



Clinical Documentation Integrity (CDI) for HIM Training Course

12 – 16 April 2027
Porto

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Overview

Clinical Documentation Integrity CDI for HIM Training Course is a one-week intermediate course for health information management, documentation, coding, revenue-cycle, quality, compliance, and healthcare management functions who leave with a CDI Governance and Improvement Plan. Participants connect health record integrity, documentation gap analysis, compliant clarification, clinical validation boundaries, coding-quality collaboration, audit readiness, and CDI performance measures. Agile Leaders Training Center presents CDI and HIM through record-review decisions and governance practice.

Who Should Attend

- Health information functions responsible for record integrity, information quality, and lifecycle controls
- Clinical documentation functions responsible for record review and provider clarification
- Coding and revenue-cycle functions responsible for code assignment support and denial analysis
- Quality and compliance functions responsible for data reliability, audit readiness, and oversight
- Healthcare management functions responsible for CDI governance, resources, and performance

The course assumes participants work with health records, coded data, quality information, or documentation processes and leaves out clinical diagnosis, treatment decisions, and unsupported record changes.

Departments and Industries

The course supports departments and industries that rely on accurate, complete, and timely clinical documentation.

- Hospitals, ambulatory services, and specialty care providers
- Health information management, coding, and clinical documentation teams
- Revenue cycle, utilization review, and denial management functions
- Quality, patient safety, compliance, and internal audit teams
- Health technology, analytics, and healthcare advisory services

Learning Objectives

By the end of this course, participants will be able to:



- Apply CDI and HIM integrity criteria to record review
- Analyze documentation gaps and clinical-validation boundaries
- Use compliant clarification and query decision methods
- Compare documentation, coding, quality, and audit perspectives
- Build CDI governance and performance measures
- Evaluate a documentation improvement action plan

Course Agenda

Day 1: Documentation Integrity Foundations

- CDI and HIM Responsibility Map
- Health Record Integrity Criteria Checklist
- Documentation Completeness and Consistency Matrix
- Clinical Data Reliability Trace
- Documentation Risk Prioritization Grid

Day 2: Record Review and Validation Boundaries

- Concurrent and Retrospective Review Workflow
- Documentation Gap Identification Method
- Clinical Indicator Evidence Map
- Clinical Validation Boundary Guide
- Unsupported Documentation Risk Screen

Day 3: Compliant Clarification Practice

- Query Necessity Decision Tree
- Non-Leading Clarification Design Checklist
- Multiple-Choice Response Option Test
- Verbal and Written Query Tracking Log
- Provider Response Escalation Pathway

Day 4: Governance, Metrics, and Assurance

- CDI Coding Quality Collaboration Map
- Denial and Audit Finding Analysis Grid
- Quality Reporting Data Lineage Map
- CDI Performance Indicator Dashboard
- Documentation Education and Governance Charter



Day 5: CDI Improvement Practice

- Exercise: Review a Documentation Integrity Case
- Exercise: Assess Clinical Validation Boundaries
- Exercise: Draft a Non-Leading Clarification
- Exercise: Analyze CDI Performance Measures
- Capstone Exercise: CDI Governance and Improvement Plan

Practical Exercises

The course uses suggested activities from hospital, ambulatory, quality, coding, and revenue-cycle settings.

- Suggested activity: review a health record excerpt against completeness, clarity, consistency, precision, reliability, and timeliness criteria.
- Suggested activity: separate documentation clarification from diagnosis and treatment decisions using a clinical-validation boundary guide.
- Suggested activity: test a provider clarification for relevant indicators, neutral wording, supported choices, and trackable disposition.
- Suggested activity: build a CDI Governance and Improvement Plan with roles, measures, education actions, audit controls, and review cycles.

FAQs

Who suits Clinical Documentation Integrity CDI training, and what does it assume?

Clinical Documentation Integrity CDI training suits HIM, documentation, coding, revenue-cycle, quality, compliance, and management functions. It assumes experience with records or healthcare data and does not authorize diagnosis, treatment, or unsupported documentation changes.

How does Clinical Documentation Integrity differ from general medical coding training?

Clinical Documentation Integrity focuses on the clarity, completeness, consistency, and reliability of the health record and compliant clarification. Medical coding training focuses on assigning codes under the applicable coding rules.

What is a compliant CDI documentation query?

A compliant CDI documentation query is a clear, concise, non-leading request for clarification supported by relevant indicators in the health record. It allows an unbiased provider response and avoids pressure linked to reimbursement or quality results.



How do CDI and HIM teams manage clinical validation boundaries?

CDI and HIM teams identify gaps, organize record evidence, and request clarification without making clinical diagnoses. Qualified providers retain responsibility for clinical judgment, diagnosis, and treatment documentation.

Which CDI performance measures support improvement?

CDI performance measures can track review activity, query use, response patterns, documentation quality, education needs, denials, and audit findings. Measures are interpreted together and aligned with service maturity rather than used as isolated volume targets.

Conclusion

The course links record integrity, clinical-validation boundaries, compliant clarification, coding collaboration, audit readiness, and CDI measurement. Participants take back a CDI Governance and Improvement Plan. The plan clarifies responsibilities, review criteria, query controls, measures, education priorities, assurance steps, and improvement cycles across health information and clinical operations.