One giant step for CDI

By Melissa Varnavas


The 50th anniversary of the moon landing has caused many in our country to look back at that accomplishment and take stock of the technological and societal advances made in merely half the lifespan of a person. While much positive change has come during that short time, there’s still a lot more we can do to make life on this planet better.

In June, the ACDIS Advisory Board published a position paper titled “CDI yesterday, today, and tomorrow: Staying relevant in changing times.” In it, as one might expect, they outlined the history of our CDI project, our moon mission, which aimed at a simple goal: improve organizational financial performance and quality outcome scores where it’s due. This goal was principally grounded in hospital-related visions and tied to the implementation of the MS-DRG system.

But “healthcare is rapidly changing, and the CDI profession will [need to] change with it,” according to the paper. Inpatient volumes have been declining for more than a decade, and thanks to a host of factors, “organizations are not the same delivery systems as they once were.”

In response, CDI efforts have begun to expand into outpatient services, opening the door to tracking additional documentation performance measures. The position paper points out the increased focus on pay-for-quality initiatives by the federal government and consequently by private payers. And while that focus on reimbursement and quality may have been envisioned during CDI programs’ first steps, its underlying rationale has become as vast as the starscape. Value-based purchasing, the Merit-based Incentive Payment System, hospital-acquired conditions, Patient Safety Indicators, and more all vie for documentation attention.

In the paper, the Advisory Board divides CDI’s future challenges into three groups: revenue accuracy, provider documentation quality and integrity, and patient care/patient as consumer.

The paper says that “reimbursement is often the elephant in the room”; many CDI programs don’t want to talk about the positive financial
outcomes they provide, as such conversations often raise concerns of potentially noncompliant/finance-focused activities. Instead, the Advisory Board advocates for clear conversations that provide transparent data and information about appropriate reimbursement related to the care provided. The Advisory Board also addresses two areas of focus found throughout this edition of the CDI Journal—denials management and clinical validation. It identifies these as growth areas as CDI becomes increasingly integrated within healthcare revenue integrity systems.

On the provider education side, while trends show increased opportunities for remote CDI work, the Advisory Board states that “time spent with providers—whether daily rounds, monthly meetings, or one-on-one conversation—is never wasted.” The paper points out that CDI efforts can help alleviate feelings of physician burnout, reduce copy-and-paste errors, and help physicians understand how the medical record represents an extension of the care they provide to their patients.

That care is becoming increasingly inter-related to its representation via a coded disease classification system. Back in the 1700s, John Graunt tried to determine how many London children died before the age of 6; he estimated roughly 36% mortality at the time. Prior to Graunt’s work, no one knew how many children were dying of what diseases. That type of research ultimately led to the creation of the World Health Organization and the International Classification of Diseases. Today, we not only live in a world where people can walk on the moon, we live in a world where integrated technologies can track and measure healthcare trends in order to identify new care treatments and improve social determinants of health for all. But that data is only as good as the documentation and codes it stems from.

That’s why the paper closes with a call to interrogate the term “CDI” and determine whether the “I” should be changed from “improvement” to “integrity” to reflect the changes in the profession. In July, ACDIS asked its membership if the change was warranted. The overwhelming response was yes. During the August 15 quarterly membership conference call, the ACDIS Advisory Board announced its intention to change the organization’s name and place the emphasis on integrity.

“The term ‘integrity’ implies honor, dedication, commitment, and credibility. Which are all the qualities a CDI specialist should possess,” wrote one survey respondent. “We have grown as an industry and our title should reflect that.”

“Our job is to ensure the integrity of each patient chart,” wrote another.

And so, with this small change for our organization and our ACDIS family, we hope we’ll be helping to make one giant leap in advancing our members’ CDI efforts far into the future.