Quality Clinical Documentation—A Costly Challenge

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The debate continues over how to reform healthcare while controlling costs and spending. The options are complex and controversial, and after decades of failed cost and spending control efforts, it's not surprising that there is skepticism.

Reforming one of the world's most complex healthcare systems requires redesigning care processes and delivery systems, simplifying administration, reforming the payment system, and realigning consumer expectations. Little wonder it has taken a high level of public discomfort with the status quo to move us from incremental tinkering to transformational change.

Data, Documentation Key to Reform

Accurate clinical data and complete and accessible documentation are prerequisites to all efforts to reduce costs and improve safety and quality. This is, after all, the reason for electronic health record (EHR) adoption and health information exchange.

Yet, implementing an EHR does not guarantee more reliable clinical data or improved documentation. Instead, we must employ labor-intensive manual processes to ensure a "complete" record and the availability of documentation to substantiate medical necessity and compliance with regulatory and payment requirements. These include retrospective chart analysis, concurrent utilization review, and clinical documentation improvement (CDI).

Many hospitals have implemented CDI programs over the past several years. As noted in the feature "Clinical Documentation Improvement," AHIMA's CDI workgroup is developing best practices in forms and tools, program management, program evaluation, competencies, and ethics for CDI professionals.

I look forward to the day when more robust EHR information management functionality supports monitoring and management of the integrity and accuracy of clinical data and more complete clinical documentation. This functionality is not necessarily part of EHR solutions today, but advanced information management solutions will be needed to optimize EHRs to derive fuller benefits.

Structured documentation, rules-based documentation alerts, prompts, and clinical vocabularies will begin to automate CDI. We need research and development focused on information integrity, data standardization, data capture, and use.

ICD-10 also has the potential to enable improved data because of its greater specificity and because the advanced code set will trigger innovation in computer-assisted coding and CDI. In "ICD-10 Coding Training in England" Janis L. Huston discusses the lessons of implementation in the UK and emphasizes the value of comprehensive training and support.

The US starts with a competent coding work force and programs such as CDI. These should facilitate the transition, but we can expect documentation to be an ongoing barrier until we leverage technology for coding and managing underlying documentation.

Mentoring HIM's Future

"Help Wanted" explores the availability of professional practice experience for students. While HIM educators are not alone in grappling with this problem, PPE is becoming more and more limited, shortchanging students, college programs, and prospective employers. No one wins in this short-sighted trend.

Because helping to prepare the next generation is such an integral part of the HIM professional's responsibilities, the AHIMA Code of Ethics calls upon all HIM professionals to "Recruit and mentor students, peers and colleagues to develop and strengthen professional workforce."

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