The ins and outs of CDE
10 steps for addressing clinical documentation excellence
What’s at stake for CDE outpatient/inpatient integration?

Historically, provider organizations have focused their clinical documentation improvement (CDI) or clinical documentation excellence (CDE) efforts on improving the quality of care and reimbursement in the inpatient arena. But multiple changes in the health care environment are commanding high-quality clinical documentation more than ever before across inpatient, outpatient, and clinic settings.

These changes include:

• A continual shift of hospital patient volume from inpatient to outpatient, making outpatient reimbursement a more prominent part of provider organizations’ businesses

• Implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), which impacts how providers will be reimbursed for their clinic practices

• An increasing number of Medicare Advantage enrollees, making hierarchical condition categories (HCCs) and risk adjustment factors (RAFs) a critical focus across the care settings

• The rapid rise of health care consumerism, compelling providers to pay extra attention to their public profiles and other publicly available data

Regulatory entities require individual providers to submit timely, accurate, and properly coded claims while ensuring that services are medically necessary, meet quality measures, and are adequately documented by the provider. At its early stage, the basic goal of an inpatient CDI program is to positively impact the assignment of Medical Severity Diagnosis Related Groups (MS-DRGs) and accurately reflect a patient’s severity of illness (SOI) and risk of mortality (ROM) through promoting accurate and comprehensive clinical documentation.

To inspire hospitals to further improve the quality of patient care and cost efficiency, the Centers for Medicare and Medicaid Services (CMS) implemented pay-for-performance (P4P) incentive models through such programs as:

• Hospital-Acquired Conditions (HAC) Reduction

• Hospital Readmissions Reduction

• Patient Safety Indicators (PSI)

• Hospital Value-Based Purchasing

Along with the MS-DRG inpatient reimbursement methodologies, these P4P risk-adjustment methodologies encourage and reward quality over quantity. They have also contributed to the evolution of CDI programs.
As the delivery of health care and reimbursement methodologies evolve, the importance of a holistic CDI program becomes evident. Requirements of clinical documentation and accuracy of data are essential in achieving quality and cost-saving outcomes, regardless of place of service or health care setting.

MACRA accelerates health care’s transition to value-based payment models by financially motivating physicians and clinicians to manage more of their patients under risk-bearing or coordinated care contracts. For Medicare physician reimbursement, there are two separate paths under MACRA: Advanced Alternative Payment Models (APMs) and Merit-Based Incentive Payment Systems (MIPS). Both are dependent on appropriate clinical documentation to capture accurate risk adjustment scores. Risk adjustment methodologies, such as the hierarchical condition category (HCC), impact documentation practices and requirements. They also have an effect on reimbursement and require continuous documentation of all chronic conditions to be reported on a yearly basis for the patient population, regardless of care setting, in order to properly estimate the population’s risk score.

Documentation and coding of all diagnoses is the foundation for HCC selection and appropriate risk adjustment reimbursement. Accurate and proper documentation of complications and comorbidities also plays an important role in risk adjustment. The documentation should clearly specify cause-and-effect relationships as required by the coding guidelines.

The provider should specify the causal relationship in the documentation for that particular condition to be coded. In the risk adjustment model, any complications and comorbidities are weighted higher, but many of these conditions go undocumented. Risk scores will change year over year, depending on the number of chronic conditions submitted. This hampers data collection on a larger scale and does not reflect the appropriate illness burden and severity of the patient population being treated.

Building a foundation for accurate documentation

The rise of value-based care in commercial and Medicare settings, including Medicare Advantage, has become the catalyst to strategically align inpatient with outpatient and clinic documentation programs. It also enables provider organizations to better capture accurate clinical documentation, coding, and subsequent data needed for risk-adjustment scores.

Unlike reimbursement models for facility reporting, the proposed implementation of MACRA via the two payment models, MIPS and APMs, shifts the risk to the provider. In addition, it specifically impacts physician reimbursement and quality measures. CDI programs should focus on accurate documentation that supports both comorbid conditions treated and quality measures reported in the hospital and clinic setting:

- Under the Resource Use MIPS category of MACRA, clinical documentation and risk adjustment will rely on licensed providers, such as physicians (MD), doctor of osteopathy (DO), physician assistants, or nurse practitioners, to provide specificity in documenting diagnoses on the date of service and sign-off, and to continue to document applicable chronic and acute conditions.
- For APMs, the Medicare Shared Savings Program (MSSP) bonuses and penalties will impact physicians and clinicians. It will be based on risk-adjusted actual versus expected cost performance and rely on documentation-driven diagnoses and coding.²

While the need for more precise clinical documentation and coding has always been important, the increasing adoption of risk-adjustment models has made CDI all the more vital. With the performance period of MACRA beginning in January 2017, it’s become even more crucial for providers in inpatient, outpatient, and clinic settings to ensure they have the necessary foundation to capture accurate documentation and other variables to demonstrate quality of care and compliance with regulatory requirements while reducing financial risks.

Risk-adjustment models are based on continuous care over the course of a calendar year, and they involve multiple encounters to capture all chronic conditions affecting the patient. Analyzing HCCs under APMS or MIPS won’t change the general focus in CDI practices that encourage precise clinical documentation to capture the patient’s SOI and ROM. However, current CDI and coding processes are based on individual visits or encounters, and HCCs introduce continuum of care that’s not being accounted for in present-day, encounter-based processes.

The following 10 steps can be considered to help provider organizations leverage inpatient CDI capabilities and address the increasing demand for accurate clinical documentation in the outpatient and clinic setting:

1. **Plan ahead and implement sooner.** Providers won’t be seeing the reimbursement impact from MACRA until January 2019. But the first performance period started in January 2017, in which high-quality clinic-based documentation will become more important than ever.

2. **Analyze current policies and procedures and assess workflows pertaining to outpatient and clinic documentation and data capturing.** Identify gaps impacting data quality in outpatient and clinic settings: who the owners of documentation are based on CMS definitions, and how and when documentation occurs for an encounter.

3. **Reevaluate the current state of your CDI program.** Consider current CDI focus areas (e.g., payer/medical unit/specialty coverage), scope of responsibilities (e.g., documentation review, core measure monitoring), team member capacity (e.g., productivity and effectiveness), and key performance metrics (e.g., coverage rates, DRG shifts, Case Mix Index (CMI)) to understand resources, process flows, and management reports required to enhance the inpatient CDI program while shifting additional resources to jump-start the outpatient CDI program.

4. **Identify synergies between CDI needs in the inpatient, outpatient, and clinic settings.** Leverage existing inpatient CDI resources when designing the outpatient and clinic-based CDI program. Inpatient CDI resources, such as education materials, query templates, management reports, and documentation templates, can serve as starting points for outpatient and clinic use to assist providers in documenting all conditions that are being treated, evaluated, assessed, and monitored. Inpatient, outpatient, and clinic-based clinical documentation specialists (CDSs) should align messaging and be consistent with their deliveries to providers. They should also identify opportunities to educate across all care settings.

5. **Determine if the right technology is available for operationalizing the outpatient and clinic CDI programs.** CDI technologies currently available in the market are designed for inpatient CDI programs, but certain functionalities may be leveraged for outpatient and clinic use (e.g., workflow drivers with a specific algorithm). At a minimum, technology tools used for outpatient and clinic CDI programs must be able to capture data for risk-adjustment measurements. Outpatient and clinic CDI programs may initially utilize manual processes due to the lack of workable and cost-effective technology. But CDI leaders should continue searching for tools, as the popularity of outpatient and clinic CDI will likely drive development of cost-effective technology solutions.

6. **Understand and prepare for the impact of the changing health care operational environment.** The need to create an outpatient and clinic CDI program was identified in the 2000s. But the idea hasn’t gained much traction until recently, thanks to various health care and reimbursement reforms. To be better prepared, CDI leaders are advised to become fully aware of implications of regulatory changes and operating model transformation on physician documentation. They should also understand the importance of improving documentation across the health care spectrum.

7. **Secure talent for the outpatient and clinic CDI programs.** Consider staffing for these CDI programs: Are there sufficient talent resources and credentialed staff knowledgeable in the subject matter? CDI leaders getting ready to initiate an outpatient and clinic CDI program should consider the must-have and nice-to-have skillsets of these focused CDSs. They should...
identify candidates with foundational knowledge to address outpatient and clinic CDI needs who are eager and have great capacity to learn. And they should be prepared to offer robust training to improve candidates’ CDI skills.

8. Determine performance measures for the integrated CDI program. Inpatient CDI key performance indicators (KPIs) such as CMI, complication/comorbidity capture rate, SOI, ROM, and reimbursement changes with different DRG assignments are likely not applicable for measuring outpatient and clinic CDI program performance. Productivity targets may also vary as inpatient, outpatient, and clinic CDI review requirements and documentation structure differ. KPIs for outpatient and clinic CDI programs should align with and measure their impact on HCCs, value-based purchasing, and MACRA’s quality reporting requirements. Provider organizations that plan to develop an integrated CDI model will need to identify how best to measure and compare performance of all programs to promote ongoing improvement and sustainable success.

9. Educate providers, CDSs, coders, and other clinical professionals. Outpatient and clinic CDI is likely a new concept for most health care practitioners. Therefore, it will require a robust education platform to establish common goals and objectives for enhancing collaboration and future success. Educate physicians and other clinical providers (e.g., residents, nurse practitioners) to understand how hospital coding determines the SOI, ROM, and risk scores in risk-based programs—and now physician-based programs such as MACRA. Good clinical documentation benefits the physician as well as the hospital.

10. Identify strategic leadership and stakeholders to rectify and fill any identified risks/gaps. Stakeholders may include executive physician leadership, service line physician leadership, coding and HIM leadership, and quality and finance leadership to collaborate on the type of framework or foundation needed to improve operational readiness.

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Meet ongoing data demands for improved quality of care

The importance of accurate and complete clinical documentation will continue to grow across care settings and provider groups. As multiple regulatory and operational changes in the current health care landscape rely on data from clinical documentation, provider organizations will need to establish outpatient and clinic CDI programs that are tuned to the care setting and prioritized based on an organization’s strategy to operate in the new environment. Health care providers should:

1. Create strong alignment and common leadership (at the highest level, not necessarily at the operational level)
2. Focus on quality and compliance risk—as the stakes grow, so does the need for an effective CDI program
3. Review different CDI integration models and consider how to tackle challenges across organizational boundaries

Finally, with the introduction of PSIs, MACRA, and other value-based reimbursement models, the health care focus shifts to such factors as quality of care, clinical outcomes, population risk, and cost savings. Risk-adjustment payment methodologies rely heavily on historical data to predict health care costs based on the relative risk of the patient population. CDI can be the mechanism to provide the quality clinical documentation and data needed for health care providers to meet the ongoing data demands for validation of quality of care.
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