



news

233 N. Michigan Ave., 21st Fl.
Chicago, IL 60601

phone >>(312) 233-1100
fax >>(312) 233-1090
web >>www.ahima.org

For more information, please contact:

Bridget Stratton
Public Relations
312-233-1097
bridget.stratton@ahima.org

AHIMA, AHA Connect ICD-10, Clinical Documentation Improvement with Better Care at Annual Summit

Washington, D.C. – August 8, 2014 – There is significant value in Clinical Documentation Improvement (CDI) in and of itself. Paired with the greater specificity of ICD-10, leaders from the American Health Information Management Association and American Hospital Association (AHA) said CDI can promote better patient care and lead to more accurate captures of acuity, severity and risk of mortality.

Sue Bowman, MJ, RHIA, CCS, FAHIMA, senior director, coding policy and compliance at AHIMA and Nelly Leon-Chisen, RHIA, AHA director of coding and classification at AHA, delivered these comments this week at AHIMA's annual Clinical Documentation Improvement Summit.

Bowman and Leon-Chisen noted the important effect ICD-10-CM/PCS has on CDI, as well as other external forces such as healthcare reform, electronic healthcare record adoption and pay-for-performance standards. Quality documentation and data are foundational to national healthcare initiatives aimed at improving care and lowering costs, including Meaningful Use, accountable care organizations, and value-based purchasing. And a good clinical documentation improvement program can ease the transition to ICD-10.

EHR documentation prompts and templates can be used to facilitate complete and accurate documentation, including capture of increased specificity needed for ICD-10 codes. "These templates will let physicians spend more time on patient care and less time on clinical documentation," Bowman said. "EHR templates will ease the ICD-10 transition for all involved and provide greater coding accuracy, productivity and coder and physician satisfaction."

The pair also shared strategies for healthcare organizations looking to initiate CDI programs. They emphasized the overarching goal is not a greater volume of clinical documentation but better and more efficient documentation. Strategies include:

- Identify documentation improvement opportunities that could affect various initiatives including ICD-10, Meaningful Use, value-based purchasing, present on admission and hospital acquired condition reporting
- Determine the best solution for addressing each documentation gap – one size doesn't fit all
- Prioritize - start with 'low hanging fruit' or issues with greatest potential to make a difference
- Educate medical staff
- Demonstrate to physicians the value of high-quality documentation

“Improving clinical documentation now has immediate benefits,” said AHIMA CEO Lynne Thomas Gordon, MBA, RHIA, CAE, FACHE, FAHIMA. “AHIMA is confident that this powerful tool will improve our ability to measure the quality of care delivered to patients.”

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About AHIMA

The American Health Information Management Association (AHIMA) represents more than 71,000 health information management and health informatics professionals in the United States and around the world. AHIMA is committed to promoting and advocating for 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