Inova Health System Implements Clinical Documentation Improvement Program

Effective March 2012, Inova Health System implemented a new program to support physicians with their documentation of diagnoses, Present on Admission status and procedures for acute inpatient care.

The overall goal is to ensure that treating physician documentation reflects the complete clinical picture for the following:

- *Accurate classification of Severity of Illness (SOI) & Risk of Mortality (ROM) which drives quality & utilization profiling (expected mortality, LOS and cost)*

- *Accurate classification of complications as measured by Patient Safety Indicators and Hospital Acquired Conditions*

- *Meeting documentation requirements for ICD-10 diagnoses and procedures. Note: All HIPAA covered entities including physician practices must bill ICD10 diagnosis codes effective 10/1/2014*

- *Improving documentation requirements for medical necessity*

For a high level overview of the program, a dedicated RN or MD Clinical Documentation Specialist workforce (CDS) reviews inpatient charts while patients are being treated on nursing units.CDS prepares a Concurrent Query in Epic EMR to clarify any documentation of diagnoses or procedures not previously documented (ex, patient on ventilator with no corresponding diagnosis), clarification of Present on Admission status for a diagnosis (was catheter associated UTI present at time inpatient order was written?) or options for a more specific diagnosis (ex, acute, chronic, acute on chronic and systolic, diastolic, combined CHF). In the event that the physician is on the unit at the same time as the documentation specialist, she may request a verbal query.

This program positions Inova and its physicians to succeed in the future environment where quality will be the primary driver of value based purchasing of healthcare services.

Contact Patricia Jones (patricia.jones@inova.org), program director if you have any questions or need additional information.