



Clinical Documentation Improvement: Principles and Practice

Pamela Carroll Hess

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Clinical documentation is the foundation of every patient health record. This book clearly defines the term, explains its importance, and presents an objective and uniform set of principles that can be applied reliably in any healthcare organization's clinical documentation improvement (CDI) program. The author identifies the key users of clinical documentation from patients to clinicians to coding professionals to reimbursement entities and throughout the book addresses how a strong CDI program affects them all.

Part 1 addresses the fundamentals of clinical documentation assessing the current quality of the organization's documentation and making the decision to implement a new program or improve the current one. Part 2 describes clinical documentation program implementation from staffing and training through querying physicians, analyzing program data, and ensuring program compliance. Finally, Part 3 recommends and explains a process for growing and refining a clinical documentation program.

Key features:

Expands on how the transition to ICD-10 will have an impact on the CDI process, highlighting specific coding scenarios

Includes a new chapter on critical thinking for physicians, nurses, clinical documentation specialists, and coders

Offers extensive guidance on CDI program analytics and their importance to a sustainable program

New material including the latest on CDI technology solutions, an example query set, and work plans for CDI program implementation, APR-DRG CDI program, and denials management

Additional guidance on CDI for APR-DRG and quality scoring

Online appendices including an example presentation on physician education and engagement and strategy

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