



Clinical Documentation Improvement (CDI)

Thursday, April 11, 2019

1:00-2:00PM

Online Webinar

Clinical Documentation Improvement (CDI) is the process of improving patient records to ensure optimal patient outcomes; contribute to data quality metrics and drive accurate reimbursement. CDI has been utilized in the hospital environment since 2007 for improving diagnosis capture and more detailed physician documentation. The practice of CDI is not new to Home Health and Hospice but the work efforts need to be more formalized in to a program which may be used to support improved patient outcomes and data quality. States under Value Based Purchasing measures have learned that measures improve with a concentration on CDI. Home health and hospice organizations also need to develop a robust CDI program now with Patient Driven Groupings Model (PDGM) beginning in 2020. Discussed will be lessons learned from IPPS.

Objectives:

- Understand how utilizing CDI strategies achieves better patient outcomes
- Learn the steps for creating a CDI program for home health & hospice
- Understand the importance of compliant queries for meeting regulatory compliance

Audience: This presentation is a necessary topic for Administrators; Compliance; Clinical Management; Billing; Coders; OASIS Reviewers; Medical Records

Speaker: Joan Usher, BS, RHIA, HCDS-D, ACE, AHIMA

Approved ICD-10-CM Trainer President & CEO, JLU Health Record Systems



This webinar is presented by:



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