders on clinical matters.

Three nurses cover about five service lines at EMMC, which were preselected for coverage based on an assessment that determined those lines needed the most documentation improvement. The CDSs review the charts, looking for areas that require clarifying information from physicians.

In many CDIPs, the documentation specialists are assigned a specific unit. They will first check a chart 24 to 48 hours after a patient is admitted to the unit, searching for documentation improvement opportunities. The CDS will routinely recheck the chart, either electronically or on paper, until that patient is discharged.

When a CDS spots a query, the first step in getting it answered usually comes from face-to-face contact with the physician. If the CDS can't locate the physician or if the verbal request goes unanswered, the specialist either places a paper query form in the chart, as is done at EMMC, or may e-mail the physician, which is done at UAMS.

E-mail is also popular in the CDIP at the University of Michigan (U of M) Hospitals and Health System. "We don't leave anything on the chart, because it will never get read or it will get lost," says Gwen Blackford, BS, RHIA, the facility's coding manager. "But all the physicians read e-mails."

At the U of M Hospitals and Health System, located in Ann Arbor, MI, a CDS's main job is reviewing the chart, similar to EMMC's program. The HIM-led program has six CDSs who are responsible for four clinical services each. The program was launched in October 2004 as a way to increase the percentage of DRGs with CCs, as well as limit the amount of querying post-discharge.

In addition to their usual work, CDSs at U of M must round with a physician one day a week within each of their services. This rounding is done to make the CDSs, who are all RHITs, more visible to clinicians as part of the clinical team, Blackford says. It also gives them an opportunity to increase their clinical knowledge. During rounding, CDSs can discuss specific examples of documentation improvement, using real cases on the floor.

Managing the Program

Whether a facility is seeking an RN or coding professional to fill the CDS role, many times it hires from within. With RNs, some coding training will be necessary. With coders, a brush up on clinical sciences like anatomy might be needed. At U of M, all six CDSs transitioned from a coder role.

Blackford looks for candidates with good communication skills; a basic knowledge of anatomy, oncology, and pathology; and a good disposition. "Personality is very important, because if you get up there and you start pushing—'I need this' and 'I need that'—all of a sudden you are going to get some roadblocks, and they won't answer your questions," she notes.

Coding managers may play a large role in HIM-led programs. They may oversee the program on a daily basis, at first working on the units with the CDSs to get the program rolling. Once the program is established, coding managers may meet regularly with CDSs to discuss queries. If some queries are not getting answered, managers often work with other department heads to correct problems. They serve as the go-to person for CDS coding questions. The coding manager also monitors CDSs'

performance and provides direct supervision, which is the case at EMMC, Storman says. The coding manager reports up to the director of HIM, who represents the program at the administrative level.

Keeping everyone involved in a CDIP accountable can be difficult because multiple departments are involved. The responsibility of working with other departments can fall to the coding manager or the HIM director, as is the case at EMMC. Fuchs works with the patient care administrators of each CDIP covered service line and routinely provides feedback about how each service line is contributing to the program. These administrators serve as the physician champions, promoting the program's importance to their physicians.

At U of M, it is Blackford, the coding manager, who holds the service lines accountable for working with the CDIP. If physicians are not taking part in the program, she lets their superiors know. If a physician hasn't answered a query in 24 hours, the query will be sent to that physician's division director. If the query is still not answered, it will be reported to the director of the quality department. But it goes both ways. Those who are exceptional at answering queries will get commended by Blackford in a letter to their bosses.

Getting Started

Getting started with a CDIP begins with getting buy-in. If the entire facility does not fully commit to a CDIP, it will most likely become a low priority. "Before anyone even develops a plan, they have to make sure that their hospital wants it and will support it," Fuchs says.

The U of M office of clinical affairs promoted the CDIP and encouraged full-fledged support long before go-live, an act that was priceless, Blackford says. It set the tone that the program should be taken seriously. To reiterate this point, a few times a week Blackford meets with different hospital chiefs to discuss what areas of documentation need improving. Regular appearances are made at clinician staff meetings as well. This keeps the program fresh in their minds, she says.

Though improving reimbursement is an important feature of a CDIP, that shouldn't always be promoted to physicians, Blackford says. A CDS who wants to convince a physician to embrace the program should focus on the improvements it can bring to the quality of care and severity of illness reporting. At U of M, CDSs don't just query physicians if it will increase the DRG. Instead, they look for incomplete documentation and query to fill in the holes, regardless of its monetary effect, Blackford says. That act should be heralded to physicians.

At UAMS, physician education began early. Both one-on-one education and group meetings were necessary for success, Love says.

Once EMMC's CDIP began, clinicians took part in nearly 20 training sessions during their specific staff meetings in order to prepare them for the coming queries. A physician helped deliver the CDIP education, which Storman says lent to the credibility of the program with other clinicians.

Some facilities hire a consultant to help them plan their programs. At EMMC, administrators hired a consultant to conduct a risk assessment and determine which hospital service lines would benefit most from a documentation improvement effort.

U of M hired a consultant to develop the program as a way to minimize the stress of doing two jobs at once. "Unfortunately, when you are trying to run a coding department you don't have time to sit and create a new program," Blackford says. The consultant helped design the program framework and workflow. Blackford's team picked up the rest, leading the hiring and fine-tuning the program before launch.

A consultant may not be necessary if the HIM department has the resources to both plan the program while still operating the department, Love says. UAMS designed its own program.

Whether with a consultant or done in-house, every facility considering a CDIP should first do an assessment of their services to see which service lines would most benefit from the program. That way, those services with bad documentation habits can be targeted, Blackford says. At U of M, this study was done by the clinical decision support area of the organization. "They ran some reports, looked at service areas, gave it to me and I said, 'Wow, here is a big percentage of surgical services that are without CCs, and their length of stays look a little longer than they should,'" Blackford says.

Start the program small, Love advises. First focus on one service line and get the program established before moving on to cover the rest of the facility. “It is not something that you can do overnight,” Love says. Part of the long-term success of a CDIP comes from the CDSs’ willingness to take on the challenge. Support also must come from facility administration, physicians, and clinical staff, all of which UAMS had from the start, Love says.

Recognizing the facility’s strengths and weaknesses, and finding areas that would most benefit from a CDIP gives an HIM professional a good starting point, Fuchs says.

The Benefits beyond Reimbursement

The benefits of a CDIP are far reaching. Better documentation leads to better care and higher reimbursement. The programs also bring HIM into the spotlight of the clinical floor. The program has elevated the recognition and respect for the HIM department by hospital administration and physicians at UAMS, Love says. The physicians have begun to seek out CDSs to discuss documentation queries, a sign that “they realize what we do is very important,” Love says.

The biggest benefit of the program at U of M is that it has taught physicians how to properly document. “You could have doctors document 10 pages of notes, and it might not have one thing in there you need,” Blackford says. “So it really is teaching them what are the important things to write.” The better documentation has improved reimbursement, but also strengthened the facility during audits, she notes.

At UAMS, the creation of a CDIP did indeed help them transition to the MS-DRG and present on admission changes, as Love had hoped. “It made it a tremendous amount easier,” Love says. “Had we not done this, nobody would have had a clue what was going on.”

Love is proud her HIM department took hold of the project. The program educated the entire hospital on the importance of the pending changes. “It just didn’t feel like that big of a change to us because we had done a lot of preparation to begin with,” Love says, “talked it up to the physicians, the clinical staff, administration, they knew what we were up against and that we needed to put this kind of program into place in order to do a better job capturing better documentation.”

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