Poor Documentation Hazardous to Patient Health
Journal of AHIMA examines revival of Clinical Documentation Improvement programs

CHICAGO – July 2, 2014 – Advancements in health IT, enhanced patient engagement, ICD-10 and information governance (IG) all rely on clean, granular and accurate data.

The July issue of the Journal of AHIMA features a story, “Reinventing CDI,” that analyzes the trend of organizations relaunching and reworking data integrity efforts with clinical documentation improvement (CDI) programs.

“Clinical documentation is at the core of every patient encounter,” said AHIMA CEO Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA. “Health Information Management (HIM) professionals should continue to use their skills, expertise and leadership to improve the CDI process, which will help organizations collect and provide meaningful information throughout the continuum of care.”

CDI programs can be a provider’s first line of defense to make sure they are meeting the audit and quality program requirements and ensure they are being paid appropriately for their services.

Lydia Washington, MS, RHIA, CPHIMS, a senior director of HIM practice excellence at AHIMA, said in the article that sound CDI practices also contribute to IG efforts because they involve the creation of reliable, complete and authentic health information.

“As we start to think of these (concepts) from different perspectives and perhaps more strategically, such as not only the implications for payment but also things like coordination of care or patient engagement, we can see that poor documentation has far-reaching implications,” Washington said. “This broader view is what makes IG different from how we may have thought about CDI in the past.”

Lisa Campbell, PhD, CCS, CCS-P, owner of Physician Practices Resources, said that HIM professional are suited to move into CDI roles: “We are skilled in documentation review,” she said. “We manage health information. I think this is our area of expertise and we need to take it back, so to speak.”

Also in this issue
The practice brief, “Clinical Documentation Guidance for ICD-10-CM/PCS,” emphasizes the importance of CDI during this extended period of transition to the new code set. “Collaborative insight and support for CDI can result in more detailed, accurate and higher-quality data, which in turn leads to improved quality reporting, better clinical decision support and improved patient safety.”

The article, “Document Like This, Not That,” provides insight on CDI from physicians, coders and CDI experts. According to the story, CDI programs should foster collaboration between physicians, CDI specialists and coders.

Read these articles and more in the July issue of the Journal of AHIMA or online at journal.ahima.org.

###

About AHIMA
The American Health Information Management Association (AHIMA) represents more than 71,000 educated health information management and health informatics professionals in the United States and around the world. AHIMA is committed to promoting and advocating for high quality research, best practices and effective standards in health information and to actively contributing to the development and advancement of health information professionals worldwide. AHIMA’s enduring goal is quality healthcare through quality information.

www.ahima.org