The Future of Clinical Documentation Improvement

Prepare for the Intersection of Finance and Quality

Highlights

- **Significant untapped revenue potential:** Our research indicates top quartile CDI programs more than double their return on investment compared to average performers. This translates into a $2M opportunity for an average 250-bed hospital looking to improve their CDI efforts. Improve your program in order to capitalize on this ROI.
- **Quality penalties defray reimbursement gains:** Despite the capability for revenue maximization, CDI programs risk losing as much as they gain by not incorporating quality improvement goals. Programs must concurrently focus on financial and quality interests, yet most require major adjustments to meet this requirement.
- **Deadline to reshape CDI is rapidly approaching:** The transition to alternative payment models based on value or risk has accelerated the need for organizations to improve documentation accuracy and quality. Because CDI programs take a minimum of 18 months to mature, now in the time to begin expanding or enhancing CDI efforts.

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Refocus CDI now to prepare for new payment models

Most organizations narrowly focus clinical documentation improvement (CDI) efforts on *either* financial *or* quality goals, but must adjust to support *both* interests. CMS has set a goal of 2018 for shifting 50% of payments to alternative payment models, which quickens the pace toward widespread quality-linked reimbursement. Do not delay expanding the scope of your CDI program; our research indicates at least an 18 month timeframe to add capabilities or enhance effectiveness.

Leverage quality metrics to protect captured revenue

Expand CDI goals to focus on quality metrics that impact performance or influence penalties on risk adjustment measures such as hospital-acquired conditions (HAC), readmissions, or patient safety indicators. Because quality-based measures will increasingly factor into reimbursement, ensure CDI efforts are equipped to minimize risk for quality penalties, especially in areas where revenue capture improvement efforts have been historically focused.

Proactively engage physicians

Physician buy-in is the most critical success factor of any CDI program. But engaging physicians often requires altering long-standing attitudes towards documentation. CDI teams must proactively build in-person relationships with physicians in order to establish a network of supportive stakeholders required for future CDI growth.

Expand into outpatient areas at the right time

Extend CDI efforts into the outpatient care setting (e.g., professional, ambulatory, or post-acute) to obtain the most complete clinical profile of patients. Significant quality and financial implications exist if outpatient documentation is overlooked or poorly captured. While worth pursuing, weigh CDI expansion into outpatient areas carefully as it requires

a greater coordination of stakeholders as well as different team skillsets. Consider adding an outpatient effort after establishing a successful inpatient CDI initiative.

Protect more revenue by expanding CDI to support audit/denial prevention

Clinical documentation improvement (CDI) programs cannot afford to prioritize only revenue maximization or quality improvement (most have historically focused on one or another). Successful evolution of CDI must not only pursue both vectors, but also incorporate a third interest: audit/denials risk remediation. Efforts to avert audit or denial risk must compose an equal share of CDI's future state. Together, all three interests (revenue capture, quality improvement, and risk remediation) are required to improve documentation in support of quality imperatives and financial bottom lines. Maintain the right mix of these three initiatives as you expand your program, ensuring a balance that matches your organization's goals and team's capabilities.

Prioritize program focus by targeting your most at-risk areas

When attempting to intensify CDI efforts, many organizations incorrectly expand scope too broadly or concentrate only on areas with high revenue capture potential. Instead, begin by identifying where revenue or quality risk is most acute. Target your efforts in those selected areas. Our research indicates that few organizations fully understand their current performance on quality or risk adjustment factor scores. Thus aggressive revenue capture may trigger reimbursement losses from offsetting penalties. Maintain your existing revenue capture efforts only if they generate minimal risk. Devote renewed or expanded CDI resources to areas where you stand to lose the most across quality penalties, denials, and audit takebacks.

Actively build physician relationships to expand the ranks of influential documentation advocates

Widespread physician engagement across the organization is essential to the future goals of CDI efforts. Equip your CDI teams to take the initiative on relationship building. Do not rely on the query process or other remote communication methods to provide the kind of personal dialog that will result in trusted relationships. Utilize CDI staff with clinical backgrounds because they can connect with physicians in ways that foster mutual understanding. Because winning over physicians is both critical and challenging, assess their level of support on a recurring basis. Use the five indicators below to evaluate if your physicians are engaged documentation advocates.

Indicators of Engaged Physician Champions	
✔	Seeks guidance proactively from CDI staff on documentation issues
✔	Has adopted and understand the most important documentation concepts for their service area
✔	Requires more novel queries
✔	Advocates for peers to improve documentation
✔	Seeks administrative support of increased documentation aids (e.g., NLP software, ongoing education)

Ensure CDI's future state fulfills baseline criteria of successful programs

Our research indicates the most successful CDI efforts share five main characteristics. Ensure your program fulfills each of these at minimum. Even long-standing CDI initiatives may fall short against all five criteria given wide variability in program quality and effectiveness. Considering the importance of expanding CDI programs, all organizations should use these characteristics to evaluate their current performance and benchmark the progress of their improvement efforts.

Components of Successful CDI Programs

- **Clearly defined mission and team structure:** focus is balanced on finance and quality; goals are supported by reporting structure.
- **Optimal staffing:** combination of dedicated resources alongside a network of stakeholders and champions; staff skills and type should adapt according to focus of mission and maturity of your program.
- **Efficient process flow:** processes are standardized to maximize efficiency and consistency; technology is well-integrated and enhances process objectives.
- **Strong relationships and rapport:** well-established intra-department relationships position CDI specialists as well-respected translators between clinicians and coders; physician champions are essential.
- **Performance accountability:** broad range of outcome metrics to measure performance on the goals identified in the mission; progress is transparent to CDI, Physicians, and senior executive leaders.

Determine pace of program evolution based on current stage of development

CDI programs take time to mature and achieve an expanded scope. Our research identified three levels of maturity with tiered capabilities and common pitfalls associated with each phase. Organizations should match their current capabilities to the stages below to appropriately pace their development. Use the examples to prepare for adjustments in scope and potential challenges.

	Typical Focus	Common Pitfalls
Developing Program	• Hire, train, develop staff • Orient physicians to CDI concepts • Scope is narrowly focused, typically Medicare	• Lack of awareness, acceptance from physicians • Poor query response/agreement rates • Low involvement from CXOs • Coding resistance to CDI objectives
Maturing Program	• Continue building physician buy-in • Increase physician education across key more documentation concepts • Expand review scope (MS-DRG; denials)	• Inconsistent success with physicians • Staff turnover or limited resources • Insufficient technology for robust, efficient program tracking
Top Performer	• Leverage technology to gain efficiency and improved effectiveness • Maintain and build widespread physician engagement, education • Capable of broadening reach	• Physicians uneducated on coding • New physicians require engagement • Pressure to meet financial ROI goals • Coding/CDI requires more coordination

Launch outpatient CDI, but only under optimal conditions

Expanding to the outpatient space will be a requirement for most future CDI efforts. However, installing generic CDI programs designed for the inpatient space can undermine efforts and lead to unintended consequences. Outpatient documentation

requires staff with specific skillsets and the capability to navigate a more complex array of stakeholders. Proceed with expansion carefully and at the right time.

For example, consider delaying an outpatient CDI program until your inpatient program expansion is complete or has achieved mature levels. Potential efficiencies may be achieved once both outpatient and inpatient programs are sufficiently implemented. Establish program goals ahead of time by first auditing enough areas to determine where the documentation or coding risk warrants immediate focus.

Ensure performance tracking includes Risk Adjustment Factor (RAF) scores, Hierarchical Condition Categories (HCCs), Medical Expense Ratios (MERs), and Physician Quality Reporting System (PQSR) measures at minimum. Prioritize data capture and reporting capabilities for these measures to ensure progress against baseline is tracked and updates are sent to teams on recurring basis.

Ensure staffing and resources adequately reflect program mission

The composition of team personnel must evolve to support your CDI program's new or expanded scope. Require coding and clinical backgrounds as mandatory skillsets for all staff, not just as a desirable job qualification. Discourage remote working conditions (e.g., from home or buildings outside clinical areas) to emphasize in-person interactions required to build widespread trust and engagement. In addition to selecting staff with appropriate backgrounds, also consider those who excel at interpersonal relationships.

Background

There are many variations of clinical documentation improvement (CDI) programs differing based on where they focus documentation improvement efforts and what goals are used to measure success. Two main categories of programs currently exist: those using documentation improvement initiatives to achieve revenue maximization goals and those pursuing quality improvement efforts. As health care continues its transition from fee-for-service to payment for value, the divide in program focus must converge. Documentation initiatives need to support financial and quality interests, which also includes remediation of reimbursement risk from denials or post-payment audits. Because CDI programs take time to mature into more effective utilization or expanded scope, organizations should not delay efforts to re-tool existing programs.

Unfortunately, performance on clinical documentation varies widely from program to program. Many have inadequate resources, poorly defined scope, or a lack of accountability. Now that ICD-10 has passed, many CDI programs face the challenge of re-defining their mission going forward. Without a clearly defined plan for re-tooling, CDI programs may lose existing momentum or fall behind on critical expansion areas like outpatient care settings.

Related Resources

- **Study:** Re-thinking Clinical Documentation Improvement: https://www.advisory.com/research/financial-leadership-council/white-papers/2014/rethinking-clinical-documentation-improvement
- **Study:** A Primer on Readmission Penalties: https://www.advisory.com/research/financial-leadership-council/resources/cfo-briefs/readmissions
- **Study:** Short-Stay Admissions: What Cases Are 'At-Risk'? https://www.advisory.com/research/financial-leadership-council/resources/cfo-briefs/two-midnight
- **Tool:** Hospital Benchmark Generator for Finance, Utilization, and Quality Benchmarks: https://www.advisory.com/research/health-care-advisory-board/tools/2014/benchmark-generator