MERCURY

Clinical Documentation Improvement (CDI) for (HIM) Training

5 – 9 April 2027
Johannesburg (South Africa)



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Clinical Documentation Improvement (CDI) for (HIM) Training

Ref: 15484_1064222 **Date:** 5 – 9 April 2027 **Location:** Johannesburg (South Africa) **Fees:** 5300 Euro

Introduction:

In healthcare, the accuracy and completeness of documentation stand as linchpins for optimal patient care, regulatory compliance, and efficient reimbursement processes. The Clinical Documentation Improvement CDI for HIM course is a cornerstone for professionals navigating this critical terrain. It will empower health information managers, clinical coding, medical records specialists, and healthcare compliance officers with the indispensable skills to elevate clinical documentation practices.

Participants in this Clinical Documentation Improvement CDI for HIM course will understand CDI protocols and the fundamental principles that underscore meticulous documentation. They will explore how CDI safeguards data integrity and catalyzes healthcare quality enhancement and financial reimbursement optimization. As healthcare systems rely on electronic health records EHRs, professionals with strategies to integrate CDI into these digital frameworks ensure a holistic approach to information management.

By elucidating the relationship between CDI and coding/classification systems, fostering adept communication skills, and honing the ability to bridge documentation gaps, this Clinical Documentation Improvement CDI for HIM training seeks to empower professionals to meet regulatory standards and champion a culture of continuous improvement in clinical documentation. It is a transformative journey into the nexus of healthcare data precision and the art of delivering quality patient care.

Clinical Documentation Improvement CDI is a systematic approach to ensuring and completing health records, enhancing patient outcomes, maximizing reimbursement, achieving regulatory compliance, and improving data quality for healthcare. The Clinical Documentation Improvement CDI for HIM program fosters effective communication between clinicians, coders, and all healthcare stakeholders, ultimately promoting the reliability of health information for patient care and management decisions.

Targeted Groups:

- Health Information Managers.
- Clinical Coders.
- Medical Records Specialists.
- Healthcare Compliance Officers.
- Clinical Documentation Improvement Specialists.

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Targeted Competencies:

At the end of this Clinical Documentation Improvement CDI for HIM training, participants competencies will:

- Comprehensive understanding of clinical documentation standards.
- Proficiency in coding and classification systems.
- Ability to identify and rectify documentation gaps.
- Skills in communicating effectively with healthcare providers.
- Expertise in maintaining compliance with regulatory requirements.

Course Objectives:

Upon completion of this Clinical Documentation Improvement CDI for HIM course, participants will:

- Grasp the importance of accurate clinical documentation in healthcare settings.
- Develop proficiency in identifying and rectifying documentation gaps.
- Gain insights into coding and classification systems relevant to CDI.
- Enhance communication skills for effective collaboration with healthcare providers.
- Understand the regulatory requirements and compliance aspects of clinical documentation.

Understanding Clinical Documentation Improvement CDI:

Obtaining a Clinical Documentation Improvement Certification equips professionals with formal credentials that signify expertise in the field of CDI. It can enhance the professional credibility of individuals involved in clinical documentation and open new career opportunities and avenues for professional growth within healthcare organizations.

The goals of CDI include promoting accurate clinical documentation that accurately reflects patient insight, complexity, and treatment. To achieve these goals, professionals must adhere to established CDI guidelines and principles, ensuring a standardized and evidence-based practice that maintains the integrity of the clinical narrative.

The core principles of CDI are capturing patient care events, contributing to data quality, and ensuring the documentation is clear, concise, and clinically valid. This practice involves collaboration among clinicians, coders, and CDI specialists to identify and resolve documentation variances, discrepancies, or clarifications for accurate coding and representation of the health services.

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Course Outline:

Unit 1: Fundamentals of Clinical Documentation Improvement CDI:

- Importance of accurate clinical documentation.
- Role of CDI in healthcare quality and reimbursement.
- Overview of regulatory standards governing clinical documentation.
- CDIs impact on healthcare data integrity.
- Case studies illustrate the consequences of inadequate documentation.

Unit 2: CDI Process and Workflow:

- Step-by-step CDI workflow.
- Integrating CDI with electronic health records EHRs.
- Collaborative strategies with healthcare providers.
- Metrics and key performance indicators for CDI success.
- Real-world examples of successful CDI implementations.

Unit 3: Coding and Classification Systems:

- In-depth exploration of ICD-10-CM and PCS.
- CPT coding and its relevance to CDI.
- Hierarchical Condition Categories HCCs and risk adjustment.
- SNOMED CT and other terminology standards.
- Practical coding exercises and case scenarios.

Unit 4: Identification and Resolution of Documentation Gaps:

- Methods for identifying common documentation gaps.
- Physician queries best practices.
- Strategies for engaging healthcare providers in documentation improvement.
- CDI tools and technologies.
- Analysis of real-world documentation improvement scenarios.

Unit 5: Communication Skills for CDI Professionals:

- Effective communication with physicians and nurses.
- Constructing queries that elicit accurate and detailed responses.
- Handling challenging conversations.
- Collaborative approaches to address documentation discrepancies.
- Role-playing exercises for honing communication skills.

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Unit 6: Benefits of Clinical Documentation Improvement:

- Ensuring precise and thorough patient records.
- Increasing the accuracy of health information used for patient care and hospital management.
- Potentially improving the financial health of healthcare institutions through optimized billing and coding.
- Enabling more accurate quality reporting, medical statistics, and public health information.
- Helping to meet compliance with federal, state, and payer-specific regulations.