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Kısa Derleme / Mini Review

Klinik dokümantasyon iyileştirme programı konusunda bir rehber

A primer on Clinical Documentation Improvement Program

Pavani Priyadarsini

Freelance Medical Writer, Dr Pavani Clinic, Red Hills, Hyderabad, India.

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Yazışma Adresi/Address for correspondence:
Pavani Priyadarsini,
Freelance Medical Writer, Dr Pavani Clinic, Red Hills, Hyderabad, India.
pavanibank9@gmail.com

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ÖZET

Klinik Belgelemenin alanı hekimlerin belgelerinden daha fazlasını kapsamak amacıyla geliştirildi.Şu an Klinik Belgeleme laboratuvar raporlarını,teknisyen belgelerini , bakım belgelerini vb.içeriyor.Ayrıca Klinik Belgeleme , hastaya sunulan bakımla diğer bakım ekibinin üyeleri arasındaki iletişimi kurar.Şu aralar tedarikçi kurumlar,teknoloji sağlayıcılar,kamusal düzenleyiciler ve muhataplar gibi diğer paydaşlar doğrudan hasta bakımının haricinde Klinik Belgeleme sürecindeki ek gereksinimlerdeki yerlerini aldı.Klinik Belgeleme Gelişim Programının amacı Klinik Belgeleme kalitesini artırmak ve bu belgelemeye hasta bakımı gelişimi konusunda çok daha fazla verim kazandırmaktır.

ABSTRACT

The domain of Clinical Documentation (CD) has grown to encompass more than just physician notes. Now CD includes Laboratory reports, Operative notes, Nursing notes, etc.CD is also to communicate the care given to the patient to other members of the care team. Now other stakeholders like provider institutions, technology vendors, government regulators and payers have placed additional requirements on the CD process for purposes other than direct care of the patient. The aim of CD improvement program is to improve the quality of CD and to better use this documentation to improve patient care.

INTRODUCTION

Sir William Osler said, "Observe, record, tabulate, communicate"[1]. This was long before Clinical Documentation Improvement (CDI) programs came into being. Over the years, the domain of Clinical Documentation (CD) has grown to encompass more than just physician notes. Now CD includes Laboratory reports, Operative notes, Nursing notes, etc.

Each patient is unique. For instance, no two Community Acquired Pneumonia patients are the same. One may be associated with urinary incontinence; the other with acute renal failure. They belong to two separate Disease Related Groups (DRGs).The latter has more Case Weight (CW) than the former. So, health care facilities have standardized this data for comparison. This is done by converting CD into codes such as ICD-10-CM, CPT, PCS, etc.

The focus of CDI programs is on improving the quality of care given to patients regardless of revenue generated. A CDI program is for facilitating an accurate representation of healthcare services through 4C's -Clear, Concise, Complete and Compliant - and accurate documentation of diagnoses and procedures. CDI is for better patient care not just about revenue, which anyway follows. Cooperation is needed among industry health care providers, health care systems, government and insurers to continue to improve the documentation[2.

Individuals qualified to serve as a CDI specialist include, but are not limited to, physicians, health information management professionals, coding professionals, nurses,

and other professionals with a clinical and/or coding background[3] . There is need for physician partnerships to sustain the program and achieve results [4]. Creating a new position of Coding/Documentation Specialist, working at the point of care as a regulatory interpreter and coding expert, was found to be key to cementing the successful team approach to documentation quality [4].

Clinical documentation, an essential process within electronic health records (EHRs), takes a significant amount of clinician time [5]. Physicians who dictated their notes appeared to have worse quality of care than physicians who used structured EHR documentation[6]. The use of standardized documentation improves quality documentation and retrieval of data from EHR [7].

THE VALUE OF CDI PROGRAMS

It is a myth that CDI programs are meant for revenue and reimbursement. In fact CDI is meant for improving quality and continuity of care given to patients. Accurate clinical documentation is necessary for healthcare organizations to achieve quality improvement and accurate payment [8]. Clear, complete, timely and accurate documentation serves the following purposes:

1. Proof of quality of care given.
2. Profiling of hospital physician data.
3. Data for tumor registry mortality, etc.
4. Compliance for reimbursement.
5. Protection in the event of litigation.

Physician buy-in is essential to a successful clinical documentation improvement program [8].

Clinicians, provider institutions, technology vendors, government regulators, payers, and other interested groups should improve the quality and value of clinical documentation and to better use this documentation to improve care[2].The program should not focus on revenue enhancement or a particular tool, but should encourage critical thinking by physicians [8].

CERTIFICATIONS

Numerous industry trends, such as the increased adoption of electronic health records (EHRs), an increase in health insurance fraud, and the need for complete and accurate documentation to support the requirements of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), all suggest the need for a highly qualified, specialized set of documentation improvement specialists who meet stringent professional guidelines [9]. It is projected that fraud and abuse account for between 3 to 15 percent of annual expenditures for healthcare in the United States [10]. Because clinical documentation specialists have expertise in clinical care, coding guidelines, and reimbursement methodologies, a nationally recognized CDI-related credential would distinguish those practitioners as competent to provide direction relative to clinical documentation in the patient's health record [11].

1. Certified Documentation Improvement Practitioner (CDIP):

In response to industry demand, the Commission on Certification for Health Informatics and Information Management (CCHIIM) developed the CDIP credential. The American Health Information Management Association (AHIMA) conducts the examination and awards CDIP certification.

2. Certified Clinical Documentation Specialist (CCDS):

Applicants who pass the certifying examination conducted by Association of Clinical Documentation Improvement Specialists (ACDIS) receive the designation CCDS.

SKILLS AND KNOWLEDGE NEEDED FOR THE CDI SPECIALIST

Clinical documentation specialists should have knowledge of official medical coding guidelines, CMS, and private payer regulations related to the Inpatient Prospective Payment System; an ability to analyze and interpret medical record documentation and formulate appropriate physician queries; and ability to benchmark and analyze clinical documentation program performance. Proficiency in medical record review; communication and physician query techniques; CMS quality programs and reportable diagnoses that impact quality metrics, and data mining and reporting functions are also needed.

Evaluation and management (E&M) CPT codes seem to be one area where documentation and coding issues are prevalent 10. Educational and training programs focused on CPT codes should emphasize the importance of documentation to support time spent examining the patient [10].

The following is a partial list of skills needed:

1. To differentiate between Present on Admission (POA) and Hospital Acquired Conditions (HACs) .
2. To improve continuity of care for the patient.
3. To identify and clarify any missing information in the

health record and provide accurate representation of patient severity.

4. To know state requirements for coding, documentation and reporting e.g. CMS, COP.
5. To educate coding staff members to increase their clinical knowledge.
6. To enhance communication between members of the CDI team and the medical staff.

CDI TERMINOLOGY

DRG: An inpatient classification scheme that categorizes patients who share similar clinical characteristics.

SOI: Severity Of Illness.

ROM: Risk Of Mortality

MS-DRGs : Medicare Severity Diagnosis-Related Groups .

POA : Present On Admission.

HAC: Hospital Acquired Condition.

CC : Complications or Co-morbidities.

MCC: Major Complications or Co-morbidities.

CONCLUSION

The CDI programs are meant for improving the quality of clinical documentation . CDI is for better patient care regardless of its effects on bottom-line of the health care facility. A CDI program is for facilitating an accurate representation of healthcare services through 4C's -Clear, Concise, Complete and Compliant - and accurate documentation of diagnoses and procedures. The aim is to improve the quality of CD and to better use this documentation to improve patient care.

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CONFLICT OF INTEREST

Nil.

ETHICAL APPROVAL

Not required.

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