CORE CDI

Achieving Physician Documentation Excellence
A Different Approach

- Physician Documentation Excellence versus Clinical Documentation Improvement
    - Only the physician can achieve truly sustainable documentation excellence
    - Only the physician can achieve complete and accurate documentation as defined by CMS
        - All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and services; document the course and results of care, treatment, and services; and promote continuity of care among providers. With these criteria in mind, an individual entry into the medical record must contain sufficient information on the matter that is the subject of the entry to permit the medical record to satisfy the completeness standard.

- Core-CDI embraces the realization that CDI complements and supports but does not substitute the physician's duties and responsibilities to provide complete and accurate charting and communication of patient care

- Core-CDI provides a time tested proven holistic approach to ensuring physicians achieve documentation excellence through didactic and "on the job" individual and group educational training

- Core-CDI subscribes to the philosophy that off the shelf cookie cutter approaches to physician documentation training, education, and knowledge sharing will not be effective. Instead, a better approach is undertaking an initial physician documentation assessment using proprietary physician documentation score tools utilized to design an individual physician driven physician documentation training program

- Core-CDI uses practicing hospitalist physicians as an integral part of the physician documentation training program, physicians who have mastered solid complete and accurate documentation and charting and apply in their daily practice of medicine. Outcomes and benefits to physicians at client hospitals include

    - Ability to work smarter not harder, working more efficiently, allowing more dedicated time for patient care
    - Decreased queries from clinical documentation improvement specialists
    - Less interruption from Case Management/Utilization Review seeking additional information needed for authorization and continued stay
    - Optimal determination of level of care, inpatient versus observation supported by complete documentation accurately telling, describing, and depicting the patient's clinical story and need for hospital level of care
    - Less self-inflicted medical necessity denials and level of care downgrades through a "proactive preemptive denial avoidance" approach to documentation
    - Alleviation of large volumes of clinical validation denials and DRG downgrades through physician documentation that adequately tells and describes the patient's clinical story with clinical information, clinical context, and clinical facts that support the physician's arrival at diagnoses with appropriate workup and management
    - Ability to overcome payer adverse level of care determinations through successful Medical Director Peer-to-Peer discussions
    - Ability to successfully appeal and overturn retrospective costly payer denials through drafting of effective appeal letters using solid medical record documentation in support of appeal

Achievement of Physician Documentation Excellence
Results of a Recent Provider Engagement

- Sustainable measurable improvement in ED provider documentation, critical component in reducing level of care downgrades by 25% and medical necessity denials by 30% in the first three months for hospitalized patient encounters

- Sustainable measurable improvement in physician H & Ps and progress notes through documentational educational training and knowledge sharing provided to all hospitalists. Baseline assessment of each hospitalist was performed and used to develop and implement a solid individualized documentation training program for individual hospitalists as well as the group
- Physician documentation scores for H & Ps, Progress Nots, and Discharge Summaries improved from an initial average score of 65% before the training to a post training average score of 90% through effective sustainable documentation training program with ongoing reinforcement. Newsletters, podcasts, videos, documentation tip sheets and presentations were utilized as integral parts of the documentation training program
- Reduced clinical validation denials from 5.2% to 2.78% within the first three months through physician documentation practices taught to include their clinical judgement, clinical rationale and thought processes used in the arrival of a diagnosis. Physicians understood the critical needs for accurate reporting, reflecting, and depicting of the patient's clinical story, clinical information, clinical facts, and clinical context as an integral part of the medical record as a communication tool. Dot phrases were created to address and report specific documentation requirements made by payers in their clinical validation denial letters
- Reduced query volumes by 50% through physician documentation educational training stressing the need for complete and accurate documentation, getting documentation right the first time. Documentation tip resources, podcasts, newsletters, and presentations were used as part of the physician documentation training and reinforcement process