Venturing into Outpatient CDI: A Growing Trend

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We see it everywhere: AHIMA is offering education programs to help their members embark on the outpatient clinical documentation improvement (CDI) journey. Consulting firms and technology companies are launching new services and solutions to support expansion of CDI programs to outpatient and physician settings. Healthcare executives are investing in resources to ensure documentation across the care continuum is accurate and complete and tells the patient's full story.

What is Driving this Trend?

As we all know, the healthcare industry is experiencing a dramatic shift toward the use of risk-based agreements and population health management. The acceleration of value-based models, such as bundled payments, is requiring cross-continuum relationships to deliver more coordinated care, improve patient outcomes, and monitor organizational performance. There is an increasing awareness that accurate data and information is a critical foundation for reform.

I'm not surprised that hospitals and health systems are now looking for information to help them identify opportunities and get started in the outpatient arena. Outpatient CDI, though different and challenging, is the next logical step for a CDI program.

Where to Begin?

When I have the opportunity to talk with HIM leaders about where they are focusing their early outpatient CDI efforts, many are starting in the emergency department (ED). Because ED providers' focus is first and foremost on taking care of patients, they often don't realize how important it is to capture the patient's story as well.

There are three reasons that I regularly hear as to why expanding CDI into the ED is a priority for HIM:

1. Support the proper level of care (inpatient, outpatient, or observation)
2. Improve accurate capture of ED-level charges (i.e., E/M)
3. Increase accuracy of present on admission (POA) indicators

With the growth of payment tied to Hierarchical Condition Categories (HCCs), the physician office is another focus area for CDI. HCCs can be used to classify patient conditions and each has an associated Risk Adjustment Factor (RAF). It is wonderful how CMOs, CFOs, and HIM leaders alike are recognizing the need to improve the documentation of chronic conditions in the physician's office, which is crucial in supporting high-quality patient care and revenue improvement.

Many HIM professionals have shared with me that their organizations are investing heavily in CDI specialists, education, and technologies to support the accurate and complete capture of the patient's chronic conditions.

As an HIM professional, I am excited to see the industry embrace the need to improve the quality of documentation and coding outside of the acute care inpatient setting. The need for documentation quality does not begin when the patient is admitted. Physicians who document well in outpatient settings and in their practices help establish a baseline for patient severity and medical necessity. By telling the patient's story regardless of care setting we can enhance care coordination, enhance patient care, and improve the health of the populations we serve.

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Article citation:
Chenoweth, Ann. "Venturing into Outpatient CDI: A Growing Trend" *Journal of AHIMA* 88, no.7 (July 2017): 7.