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DIPA Clinical Pilot Charter

Describe. Interpret. Predict. Act.

Implementation Guide

Version 3.0 · September 2026 · Working draft for review and comment

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DIPA Clinical Pilot Charter

Describe. Interpret. Predict. Act.

A phased pilot for clinical reasoning documentation and closed-loop escalation

Version 3.0 | September 2026 Aligned to DIPA Framework v3.0

About this version

Version 3.0 makes three structural changes to the v1.0 charter.

The pilot is now phased. Phase A tests DIPA as a documentation framework using low-technology tooling. Phase B tests closed-loop trigger monitoring, and begins only if Phase A clears defined gates. Combining them in a single 90-day pilot was the most likely cause of failure in the original design: it would have confounded the documentation intervention with the technology intervention, and made an unfavorable result uninterpretable.

Financial outcomes are secondary. Objectives and measures are reordered so that clinical and documentation outcomes are primary and revenue effects are observed rather than targeted. This follows the framework's scoping of Predict to clinical trajectory.

Medico-legal and data architecture are now gating requirements, not risk-table entries. Phase B cannot begin without them resolved.

1. Pilot summary

Pilot name: DIPA Clinical Reasoning Pilot **Framework:** Describe. Interpret. Predict. Act. (v3.0)

Purpose: Test whether documenting clinical reasoning in DIPA form improves the clarity, timeliness, and usefulness of the clinical story without increasing clinician burden, and, in Phase B, whether closed-loop monitoring of clinician-authored escalation triggers improves execution of documented plans.

Core principle:

Insight is seeing risk early enough to change the outcome.

Structure:

Phase	Duration	Scope
Baseline	30 days	Measurement only, no intervention
Phase A	10–12 weeks	DIPA documentation via smart phrase or template. No monitoring capability
Gate review	2 weeks	Phase A results assessed against gating criteria (§10)
Phase B	10–12 weeks	Closed-loop trigger monitoring, only if gates clear

Recommended setting: One inpatient hospitalist unit, progressive care unit, or specialty service. One facility for Phase A.

Recommended initial cohort: select one: - Sepsis and severe infection - Acute hypoxic respiratory failure - Acute decompensated heart failure - Acute kidney injury - High-risk surgical admissions

Sepsis and severe infection is the default recommendation. See §6.

2. Business and clinical need

Organizations identify clinical, documentation, and utilization issues too late in the episode of care. The traditional sequence is retrospective:

Service → Discharge → Coding → Claim → Denial → Rework

DIPA supports a prospective sequence:

Clinical encounter → Explicit clinical reasoning → Monitored commitment → Earlier recognition → Targeted action → Clearer record

The pilot targets two distinct failures:

Failure 1: reasoning not made explicit. The clinician's assessment of trajectory, deterioration signals, and escalation criteria remains in their head rather than in the record, unavailable to the covering physician, the night nurse, or anyone reviewing the case later. Phase A addresses this.

Failure 2: reasoning documented but not executed. The escalation criterion is written, the condition occurs, and nothing happens. This is the failure-to-rescue pattern in its most preventable form. Phase B addresses this.

The pilot is not designed to increase documentation volume. It is designed to make the clinical story coherent and to keep its commitments active.

3. Objectives

Primary: Phase A

1. Improve clarity and completeness of documented clinical condition, etiology, acuity, severity, anticipated course, monitoring, and treatment plan
2. Establish whether clinicians find DIPA usable and clinically meaningful without unacceptable documentation burden
3. Establish whether escalation criteria are documented as observable conditions with thresholds
4. Reduce avoidable retrospective rework, including post-discharge clarification and coding rework

Primary: Phase B

1. Establish whether closed-loop monitoring improves execution of documented escalation plans
2. Establish whether the capability operates within acceptable alert burden
3. Establish a safe, auditable, human-governed model for the capability, including data architecture and privilege structure

Secondary: both phases

- Improve communication among clinicians, nursing, CDI, coding, physician advisors, case management, and utilization review
- Improve prioritization of cases for concurrent review
- Develop practical requirements for vendor selection, EHR integration, and operating-model design
- Establish baseline measures and a business case for possible scale

Observed but not targeted

Denial activity, medical-necessity outcomes, DRG agreement, and revenue effects are measured and reported descriptively. They are **not pilot objectives**, and the pilot is not powered to demonstrate them. Framing them as objectives undermines clinician trust and contradicts the framework's clinical primacy principle.

4. Scope

In scope: Phase A

- Clinician documentation at defined workflow moments (§5)
- DIPA smart phrase, template, or assessment-and-plan prompt
- Concurrent case identification and routing to defined human reviewers

- Review of documentation clarity, trajectory statements, escalation criteria, and action plans
- Measurement per §9

In scope: Phase B, if gated

- Monitoring of clinician-authored escalation triggers against discrete clinical data
- Tiered notification and escalation on non-response
- Trigger lifecycle management including expiry
- Two-layer data architecture and privilege structure (§8)
- AI predictive support as Lever 2, if approved, proposing candidate risks and trigger language for clinician acceptance or rejection

Out of scope: both phases

- Autonomous clinical diagnosis or treatment recommendation
- **Deterioration detection or patient risk scoring independent of clinician-authored criteria**
- **AI authorship of Predict content**
- Monitoring of continuous physiologic waveforms or signal-acquisition output
- Replacement of clinician judgment
- Automatic coding or billing actions
- Reimbursement-driven diagnosis selection
- Deployment across all conditions, facilities, or user groups
- Substitution for compliant CDI query practice, coding review, utilization review, or clinical validation

The three bolded exclusions are not scope-limiting conveniences. They are the constraints that keep the capability clinically sound, medico-legally defensible, and outside medical device regulation. They do not relax at scale.

5. Workflow design

Element	Clinician prompt	Supporting-team role	Technology support
Describe	What is happening with the patient now?	Validate clinical indicators and baseline comparison	Surface trends in vitals, labs, imaging, oxygen requirement, treatment response, relevant history
Interpret	What does this mean clinically, and why?	CDI, coding, physician advisor may identify ambiguity requiring review	Present patient-specific evidence for clinician review; never establish diagnoses
Predict	What is the expected course, and what would tell us it is not going well?	Case management, UM, and physician advisors use documented risk and monitoring needs	Lever 2 only: propose candidate risks and trigger language for clinician acceptance. Never author
Act	What are we doing, monitoring, and escalating?	Track escalation, reassessment, coordination, discharge requirements	Phase B: monitor clinician-authored triggers, notify on unclosed commitments

Workflow moments

- 1. Admission / initial assessment:** establish baseline clinical story, anticipated course, and initial escalation criteria
- 2. Daily reassessment:** update interpretation, trajectory, treatment response; reaffirm, revise, or retire triggers
- 3. Change in status or transfer:** clarify deterioration, complication, new diagnosis, or level-of-care rationale
- 4. Pre-discharge review:** confirm clinical story, unresolved issues, discharge barriers, follow-up plan
- 5. Pre-final-coding review:** identify cases needing compliant clarification

Moment 2 carries the trigger expiry cycle in Phase B. Triggers not reaffirmed at daily reassessment retire automatically.

6. Cohort selection

Criteria

- Meaningful clinical complexity with variable trajectory
- Frequent documentation ambiguity or CDI review
- Sufficient volume for measurement within 10–12 weeks
- Engaged clinical leadership and an available champion
- Manageable implementation scope

Default recommendation: sepsis and severe infection

Rationale	Pilot relevance
Multiple etiologies and severity levels	Tests Describe and Interpret
Rapidly changing trajectory	Tests Predict and Act
Well-established escalation parameters (MAP, lactate, oxygen requirement, mental status)	Produces high-quality, observable triggers for Phase B
Frequent monitoring and escalation needs	Supports care communication and utilization review
Cross-functional involvement	Engages clinicians, nursing, CDI, coding, case management, physician advisors

Sepsis is recommended specifically because its escalation criteria are already familiar, quantitative, and time-bounded. Cohorts where escalation criteria are inherently subjective will produce poor Phase B triggers and an uninterpretable result.

Final cohort selection rests with the governance group after baseline review.

7. Governance

Executive sponsor

Chief Medical Officer, Chief Quality Officer, or Chief Clinical Informatics Officer. A revenue cycle executive should participate but must not be the sole sponsor. Sponsorship signals what the pilot is about, and clinicians read that signal accurately.

Clinical champion

A practicing physician or APP from the pilot service who will co-design the workflow, validate usability, lead peer education, and escalate safety, burden, or adoption concerns.

Core team

Role	Responsibilities
Physician executive sponsor	Strategic oversight, barrier removal, clinical accountability
Clinical champion(s)	Workflow design, peer education, usability feedback
Nursing and APP representative	Care-team workflow, handoff alignment; Phase B tier-1 routing design
CDI leader	Documentation review criteria, query governance, concurrent workflow
HIM and coding leader	Coding integrity, post-discharge review, audit design; record content determination for Phase B
Physician advisor / UM leader	Medical necessity, level of care, clinical validation
Case management leader	Discharge barriers, transitions, coordination
Quality and patient safety leader	Clinical appropriateness, safety metrics, equity review
Patient safety officer	PSES design, PSO reporting arrangement (Phase B)
Risk management	Foreseeability guidance, documentation standards, incident review
Compliance and legal	Policy review, query compliance, audit and privilege structure
Rapid response / code team leadership	Phase B tier-3 routing design and load assessment
IT, informatics, security	EHR build, interfaces, access controls, layer separation
Revenue integrity and finance	Descriptive financial measurement only
Vendor partner, where applicable	Configuration, implementation, support, performance reporting

Bolded roles are additions in v3.0, required for Phase B.

Cadence

- **Weekly implementation huddle:** build, workflow, data, adoption, issues
- **Biweekly clinical review:** clinician feedback, sample-case review, trigger quality, safety concerns
- **Monthly steering committee:** outcomes, risks, resource decisions, gate and scale assessment
- **Ad hoc escalation:** immediate review for any potential patient safety event, inappropriate system behavior, privacy or security concern, or significant compliance issue

Phase B adds a **weekly trigger review:** a sample of fired triggers examined for appropriateness, routing performance, and close-path distribution.

8. Technology, data architecture, and guardrails

8.1 Phase A

Phase A requires no AI capability. A smart phrase, template, or structured assessment-and-plan prompt is sufficient and preferred. Starting low-technology isolates the documentation intervention and produces an interpretable result.

8.2 Phase B required controls

- Patient-specific source evidence displayed for every prompt, trigger, and notification
- Clear separation between evidence, clinician assessment, coded data, and financial outcome
- Clinician ability to accept, reject, modify, defer, suppress, or retire any suggestion or trigger
- **No trigger exists without affirmative clinician authorship**
- **Discrete clinical data only:** documented vitals, laboratory values, medication administration, order status
- Role-based access and minimum-necessary data use
- Configurable thresholds, routing tiers, and notification intervals
- Audit logs covering data source, model and version, trigger, notification, user action, close path, and disposition
- Sandbox testing before production deployment
- Ongoing monitoring for false positives, alert fatigue, bias, drift, and workflow disruption

8.3 Two-layer data architecture: required before Phase B

Layer 1: Clinical record. Trigger, the data meeting it, and the clinician or nurse response including documented reassessment. Part of the medical record. Discoverable, and appropriately so.

Layer 2: Aggregate analysis. Closure rates, response time distributions, unit and shift patterns, trigger quality, routing performance, override analysis. Quality improvement artifact.

Separation must be implemented **architecturally, not by policy alone**. HIM and coding leadership determine Layer 1 content. Patient safety and legal determine Layer 2 structure.

8.4 Privilege structure: required before Phase B

Layer 2 should be evaluated for structuring as patient safety work product under the Patient Safety and Quality Improvement Act of 2005:

1. Patient safety evaluation system defined and documented before any Layer 2 data collection
2. Reporting arrangement with a listed PSO established
3. Architectural separation maintained between layers
4. Retention and disposition policy set for both layers at design time
5. Quality improvement purpose documented contemporaneously

Protection is not absolute and must be designed by counsel. PSWP does not reach the original medical record, does not shield independently required information, and has been construed narrowly by some courts. The objective is a deliberate, documented, defensible structure, not immunity.

8.5 Regulatory review: required before Phase B

Regulatory counsel must review the monitoring capability against the non-device CDS criteria in FD&C Act §520(o)(1) (E), with attention to the January 2026 FDA guidance update. The design constraints in §4 and §8.2 are written to support a non-device position. A capability that authors predictions, monitors continuous physiologic streams, or is positioned as deterioration detection will not sustain that position.

8.6 Prohibited

- Autonomous generation of diagnoses or Predict content
 - Independent characterization of patient clinical state
 - Reimbursement-first prompts or workflow logic
 - Leading queries
 - Automated final coding, billing, clinical escalation, or appeal decisions outside approved controls
 - Deployment without clinical, CDI/HIM, compliance, risk management, IT/security, and governance approval
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9. Measurement

9.1 Baseline

Minimum 30 days before Phase A go-live, using the same cohort definitions and denominators. Baseline must include documentation completeness audit and, where feasible, retrospective assessment of how often documented escalation criteria were met and what followed; this establishes the Phase B comparison.

9.2 Phase A primary measures

Declare thresholds before baseline collection.

#	Measure	Direction
1	Documentation time per note	No material increase (balancing)
2	Documentation completeness audit score	Improvement vs. baseline
3	Paired-statement rate: Predict statements with corresponding Act content	High and stable
4	Trigger specificity: escalation criteria written as observable conditions with thresholds	High and stable
5	Retrospective query volume per 100 discharges	Reduction
6	Unsupported diagnosis rate	No increase (balancing)
7	Clinician-reported usefulness	Majority report clinical value

Measures 1 and 6 are balancing measures. The pilot fails if completeness improves through added burden or through diagnoses the record does not support.

9.3 Phase B additional measures

#	Measure	Direction
8	Trigger close rate within defined interval	High
9	Time to close, by routing tier	Short and stable
10	Close-path distribution: intervention vs. documented reassessment vs. revision vs. retirement	Balanced; see below
11	Tier-3 escalation rate	Low and stable
12	Notification volume per clinician per shift	Within declared ceiling (balancing)
13	Trigger specificity, continued from Phase A	No degradation (balancing)

Measure 13 is the most important and the most easily overlooked. Clinicians under notification pressure will write vaguer triggers to avoid firing them. Declining specificity is the earliest signal that the system is being worked around, and it appears before closure rates degrade.

Measure 10 detects two distinct failures. A distribution dominated by retirement suggests triggers are being dismissed rather than considered. One dominated by intervention with almost no documented reassessment suggests the non-action close path is too difficult to use.

9.4 Descriptive only

Query response time, concurrent review coverage, final DRG agreement, coding rework, discharge barriers identified, length of stay, rapid response calls, unplanned ICU transfers, medical-necessity and clinical-validation denials, avoidable write-offs.

Financial outcomes are reported here with explicit caveats for claim lag, case-mix variation, and concurrent initiatives. No causal claims from a single-unit pilot.

9.5 Required analytic practices

- Denominators defined before baseline collection
- Stratification by clinician group, service line, shift, and relevant patient population
- Clinical and documentation measures reported before financial measures
- Unintended consequences reported alongside benefits
- No causal attribution where concurrent initiatives affect the cohort
- Qualitative clinician feedback reported alongside quantitative results

9.6 Equity

Review documentation completeness, trigger authorship, close rates, routing outcomes, and override patterns across relevant patient populations. Where Lever 2 is implemented, review candidate-risk performance across the same dimensions. Investigate and remediate unexplained variation.

10. Gate between Phase A and Phase B

Phase B begins only if **all** of the following are satisfied.

Clinical and documentation gates

- No material increase in documentation time
- Measurable improvement in documentation completeness
- Paired-statement rate at or above the declared threshold
- **Trigger specificity at or above the declared threshold:** without observable, thresholded triggers there is nothing to monitor and Phase B cannot be run
- No increase in unsupported diagnosis rate
- Majority clinician-reported value

Structural gates

- Two-layer data architecture designed and implemented

- PSES defined, PSO reporting arrangement established, retention policy set
- Regulatory counsel review complete with a documented position
- Risk management and malpractice counsel guidance issued
- Routing tiers designed with nursing and rapid response leadership
- Non-action close path built and usability-tested
- Trigger expiry mechanism built and tested

If trigger specificity fails, do not proceed to Phase B. Extend Phase A and address trigger-writing education instead. Monitoring poorly specified triggers produces alert burden without clinical benefit and will destroy clinician trust in the capability permanently.

11. Education and change management

Core message

DIPA is not additional documentation for its own sake. It is a concise way to make the clinical story clear: what is happening, why, what may happen next, and what the care team is doing about it.

For Phase B, add:

The system does not assess your patient. It returns your own escalation criteria to you when they are met and nothing has been documented. You set the criteria. You can change or retire them at any time. Documented reassessment closes a trigger exactly as intervention does.

Audience focus

Audience	Focus
Clinicians and APPs	Clinical value, ease of use, examples, documentation ownership, ability to override; Phase B: trigger authorship and the non-action close path
Nursing	Shared clinical story, escalation criteria, handoffs; Phase B: tier-1 notification role
CDI and coding	DIPA elements, evidence standards, concurrent workflow, query governance
Case management and UM	Risk, level-of-care rationale, discharge barriers, escalation
Risk management and legal	Foreseeability, paired-statement discipline, documentation of reassessment
Revenue integrity and finance	Upstream prevention, measured outcomes, no interference with clinical primacy
Leaders	Governance, adoption measures, resource needs, gate and scale criteria

Methods

Fifteen-minute huddles; one-page quick reference; two to three specialty-specific examples; short EHR tip sheet; weekly feedback loop during the first month; office hours with the clinical champion, CDI, and informatics.

Phase B requires trigger-writing education specifically. Most clinicians have never written escalation criteria as machine-observable conditions. This is a teachable skill and it determines whether Phase B works.

12. Timeline

Phase	Timing	Key activities
1. Charter and governance	Weeks 0–2	Confirm sponsor, cohort, team, scope, guardrails, decision rights
2. Baseline and mapping	Weeks 1–5	Baseline measurement, current-state mapping, pain points
3. Phase A build	Weeks 3–6	Smart phrase or template; education materials
4. Education and readiness	Weeks 5–6	Train users, publish quick reference, establish support
5. Phase A limited go-live	Weeks 7–8	Limited group; monitor burden, quality, safety closely
6. Phase A active	Weeks 8–18	Full pilot population; weekly huddles, biweekly clinical review
7. Gate review	Weeks 18–20	Assess against §10; go/no-go for Phase B
8. Phase B structural work	Weeks 12–22, parallel	Architecture, PSES, PSO, regulatory review, routing design, build
9. Phase B limited go-live	Weeks 21–22	Small group; intensive trigger review
10. Phase B active	Weeks 22–32	Full pilot population; weekly trigger review
11. Evaluation	Weeks 32–34	Compare with baseline; scale/no-scale recommendation

Phase 8 runs in parallel with Phase A deliberately. The legal, privilege, and regulatory work takes longer than the build and is the most common cause of delay.

13. Risks and mitigations

Risk	Mitigation
Clinician perception of added burden	Concise prompts; embedded workflow; clinician co-design; measure time and satisfaction
Reimbursement-first framing undermines trust	Lead with care communication and patient safety; clinical sponsor; financial measures reported separately and last
Documented foreseeability creates liability exposure	Paired-statement rule; risk management and malpractice counsel guidance before Phase A; documented reassessment as an equal close path
Monitoring log creates discoverable evidence of non-response	Two-layer architecture; PSES and PSO structure; retention policy; all gated before Phase B
Capability drifts toward deterioration detection	Scope exclusions in §4; regulatory position documented; governance review of any scope change
Clinicians write vague triggers to avoid notifications	Trigger specificity tracked as a balancing measure in both phases; gate criterion; trigger-writing education
Alert fatigue	Narrow cohort; tiered routing; escalation on non-response not on trigger; notification ceiling as balancing measure; trigger expiry
Notification routing overloads rapid response	Tier-3 load assessed with rapid response leadership before go-live; tier-3 rate tracked
AI produces unsupported or leading suggestions	Clinician authorship requirement; evidence traceability; approved prompt language; audit; escalation
Inconsistent adoption	Clinical champion; specialty-specific examples; feedback loops; transparent adoption data
Duplicate work across CDI, coding, UM, case management	Defined case ownership, routing rules, shared worklist visibility
Weak measurement from small samples	Sufficient-volume cohort; structured qualitative assessment alongside quantitative
Unequal performance across populations	Monitor by patient and operational groups; investigate and remediate
Technology integration delay	Phase A requires no integration; Phase B structural work runs in parallel

Bolded rows are additions in v3.0.

14. Scale, modify, or stop

Scale when

- Clinicians report improved clinical communication or documentation clarity with acceptable burden
- Structured audit shows improvement in targeted documentation measures
- Trigger specificity is sustained
- Phase B demonstrates improved execution of documented escalation plans within acceptable notification burden
- No significant safety, compliance, privacy, or equity concerns
- Evidence traceability, audit logs, layer separation, and human-review controls function as designed
- Operating model, ownership, and resource requirements are sustainable

Modify when

- Value is evident but prompts, workflow fit, cohort definition, routing, or training need refinement
- Benefit is limited to a narrower condition, user group, or workflow moment
- Notification burden or duplicate work exceeds thresholds but is remediable
- Trigger quality is inconsistent across clinician groups

Pause or stop when

- The intervention increases unsupported diagnoses, inappropriate queries, or clinically unsafe behavior
- **Trigger specificity degrades materially, indicating workaround behavior**
- **Notification volume exceeds the declared ceiling without remediation**
- Clinician burden or adoption barriers outweigh measured benefit
- Technology lacks evidence traceability, reliable auditability, or adequate human oversight
- **Layer separation or privilege structure proves unworkable**
- Equity, privacy, security, or compliance concerns cannot be resolved promptly

15. Closing

DIPA makes the clinical story visible while it can still change care. Phase A tests whether clinicians will make their reasoning explicit. Phase B tests whether the organization can keep the commitments in that reasoning active.

The desired outcome is not more documentation. It is clearer clinical reasoning, plans that get executed, less avoidable rework, and human judgment applied where it matters most.

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