New Frontier of Clinical Documentation Improvement

By Cassi Birnbaum, MS, RHIA, CPHQ, FAHIMA

The health information management (HIM) profession reached a new milestone in 2014 with over 79 percent of clinical documentation improvement (CDI) programs now led by HIM professionals.

The 2014 AHIMA Workforce Survey revealed strong similarities between the priorities of HIM professionals and employers when it came to ranking the importance of the top 10 HIM skills both now and 10 years from now. Data integrity and CDI were ranked respectively by employers as numbers four and six now, and numbers five and eight in 10 years. The delays in the ICD-10-CM/PCS transition, coupled with healthcare reform initiatives, has given organizations a chance to implement, revitalize, overhaul, and expand CDI programs.

I had the opportunity to pave the way in my own hospital system years ago by establishing a new CDI program in a field dominated by clinician leaders. I truly felt that my pathway to success was demonstrating the business and clinical case for improvement in clinical documentation to the stakeholder group and senior leaders.

I accomplished this task through the selection and education of outstanding physician champions and the establishment of a partnership with the medical staff and clinicians. These relationships helped us to achieve an impressive return on investment while improving our ability to accurately tell the patient's story.

Our hybrid team of nurses and HIM professionals didn't just chase after a higher weighted DRG, but instead focused on ensuring the documentation supported the clinical presentation, treatment, and clinical course. The CDI team monitored the accuracy of the problem list, accurately captured any conditions "present on admission," and had crucial conversations with the physicians to demonstrate through their own case examples why documentation really matters.

I am proud of my HIM colleagues facilitating the improvement of the integrity, specificity, appropriateness, and relevancy of documentation for sound clinical decision making. Excellent documentation will support transitions of care and enable a medical group, hospital, and health system to capture the diagnostic and procedural information to support accurate reimbursement, research, comparative and quality reporting, and value-based purchasing.

If HIM is not at the CDI table in your organization, now is the time to showcase your talents in assisting with clinical content redesign. With just a few months left prior to the transition to ICD-10, it is essential to ensure there is excellent communication, reconciliation, and an educational process between the CDI and coding teams.

CDI is moving beyond a traditional model to include all payers and settings of care. As the care delivery and payment models continue to shift, putting the CDI team in an ambulatory setting to ensure accurate, reliable, timely, relevant, and appropriate documentation at the point of care will ensure an optimal patient experience, minimize chasing of documentation after the fact, speed up payments, and minimize denials.

Now is the time to realize your CDI vision by sharpening your skills and gaining new knowledge. AHIMA has plenty of resources to offer in support, from a CDI Bootcamp to Practice Briefs, toolkits, and query guidance.

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