Professional Practice Brief

PPB – 0046.18

Clinical Documentation Improvement (CDI)

A professional practice brief (PPB) consists of two major categories, both designed as professional development (PD) tools to advance health information professional practice and standards to support the delivery of quality healthcare. A PPB may relate to either category or both. The two major categories are as follows:

☑ Guidelines for Practice **☑ Professional Resource**

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Dec 2018

Clinical Documentation Improvement

Introduction

This professional practice brief (PBB) focuses on the concept of clinical documentation improvement (CDI) and how it can be used to benefit the health care system. It will also explore the role that HIM professionals play in the implementation and maintenance of a CDI program. This PPB will not cover the development of CDI programs and query policies.

What is CDI?

CDI is a specialized discipline emerging within the Canadian health care system that focuses on improving the accuracy and clarity of health records (Arrowood et al., 2015). CDI programs involve the concurrent or retrospective review of inpatient and outpatient health records to look for inconsistencies or nonspecific data documented by health care providers (Arrowood et al., 2016). With advances in technology and the adoption of electronic medical records, CDI may also be performed from a remote location if technological and staffing resources are available.

The goal of CDI is to ensure that clinical documentation of diagnoses and services provided in the patient record are specific enough to support the assignment of accurate diagnostic and procedural codes (McDonald, 2015; Shepheard, 2018). CDI programs generally function with queries, which may also be referred to as documentation alerts or clinical clarification (Bryant et al., 2010). A CDI specialist will submit a query either verbally, in writing, or through an electronic format to the physician responsible for the documentation in the patient's record. Potential situations that may be addressed through a query include a request for an undocumented diagnosis or clarification of disease specificity or complexity. Different query formats have advantages and disadvantages. Written and electronic queries allow new programs or staff the opportunity to follow a template that can make the transition of CDI easier, while verbal queries allow for direct interaction with care providers and immediate feedback. Health care organizations that implement a CDI program may choose to use one or a variety of methods to query physicians.

CDI specialists can work in several different health care settings and often have an in-depth knowledge and high level of responsibility (ACDIS, 2014). They can deal with the information of a wide variety of patients who have received care in various clinical disciplines, bridging the gap between the clinical documentation and ensuring it accurately reflects the care provided.

The concept of CDI became widely popular in the United States when it was determined that physicians were not providing sufficient diagnostic documentation (Combs, 2016). This same issue

has been noted in Canadian Hospitals. As a result, coders were often unable to effectively assign appropriate International Classification of Diseases (ICD) and Canadian Classification of Health Intervention (CCI) codes. CDI initiatives have since been adopted and have been successful, with the benefits seen in the form of more appropriate funding, the completeness and specificity of documentation, and, most importantly, improvements in the quality of health care services. CDI has become increasingly important since the development of the tenth revision of the ICD code set (ICD-10), which has been adopted for use and modified by many countries (Combs, 2016; Wiedemann, 2014). With the upcoming release of ICD-11, CDI will continue to prove important as we see additional specificity and complexity added to code sets.

Goals of CDI

All health care organizations aim for complete and accurate documentation; however, research suggests that this is difficult to achieve and that facilities often struggle to maintain a consistent level of high quality documentation (Arrowood et al., 2016). By implementing a functional CDI program, organizations are often able to work toward achieving goals such as:

- Identifying missing or nonspecific data entered into medical records
- Improving documentation to ensure accuracy and quality of care and services provided
- Encouraging communication and collaboration between different health care disciplines
- Improving patient safety
- Improving the continuity of patient care during the episode of care and post-discharge
- Improving the accuracy of coding, which contributes to accurate representation of case mix groups (CMGs)
- Promoting accurate health care funding and resources
- Enhancing the quality of data and information submitted to the Canadian Institute for Health Information (CIHI) and provincial health ministries
- Enhancing opportunities for learning and further improvement
- Improving discharge planning and reducing readmissions

A CDI program can help an organization to make improvements in these areas and benefit both patient care and the overall function of the health care system.

The Role of HIM and Other Healthcare Professionals in CDI

It is the legal responsibility of all health care providers to ensure that any patient encounter within the health care system is documented in an accurate and timely manner. For a facility to develop a successful CDI program, there must be strong leadership and support from professional staff (Nash & Land, 2008). CDI programs have typically been staffed using two different models: a team staffed by a single discipline (i.e. HIM professionals, registered nurses, physicians, etc.) or hybrid/multidisciplinary teams (Bryant et al., 2010). Often viewed as a collaboration between HIM

professionals and clinical care providers, CDI initiatives usually rely on health information staff, physician and nursing staff, pharmacists, director and management personnel, other allied health professionals, and dedicated CDI specialists (Seto et al., 2014). CDI is not just about improving the practice of documentation, but also improving the quality of how all these health services are delivered.

HIM professionals are key stakeholders in the CDI process and are a highly sought after resource due to their extensive comprehension of thorough documentation to support code assignment. It has been reported that HIM staff are among the best candidates to lead these initiatives as CDI specialists, as they often have a small learning curve to develop expertise in the clinical environment (Shepheard, 2018). In 2014, over 79% of the CDI programs in the United States were led by HIM professionals (Birnbaum, 2015). One report from an urban health care system described the use of registered health information technologists as CDI specialists who were paired with a particular hospital service (cardiology, orthopedics, neurosurgery, etc.) (Blackford & Slater, 2006). With the assistance of HIM managers, these professionals rounded with their respective service staff, performing CDI queries and providing documentation education. As a result, this CDI program run by HIM personnel was a great success.

Because they are well versed in coding terminology, HIM professionals are often an organization's best resource for documentation improvement and understanding how physicians can document clinical encounters to the highest degree of specificity (Mills, 2005). Other health care providers often have a steeper learning curve when it comes to gaining an understanding of coding for funding purposes and the applications of health data outside of the clinical setting. Areas in which HIM professionals have already received training include code assignment, coding standards, and grouping methodologies. They are also well educated on the concepts of privacy, confidentiality, and the security of personal health information. Most physicians and nurses have no exposure to the coding and abstracting of health data, but the training that HIM professionals receive allows them to quickly adapt to the role of a CDI specialist (Dimick, 2008). HIM professional coders are integral stakeholders in any CDI program, as they can contribute to the quality and content of clinical documentation (Jamal & Grant, 2014). The quality of documentation greatly impacts their ability to accurately code and abstract diagnoses and interventions. They can also assist with the provision of education on aspects of clinical documentation and the coding process.

A qualified CDI specialist – often an HIM professional – plays many roles in the process of ensuring documentation improvement. According to Arrowood et al. (2015), there are four main duties that a CDI specialist must perform: reviewer, educator, analyst, and collaborator.

- **Reviewer** – This involves the identification of opportunities for improving or clarifying insufficient or inconsistent data in the health record. It also includes the responsibility of keeping up to date on changes to coding standards and trends for CMGs.

- **Educator** – CDI specialists provide knowledge of what their discipline does and how it can benefit the health care system, including educating other health care professionals. They also demonstrate what degree of impact their program is having and any trends, positive

or negative, that can be used to determine the future direction of CDI within their facility. By providing real-time education on how the CDI process is unfolding within their organization, CDI specialists can help to improve the culture of the workplace and promote change in documentation practices (Breuer & Arquilla, 2011).

- **Analyst** – Since they need to have a working knowledge of how to interpret the data they collect (Arrowood et al., 2015), CDI specialists must be able to recognize trends and how they can be used to support or make changes to their program.

- **Collaborator** – CDI programs can only be successful when there is communication and teamwork among the health care providers, HIM staff, administrators, and all other professionals involved.

Please refer to Appendix I for an excerpt of a CDI specialist position description provided by Bluewater Health.

Support from senior management is important for the implementation and maintenance of a strong CDI program. HIM and coding managers are often involved, particularly if the program is largely staffed by HIM professionals (Dimick, 2008). They may oversee the initial processes of introducing a new program and regularly meet with staff to review queries, answer coding questions, and discuss any successes or concerns that may arise. Managers may also supervise and monitor the performance of CDI specialists. HIM department directors and managers can provide guidance on the best documentation practices and keep staff up to date with any changes in policies regarding health records (Jamal & Grant, 2014). Management from quality improvement departments are also valuable stakeholders in a CDI program. They can often provide measures of performance which can be used to guide efforts and resources and can help with making improvements to a program.

Ensuring physician involvement in the CDI process is crucial to both the uptake and delivery of a successful program. Strong communication and leadership from physicians and HIM staff can ensure the long-term success of a CDI program (Jamal & Grant, 2014). The concept of having a physician champion or advisor as part of a CDI program is important, as such an individual can engage their colleagues, including medical students and residents, and educate them on the importance of CDI. A physician champion is also able to serve as a liaison between care providers, HIM professionals, and CDI specialists to encourage cooperation and accurate clinical documentation, which reflects the status of patients and the delivery of care (Arrowood et al., 2016).

Physician documentation is used by coders to determine the appropriate diagnostic ICD codes and CCI intervention codes that need to be captured. When documentation is clear and complete, coders can review documentation in the health record faster and can more easily clarify a diagnosis or procedure to accurately code the patient record so that it accurately reflects the care provided to the patient. Practicing physicians who have received little training in the importance

of thorough documentation may be more resistant to the efforts of CDI specialists or simply unaware of what information coders require (Brown, 2013; Brazelton et al., 2017). It has been reported that some providers may not recognize the benefits of these programs and are open to feedback, while others may be defensive about having their documentation questioned. In any case, it is the role of the CDI specialist to advocate for their discipline and help to educate and assist health care providers so that they may better understand how CDI can improve the overall delivery of patient care. The lack of specificity on clinical documentation can ultimately affect funding and underrepresent the actual quality of care that a patient has received (Towers, 2013).

Nursing staff also play an integral part in CDI. Many nurses have pursued further training to become CDI specialists, where they are able to fulfill duties as educators, facilitators, and successful collaborators (Brazelton et al., 2017). In the majority of care settings, nurses arguably spend the most time in direct contact with patients and can therefore apply acquired coding knowledge to determine the best diagnosis for the patient. By combining their CDI and nursing skills, they can use health information and communicate with other health care professionals to assist with chart completion and thorough documentation practices.

Regardless of their background, all CDI specialists will abide by professional practices and ethics. HIM professionals must adhere to their code of ethics and support their daily processes by referring to guidelines published by CHIMA, ACDIS, or other professional bodies (ACDIS, 2014).

Becoming a CDI Specialist

CHIMA is now offering an advanced certificate program developed in collaboration with 3M that will allow HIM professionals, nurses, and other approved clinical professionals that meet eligibility requirements to receive the training required to become a CDI specialist. HIM professionals who receive this certification will be able to fulfill the roles discussed throughout this PPB and have a positive impact on their respective health organization by helping to improve the quality of patient outcomes and care and the appropriate distribution of resources.

The online program can be completed over a maximum of 12 months. Learning modules include education on coding standards, the clinical concepts of various anatomical body systems (ex: circulatory, nervous, etc.) and infectious diseases, as well as how CDI programs are implemented.

Credentialing planning for CDI is currently underway and qualified individuals will be able to challenge a CDI exam. They will earn the credential CCDI-Certified in Clinical Documentation. For more information, including a full information package, visit https://www.echima.ca/professional-development/cdi.

References

Arrowood, D., Bailey-Woods, L., Easterling, S., Endicott, M., Love, T., McDonald, L., … Wieczorek, M. (2015). Best practices in the art and science of clinical documentation improvement. *Journal of AHIMA 86*(7), 46-50.

Arrowood, D., Bailey-Woods, L., Barnette, E., Combs, T., Endicott, M., & Miller, J. (2016). *Clinical Documentation Improvement Toolkit*. Chicago, IL: AHIMA Press.

Association of Clinical Documentation Improvement Specialists. (2014, April 1). *Defining the CDI specialist's roles and responsibilities.* Retrieved from https://acdis.org/resources/defining-cdi-specialist%E2%80%99s-roles-and-responsibilities

Birnbaum, C. (2015). The new frontier of clinical documentation improvement. *Journal of AHIMA 86*(7), 8.

Blackford, G., & Slater, D. (2006). Successful clinical documentation improvement program using RHITs. *AHIMA 78th National Convention and Exhibit Proceedings*. Available from http://bok.ahima.org/doc?oid=73729#.WtPr_ExFzOY

Brazelton, N.C., Knuckles, M.C., & Lyons, A.M. (2017). Clinical documentation improvement and nursing informatics.
Computers, Informatics, Nursing: CIN 35(6), 271-277.

Breuer, S., & Arquilla, V. (2011). Clinical documentation improvement: focus on quality. *Healthcare Financial Management 65*(8), 84-86, 88, 90.

Brown, L.R. (2013). The secret life of a clinical documentation improvement specialist. *Nursing 43*(2), 10-12.

Bryant, G., DeVault, K., Ericson, C., Garrett, G., Haik, W., Holmes, R., & Mandler, E.E. (2010). Guidance for clinical
documentation improvement programs. *Journal of AHIMA 81*(5), 45-50.

Combs, T. (2016). The impact of clinical documentation improvement on the international stage. *Journal of AHIMA*
87(7), 58-59.

Dimick, C. (2008). Leading clinical documentation improvement – three successful HIM-led programs. *Journal of*
AHIMA 79(7), 40-42, 44.

Jamal, A., & Grant, C. (2014). *An Essential Guide to Clinical Documentation Improvement*. Retrieved from https://www.echima.ca/uploaded/pdf/reports/CDI_Whitepaper_Final_rOct%202014.pdf

Land, T.L., & Nash, J.A. (2008). Clinical documentation improvement: a winning strategy in quality data and revenue cycle. *Healthcare Executive 23*(2), 71-73.

McDonald, L. (2015). So what exactly is clinical documentation improvement? *CodeWrite*. Available from http://bok.ahima.org/doc?oid=300922#.Wrca5OjwY2w

Mills, M. (2005). Clinical documentation improvement strategies. *AHIMA 77th National Convention and Exhibit Proceedings*. Available from http://bok.ahima.org/doc?oid=61551

Seto, R., Inoue, T., & Tsumura, H. (2014). Clinical documentation improvement for outpatients by implementing electronic medical records. *Studies in Health Technology & Informatics 201*, 102-107.

Shepheard, J. (2018). What do we really want from clinical documentation improvement programs? *Health Information Management Journal 47*(1), 3-5.

Towers, A.L. (2013). Clinical documentation improvement – a physician perspective. *Journal of AHIMA 84*(7), 34-41.

Wiedemann, L.A. (2014). Clinical documentation improvement eases the transition to ICD-10. *Journal of AHIMA 85*(7), 44-45.

Appendix I – Excerpt from CDI Position Description

Position Description – Bluewater Health

1. Position Identification

Position Title:	Clinical Documentation Improvement Specialist
Department:	Health Information Management
Title of Immediate Supervisor:	Manager, Health Records, Patient Registration
Department Manager's Signature:	
Date:	March 2018

2. Job Description

The Clinical Documentation Specialist (CDS) is responsible for the day to day coordination of the Clinical Documentation Improvement program. The CDS reviews inpatient medical records while patients are still in-house (concurrent review) for proper documentation. This review includes new admissions to the facility, as well as re-reviews every two to three days until the patients are discharged, along with the facilitation of modifications to documentation where necessary. Through extensive interactions with physicians, allied health professionals, nursing teams, other patient caregivers and HIM professionals, the CDS will be accountable for improving the overall quality and completeness of clinical documentation in order to ensure accurate reflection of patient acuity in coding. The CDS provides training and education as needed. The CDS will also perform focused reviews at the discretion and request of the HIM Leadership.

Activity A: Documentation Improvement 70%

Improves coding specificity by educating physicians, clinicians and other involved parties regarding the provision of complete and clear documentation of the care provided throughout a patient's stay. This includes clinically correlated diagnoses and capturing appropriate complications/comorbidities. This is achieved via queries, face to face communications, and/or other education programs and tools useful and necessary to achieve this goal. Maintains privacy as required by legislation.

Admissions Reviews:
Review charts and complete CDS tool within 24 hours of admission
Identify the most appropriate principle diagnosis, complications and comorbidities to accurately reflect patient acuity
Recognize and facilitate modifications to clinical documentation
Confer with coding specialist concurrently to ensure appropriate HIG/ELOS and completeness of supporting documentation, as well as adherence with coding guidelines
Ensure accuracy and completeness of clinical information used for measuring and reporting patient, physician, and hospital outcomes
Complete Follow Up of Admission Reviews:
Attend bullet rounds with inter-professional care team
Complete follow up reviews of clinical documentation and update CDS tool at least every 48-72 hours or as requested
Confer with physicians face to face or via query process to clarify information, obtain needed documentation, present opportunities and educate regarding the significance of appropriate documentation needed to support the acuity of the patient
Update the CDS tool for all discharges to reflect any changes in status, procedures/treatments, and discuss points of clarification with physician to finalize diagnoses
Track responses to queries

Quality Assurance Monitoring
Produce reports as requested and produce a monthly summary of response rates and other indicators as developed
Participate in documentation quality studies as assigned
Refer quality issues to appropriate resources
Maintain thorough and current knowledge of clinical care and treatment of assigned patient populations to critically assess appropriateness of documentation
Participate in year-end data quality auditing and querying process
Ensuring completion of all queries to align with CIHI submission deadlines for coding

Activity B: Collaboration and Education _______ 25%

Educate all internal customers on clinical documentation opportunities, coding and funding issues, as well as performance improvement methodologies
Develop positive interpersonal relations in interactions with all members of the inter-professional team (i.e. coworkers, supervisors, physicians, etc.)
Assist the Coding Team when querying physicians regarding unclear documentation and act as a conduit when necessary. Assist Coding Team in seeking clarification independently where possible and appropriate
Facilitate conversations between the Coding Team and appropriate Physicians to open lines of communication and shared learnings
When contacted by the Coding Team concerning disagreements about incomplete documentation, review the record and follow up with the physician if appropriate in a timely manner. Where unable to reach agreement with Coder, review chart with Manager, Health Records
Assist in monitoring of coding deadlines, submissions and CIHI data reporting
Running of reports in Crystal as requested
Promote professional and personal growth of coworkers by sharing knowledge and resources
Communicate in a positive and productive manner

Activity C: Policy, Procedure and Process, Other Duties _______ 5%

Maintain established hospital and departmental policies and procedures, objectives, performance improvement program, safety, environmental and infection control standards.
Maintains confidentiality and security of patient information
Assist in the development of the clinical documentation improvement process and in the development of associated policy and procedure documents, as well as process development (i.e. – standard work)
Assume other duties as assigned by Manager or designate

3. Education & Training

What should be the minimum schooling or formal training for a new person being hired into this job?

( ) Elementary School (up to Grade 8)
( ) Partial Secondary School (up to Grade 10)
( ) Secondary School
(x) Community College
( ) Undergraduate Degree
( ) Master's Degree
( ) Ph.D.
( ) M.D.

Note: Bachelor's Degree preferred

Is any provincial or other vocational or professional certification or degree required?
(E.g. R.N., C.M.A., ticketed journeyman etc.) (x) Mandatory ( ) Preferred
Please specify:

Accredited Health Professional (HIM, RN, RPN, etc.) **or** other Health Care/Clinical Background with quality, utilization, decision support, or clinical experience or equivalent experience/skill required

What special skills or training are needed to perform the job or operate equipment?
(E.g. word processing, computer programming, CPR, etc.)

Coding skills with ICD10/CCI experience an asset
Knowledge of HSFR funding methodology an asset
Excellent computer skills, proficient in Microsoft Office required, Meditech an asset
Experience in chart auditing/review an asset
Demonstrated knowledge of Medical Terminology
Effective interpersonal skills in order to interact and communicate effectively with all levels of hospital personnel
Organization and prioritization skills
Effective written and verbal communication skills
Analytical skills essential

Special Thanks to the Authors and Reviewers

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