Improve Data and Outcomes with CDI

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ICD-10-CM/PCS will require significantly more clinical detail than ICD-9-CM, making clinical documentation improvement (CDI) efforts paramount for healthcare providers across the continuum of care. While CDI programs aim to substantiate claims and improve revenue streams, CDI itself should be viewed as a necessary aspect to the provision of patient care and overall operational performance.

CDI calls for precise data that can address and support the complexity and severity of illness. Historically, clinical data used for coding and revenue decisions have been collected following discharge. With data emerging as a critical asset, however, it is imperative that data be created and captured in real time. Electronic health record tools are tailored to aid in the creation, capture, storage, and dissemination of clinical data to provide a complete depiction of care.

Good documentation saves time and money, and improves communication among providers as well as the overall quality of care provided to the consumer. CDI activities must resonate with all clinicians as an organizational strategy critical to the longevity and survival of the organization. Regardless of the medium used to capture it, data captured for clinical and financial decisions must be both valid and reliable. Comprehensive physician and clinician training programs are essential to the success of an organization's CDI efforts.

Balancing the priorities of an organization's documentation needs can be challenging. Quality measures and reporting requirements under the Affordable Care Act make CDI efforts an essential component to everyday practice. Data repetition and lack of data structure can pose threats to data integrity. Universal terminology and data standards are essential to achieving specificity, reliability, and validity of the data. Good communication among practitioners supports high quality care. Good data supports improved outcomes and revenue streams, mitigates risks, and ensures compliance. CDI must be firmly embedded in the creation and capture of all clinical data to ensure success across all measures of accountability for an organization.

Information governance can support CDI efforts by providing a framework to ensure the effective use of information across the enterprise. The framework provides organizations with guidelines to manage information as a business asset. The practice of evaluating clinical documentation is facilitated by information governance through the standardization of data and the standardization of policies and guidelines that govern documentation.

Trust in the documentation and information used for care decisions is vital in the life and death decisions healthcare providers must make every day. Information governance provides a unifying framework to support clinical data capture and documentation improvement. Adherence to standards is central to information governance practice. When applied across the ecosystem, the positive impact on healthcare cost and quality can be realized. Leadership must commit to an information governance strategy for all corners of the organization.

Are you a catalyst for CDI in your organization? Have you assessed your information governance needs? Commit to quality care and outcomes through quality information, and as always, Dream Big, Believe, and LEAD.

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