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CDI Expanding Beyond the Inpatient Setting as Healthcare Industry Evolves

AS THE HEALTHCARE industry moves away from traditional fee-for-service reimbursement methodologies to newer value-based models, and increased granularity becomes not only preferred but default in the ICD-10-CM/PCS code sets, the need for effective clinical documentation improvement (CDI) programs—and skilled professionals to implement and lead them—has only continued to grow.

Without question, the landscape of the healthcare and health information management (HIM) industry is more dynamic than ever before. And just as coding professionals must continually keep pace with the demands of the dynamic healthcare landscape, so too must HIM professionals look at ways to expand the reach of coding and CDI initiatives. AHIMA—much like the vendors in this Resource Guide who offer various coding and CDI resources—is working to continue to develop and deliver helpful tools and resources for coding and CDI professionals apace with the needs of the industry.

These resources include such diverse offerings from AHIMA as new education tracks at the annual Clinical Coding Meeting, updated coding and CDI Practice Briefs in the AHIMA HIM Body of Knowledge, services such as Code-Check, toolkits, and several webinars. These resources address the growing needs of HIM professionals as the industry need for their skillset continues to expand beyond more traditional roles.

To this end, the new Outpatient Clinical Documentation Improvement (CDI) Toolkit addresses the recent growth of CDI beyond the inpatient setting. As noted in the toolkit, “CDI departments are beginning to expand their scope across the continuum of care to include unchartered territories like outpatient settings, long-term acute care hospitals, and skilled nursing facilities.”

As the weight of quality measures and data from programs like the Physician Quality Reporting System and Hospital Inpatient (and Outpatient) Quality Reporting continues to grow, providers are increasingly recognizing the importance of accurate and quality clinical documentation—regardless of the setting in which care is delivered. “Due to recent changes in [Centers for Medicare and Medicaid Services] payment methodologies, including the implementation of quality measures and the evolution of technology, outpatient payment represents a larger piece of overall hospital revenue,” the Outpatient CDI toolkit authors write. “Advancements in healthcare and technology have resulted in a shift of services that were once performed in the inpatient setting to the outpatient setting.”

Available online and free to members in AHIMA’s HIM Body of Knowledge, the toolkit discusses the various aspects of starting an outpatient CDI program and includes information that should be helpful both for professionals who are looking to start a new outpatient CDI team and for those who are looking to expand an existing inpatient CDI team’s scope into the outpatient setting. Physician clinics, emergency departments, hospital observation, home health, and ambulatory surgery are all covered in the toolkit. The toolkit reviews structural differences between inpatient and outpatient CDI programs, drivers and settings for outpatient CDI, and the characteristics of high-quality clinical documentation, among other helpful topics. To view the toolkit, visit http://bok.ahima.org/PdfView?oid=302445.

Among the numerous coding and CDI webinar offerings from AHIMA are installments in the monthly “Coffee & Coding” series, which coding professionals may find helpful for brushing up on their knowledge base. Free to AHIMA members, each Coffee & Coding webinar is a half hour, and includes discussion of coding topics in ICD-10-CM, ICD-10-PCS, and CPT coding. In these webinars, coding experts from AHIMA walk attendees through a breakdown of operative notes and also give brief anatomy lessons aimed at increasing coding professionals’ applicable knowledge. If members are unable to attend live, the webinars are also available at www.ahimastore.org for replay.
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