THE CODING ACADEMY

Clinical Documentation Improvement

Overview

Clinical Documentation Improvement is the process of improving clinical documentation at all points of care by all clinicians to support safe care, communicate critical clinical information and enable accurate clinical coding and funding outcomes.

Clinical Documentation improvement is aimed at improving the integrity of clinical information to accurately reflect the clinical truth of an episode of patient care. This course is available in 2 streams: **a) clinicians Stream and; b) Healthcare Services & Leaders stream ***

Target Audience: Clinicians (doctors and nurses), Healthcare Admins, Practice Managers, Doctors, Clinical Coders, Medical transcribers, Patient liaison officers, medical billers, hospital legal department officers, medical insurance officers, claims submissions processors.

Prerequisite: Good command of English Language, past or current experience in the above roles

Duration:20 hrs

Key Takeaways

- CDI with a CDR process is a necessary role in any health organization to ensure correct data capture and safe care. This role needs to be performed in some capacity whether as part of coding or by a designated professional.
- A combination of education approaches are recommended to embed improved documentation in daily practice.
- The success of the concurrent documentations review process is reliant on consideration of many factors, including thorough assessment of existing documentation systems, impact on clinical and coder workflow, mode of query and a reliable feedback mechanism.
- A mix of responsive engagement strategies and executive support is essential to the success and sustainability of a clinical documentation improvement program
- A CDI Program undertaken by a multidisciplinary team overseen by an experienced Health Information Manager is recommended to ensure the success of this portfolio.

Course Structure

This course is delivered online and interactive, however self-paced. It is comprised of instructor led video lectures with interactive short quizzes to test your knowledge as you and a final test to examine the knowledge gained form the course. This course is available to be completed within 90 days from registration date.

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Course Modules

Clinicians Stream

Module 1 - Intro

- Unit 1-2 KSA Challenges
- Unit 1-3 Vision 2030
- Unit 1-4 DRGs and Clinical Coding
- Unit 1-5 CBAHI Standards
- Unit 1-6 SHIE Policies and Takeaways
- Unit 1-7 ACOs
- Unit 1-8 Introduction to CDI Part 1
- Unit 1-9 Introduction to CDI Part 2

Module 2 - Purpose of Good Documentation

- 2.1 What is CDI? *
- 2.2 Safe Healthcare*
- 2.3 Service Planning *
- 2.4 Clinical Decision Making*
- 2.5 Collaborative Care *
- 2.6 Transfer of Care
- 2.7 Embedding Safe Care
- 2.8 Legal Use *
- 2.9 Quality & Compliance *

Module 3 - Theory of Good Documentation

- 3.1 Introduction
- 3.2 Completeness
- 3.3 Correctness
- 3.4 Clarity
- 3.5 Client or Patient-Focused
- 3.6 Contemporaneity
- 3.7 Collaboration
- 3.8 Applied on EMR
- 3.9 Applied on Paper Records
- 3.10 Hybrid Records

Module 4 - Documentation Concepts

- 4.1 Communicating Critical Information *
- 4.2 Handover/Handoff *
- 4.3 The Principal Diagnosis *
- 4.4 Additional Diagnosis *
- 4.5 Past Medical History and Conditions
- 4.6 Complications *
- 4.7 Hospital Acquired Complications *
- 4.8 Specificity *
- 4.9 Injuries
- 4.10 Adverse Medication Events & Poisoning

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Module 5 - Different Types of Documentation

- 5.1 Referral/Transfer Letter *
- 5.2 Discharge Summary *
- 5.3 Emergency Note *
- 5.4 Admission Note *
- 5.5 Progress Note *
- 5.6 Specialist Notes *
- 5.7 Allied Health *
- 5.8 Ward Transfer Note *
- 5.9 Medication Notes *
- 5.10 Surgical Note *

Module 6 - Best Practice Documentation

- 6.1 General & Use of Abbreviations
- 6.2 Discharge Summaries
- 6.3 Surgery
- 6.4 Ophthalmology
- 6.5 ENT
- 6.6 Obstetrics
- 6.7 Gynaecology
- 6.8 Internal Medicine
- 6.9 Orthopaedics
- 6.10 Paediatrics

Module 7 - Clinical Conditions & Procedures

- 7.1 Ears, Nose & Throat (ENT) *
- 7.2 ENT Part 2
- 7.3 Obstetrics *
- 7.4 Obstetrics Part 2
- 7.5 Gynaecology *
- 7.6 Gynaecology Part 2
- 7.7 Ophthalmology *
- 7.8 Ophthalmology Part 2
- 7.9 Internal Medicine
- 7.10 Internal Medicine Part 2

Module 8 - Clinical Conditions & Procedure (Cont'd)

- 8.1 Orthopaedics Part 1 *
- 8.2 Orthopaedics Part 2
- 8.3 Paediatrics Part 1 *
- 8.4 Paediatrics Part 2
- 8.5 Surgery Part 1 *
- 8.6 Surgery Part 2
- 8.7 Allied Health *
- 8.8 Chronic Illness *
- 8.9 Documentation Requirements for Criminal Injuries
- 8.10 Documentation Requirements for the Death Notification Form

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Module 9 - Clinical Documentation Improvement

- 9.1 CDI Workflows for Documenting Procedures
- 9.2 Allied Health
- 9.3 Gynaecology
- 9.4 Ophthalmology
- 9.5 Internal Medicine
- 9.6 Orthopaedics
- 9.7 Paediatrics
- 9.8 Surgery Part 1
- 9.9 Surgery Part 2
- 9.10 Surgery Part 3

Healthcare Services & Leaders Stream

Module 1 - Intro

- Unit 1-2 KSA Challenges
- Unit 1-3 Vision 2030
- Unit 1-4 DRGs and Clinical Coding
- Unit 1-5 CBAHI Standards
- Unit 1-6 SHIE Policies and Takeaways
- Unit 1-7 ACOs
- Unit 1-8 Introduction to CDI Part 1
- Unit 1-9 Introduction to CDI Part 2

Module 2 – Purpose of Good Documentation

- 2.1 What is CDI? *
- 2.2 CDI Goals
- 2.3 CDI Specialist Responsibilities
- 2.4 Communicating Critical Information *
- 2.5 The Principal Diagnosis *
- 2.6 Additional Diagnosis *
- 2.7 Complications *
- 2.8 Hospital Acquired Complications *
- 2.9 Specificity *
- 2.10 Handover/Handoff *

Module 3 – Theory of Good Documentation

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- 3.1 Service Planning *
- 3.2 Reporting & Data Exchange
- 3.3 Costing & Funding
- 3.4 Risk Management
- 3.5 Quality & Compliance
- 3.6 Clinical Decision Making
- 3.7 Continuous Improvement
- 3.8 Safe Healthcare
- 3.9 Legal Use
- 3.1o Collaborative care

Module 4

- 4.1 Referral/Transfer Letter
- 4.2 Emergency Note
- 4.3 Admission Note
- 4.4 Progress Note
- 4.5 Specialist Notes
- 4.6 Allied Health
- 4.7 Ward Transfer Note
- 4.8 Medication Notes
- 4.9 Surgical Note
- 4.10 Discharge Summary

Module 5 – Assessing Clinical Documentation

- 5.1 What to Look For Generally
- 5.2 Surgery
- 5.3 Ophthalmology
- 5.4 ENT
- 5.5 Obstetrics
- 5.6 Gynaecology
- 5.7 Internal Medicine
- 5.8 Orthopedics
- 5.9 Paediatrics
- 5.10 Discharge Summary

Module 6 – Clinical Conditions & Procedures

- 6.1 ENT
- 6.2 Obstetrics
- 6.3 Gynaecology
- 6.4 Ophthalmology
- 6.5 Internal Medicine
- 6.6 Orthopaedics
- 6.7 Paediatrics
- 6.8 Surgery
- 6.9 Allied Health
- 6.10 Chronic Illness

Module 7 – CDI Review

- 7.1 Clinician Engagement & Education
- 7.2 Where to Conduct CDI Reviews
- 7.3 What to Focus On
- 7.4 CDI Inpatient Review Process
- 7.5 Post Discharge
- 7.6 Outpatient Review Process
- 7.7 Inpatient review Forms
- 7.8 CDI Tools & Resources (Part 1)
- 7.9 CDI Tools & Resources (Part 2)
- 7.10 CDI Tools & Resources (Part 3)

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Module 8 – Clinical Documentation Improvement

- 8.1 Types of Metrics
- 8.2 How to Report to Management
- 8.3 How to Report to a Unit Level
- 8.4 How to Feedback to Junio Clinicians
- 8.5 Using Metrics to Improve Documentation Review and CDS Skills
- 8.6 Types of Metrics: Metric 1 - Query Metric
- 8.7 Types of Metrics: Metric 2 – HACs
- 8.8 Types of Metrics: Metric 3 - Case Reviews
- 8.9 Types of Metrics: Metric 4 – PDx & ADx Change and Type
- 8.10 Types of Metrics: Metric 5 - Funding

Module 9 – CDI Challenges

- 9.1 CDI Programme Overview
- 9.2 Identifying Your Cases for Review
- 9.3 Assessing Documentation
- 9.4 Send Queries & Receive Response
- 9.5 Record Your Activity & Changes
- 9.6 Recruitment & Adequate Resourcing
- 9.7 Clinical Engagement
- 9.8 Feedback Mechanism
- 9.9 Record Type
- 9.10 Education