

CLINICAL DOCUMENTATION IMPROVEMENT (CDI)



A solid Clinical Documentation Improvement (CDI) program fuels measurable progress for a healthcare organization, and Precyse remains a committed long-term partner to ensure your CDI goals and objectives are met and sustained. A combination of technology and services, our CDI solution results in more explicit and accurate patient treatment documentation, reducing the risk of coding errors, facilitating timely and the most appropriate reimbursement, improving audit ratings and physician profiles, promoting regulatory compliance and ultimately contributing value throughout the organization.

Your organization is unique, and your medical staff has distinctive requirements when they originate the patient care narrative. Precyse's comprehensive CDI platform, precyseCDI™, can be tailored to address your specific documentation improvement goals. With the help of our services, you can integrate customized improvement programs and educational tools to meet those goals,

Immediate quality and accuracy to help your organization save money, reduce errors and prepare for ICD-10.

including integrating ICD-10 principles and demands for further documentation specificity.

Our three-phased CDI approach includes Assessment and Design, Education and Implementation, Follow-up and Monitoring. We evaluate the physicians' current clinical documentation practices, identify inefficiencies and offer strategies for improved clinical documentation. Our CDI offerings include on-site education provided by practicing physicians and CDI expert educators. This education, consultation and coaching is complemented by the Precyse University Learning System. We

can monitor results of our education and mentoring to ensure new levels of documentation specificity and accuracy are achieved and become routine practice.

Whether you have an existing CDI program or not, now is the time to evaluate the current state of your clinical documentation and implement or enhance an approach to improved documentation.

precyse™

Sparking innovation in healthcare information™

CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

FEATURES AND BENEFITS

- ICD-10-ready, allowing you to solve your CDI needs today and future-proof them for the greater clinical specificity necessary with ICD-10
- Hands-on partnership approach focused on improving existing processes and methodologies
- Workflow management supported by continual monitoring for ongoing quality improvement
- Baseline assessments that evaluate clinical documentation skill levels and knowledge base
- Works with all “vital” roles and processes and creates partnerships with all impacted populations
- Customized, comprehensive CDI education and mentoring geared to your organization and its needs, objectives, structure and workflows and tailored for your individual program participants
- Integrated with Precyse University Learning System, available on-site or via the web, 24 hours a day, 7 days a week
- Post-CDI education evaluation and results monitoring; holistic curricula to address co-dependent systems
- Detailed reporting on staff usage and clinical documentation competency
- On-site Precyse educators who are CDI experts
- Support of both MS-DRGs and APR-DRGs

RESULTS

- Improve physician clinical documentation practices
- Avoid the need to re-initiate CDI for ICD-10, saving money, increasing future compliance and avoiding participant fatigue and frustration
- Sustain CDI assessment education and mentoring programs
- Achieve lasting CDI program goals and objectives
- Improve workflow processes and relationships with physicians
- Build atmosphere of CDI partnership inside the organization
- Confirm that needed CDI upgrades and practices are embraced by physicians and documenters
- Maintain new levels of documentation specificity and accuracy with ongoing monitoring
- Improve hospital and physician profiling and scorecard data
- Prepare hospitals for ongoing adjustments to reimbursement systems
- Optimize DRG accuracy and appropriate reimbursement for resources consumed
- Enhance Case Mix Index knowledge
- Manage and mitigate RAC risk
- Improve accuracy of reporting outcomes
- Obtain support for medical necessity

SUCCESS STORY



“We sensed a real opportunity to partner with Precyse, to have a relationship that was much more dynamic than that of the traditional vendor/client.”

Rosemary Connor, Director of Care Management,
Valley Health

PICTURE OF HEALTH

CDI PROGRAM BOOSTS CASH FLOW AND REGULATORY COMPLIANCE

Valley Health's Director of Care Management Rosemary Connor selected Precyse as a Clinical Documentation Improvement (CDI) development partner to deliver MS-DRG training and tools and to share best practices on how to improve the institution's clinical documentation. Precyse CDI services were extended to develop and launch Valley's own CDI department. Positive results were realized just months into the effort.

Valley Health averaged a CMI of 1.65, which trended up throughout the year. Between \$6,000-\$10,000 per bed of annual billing potential was realized because of the enriched documentation resulting from the launch of Valley's CDI department.

Valley Health's executive team is highly satisfied with the CDI program results to date and is planning to roll out the effort to all its facilities. The hospital's CFO Craig Lewis said Valley Health not only improved its bottom line with CDI, but also prepared for future compliance audits and RAC by reducing its future overpayment exposure with completely documented and reviewed charts.

TO LEARN MORE ABOUT HOW PRECYSE HELPS HOSPITALS AND HEALTHCARE SYSTEMS
ACROSS THE COUNTRY MEET THEIR UNIQUE CHALLENGES, VISIT PRECYSE.COM