Clinical Documentation Improvement Program

Driving Excellence in Healthcare Documentation Practices

The Clinical Documentation Improvement division of Enjoin is committed to assisting healthcare organizations in achieving complete and accurate medical record documentation. Our program is designed to ensure accurate code and MS-DRG assignment, optimal profiling scores, and quality patient care outcomes by bridging the gap between clinical documentation and coding rules and regulations.

Our unique approach approach utilizes board certified physicians with certified coding credentials in ICD-9-CM and ICD-10-CM/PCS, advanced clinical coding analysts, and seasoned CDI experts, to assist clients in improving the overall quality and integrity of clinical documentation. Our daily pre-bill review program strategically allows organizations to enjoy the benefits of enhanced revenue and provides real time CDI education while building a foundation for a sustainable successful CDI program.

Our CDI Services

- Complete operational assessment of facilities with and without existing programs
- CDI quality audits to evaluate accuracy, effectiveness and compliance of CDS and coding practices
- Initiation of new programs
- Re-training and modification of existing programs to ensure program success and sustainability
- CDI & Clinical Coding seminars
- Physician DRG Advisor Training
- Hospitalist and Staff Physician Training
- Ongoing monitoring and training
- Long-term support

Our Goal

The goal of the Clinical Documentation Improvement program is to improve the quality and integrity of clinical documentation in the medical record by initiating and performing concurrent documentation reviews of selected inpatient records to clarify conditions/diagnosis and procedures where incomplete, conflicting or non-specific documentation is identified.

Program Benefits

- Complete and accurate medical record documentation
- Accurate representation of healthcare services provided
- Accurate MS-DRG assignment with optimal reimbursement
- Establishes patient's severity of illness and expected risk of mortality
- Supports length of stay, intensity of service and resource utilization
- Enhances accuracy of profiling scores for hospitals and physicians
- Reduces potential compliance issues by documenting all of the patient's conditions and treatments

Contact us today to find out how you can transform your clinical documentation.
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Clinical Documentation Improvement Program *Continued*

Onsite Operational Assessment

The onsite operational assessment is an important step to analyze current processes and staffing. This analysis is important in order to gauge the support, capabilities, and potential success of developing a comprehensive CDIP before your facility makes an investment of time and money. It also allows the correction or implementation of any processes in order to avoid delays or difficulties from arising after the CDI program initiation is begun.

Components of the Operational Assessment include:

- Conduct departmental interviews (CFO, HIM & CM/UR managers & directors)
- Evaluate staffing needs and make recommendations as appropriate
- Discuss clinical documentation specialist selection and pre-training needs
- Conduct meeting with physician leadership to introduce concepts of the program, physician benefits of program, impact of complete and accurate documentation on final DRG assignment and profiling, determine best approach for physician education, and selection of a physician champion for the program
- Conduct meeting with HIM and CM/UR staff to introduce concepts of the program
- Assist with identification of a program coordinator (if needed)
- Develop a customized program for your hospital based off of assessment findings
- Conduct an exit meeting with hospital management to discuss the assessment findings, recommendations, staffing analysis and next steps for implementation

Concurrent Documentation Specialist Program

This five-day seminar provides a detailed discussion of the structure of the MS-DRG system and important coding guidelines that must be applied to improve the accuracy of case-mix index of your facility. It includes:

- Five days of intense classroom training utilizing our proprietary Concurrent Documentation Specialist Instructional Seminar training manual
- Side-by-side mentoring onsite for 2 days with a Senior CDI Consultant immediately following the seminar with your seminar attendees to ensure the development of operational synergies between the clinical and coding staffs
- Follow-up with remote program monitoring, on-site visits and teleconferencing with our CDI professional
- Continued monitoring and analysis of CDI efforts using our daily Pre-bill MS-DRG Assurance program

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