Clinical Documentation Improvement

Help clinicians meet the rigorous documentation standards of ICD-10

Clinical Documentation Improvement

The conversion to ICD-10, implementation of Value Based Purchasing and future regulatory requirements will demand new levels of specificity and clarity in the clinical documentation in order to support the new, more specific codes. Even experienced clinical staff will require training to be able to meet the new standards for documentation. Dell's Clinical Documentation Review and Improvement Program can get your clinician's ready for ICD-10 documentation standards.

Our Clinical Documentation Improvement Program Assistance includes

- Clinical Program Development
- Clinical Process Improvement
- Physician Education and Training

Our team is comprised of Clinical Documentation Specialist, RNs, Case Managers, AHIMA ICD-10 Approved Trainers, AHIMA Certified Professionals, Physicians, and Process Improvement Subject Matter Experts. The process begins with a thorough assessment of current efforts and recommendations for closing the gaps, including:

- Assessment of current approach and challenges you are facing.
- Review of departmental structure, job roles, reporting lines, resource allocation and current scope of services.
- Evaluate key performance metrics including Case Mix Index
- Review of physician communication process
- Review of Physician and CDI staff education and training strategy and tools
- Analysis of working DRG process and tools, including variations between working/final DRGs
- HIM and CDI Query Tools and Success Rate Analysis
- Clinical Documentation Gap Analysis and Chart Review

Deliverables

- Re-design/Improvement of education strategy
- Physician Query Process Collaboration and Re-design
- Clinical Documentation Improvement Education/Training
- Staffing metrics
- Technology enhancements
- Tool re-design
- Implementation.

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