Texas Health Resources Clinical Documentation Improvement

"Clinical Documentation Improvement"
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An Online Continuing Education Enduring Material

Registration Information

To receive continuing education credit, participants need to:

a. Register
b. View presentation
c. Take quiz (must obtain 60% to pass quiz)
d. Complete evaluation

Upon completion of these steps, credit will be recorded in the Accreditation office. Print the online certificate for your records.

Participants should take 1 hour to complete the activity although they need not do this all at one sitting. Once participants have registered, they may work at their own pace on individual enduring material modules and quiz questions, and can return at any time to continue working.

Teaching Methods and Media Employed

This online enduring material uses the following teaching methods and media:

1. Lecture (audio/videotaped)
2. PowerPoint Presentation
3. Multiple Choice or True-False Quiz Questions
4. Evaluation

Acknowledgements of Commercial Support

There is no commercial support for this activity.

Continuing Education Enduring Material Description, Target Audience and Needs Statement

This online interprofessional enduring material is designed for physicians and clinical staff. Its purpose is to address the needs for bridging the gap between appropriate care and measures that need improving. An evaluation tool with a question measuring competence will be used to determine participants' intent to change practice.

Objectives

At the end of this online enduring material, participants should be able to:

- Explain how ICD-10 codes and DRG assignments are being used to determine severity of illness (SOI) and risk of mortality (ROM) scores, and how these are used for determining severity-adjusted clinical outcomes (O/E ratios), such as mortality, length of stay (LOS), and readmission rates (i.e., Value-Based Purchasing initiatives)
- Describe that individual providers are now under the same level of scrutiny as hospitals have been, by virtue of MACRA/MIPS (Merit-Based Incentive Program) initiatives
- Discuss how dependent hospital coders are on appropriate and specific provider documentation, both wording and clinical validation, for accurate determinations of ICD-10 codes, and how a CDI program is designed to help providers "get it right"
- Review how hospital-acquired conditions (HACs) and patient safety indicators (PSIs) are determined by coders, how provider documentation can lead to inaccuracies in this determination, with subsequent quality and safety determinations
- Generalize the key factors in documentation for medical necessity determinations such as inpatient versus observation status for medical and surgical patients, as well as to help prevent denials, as medical records become more scrutinized

For Further Study

Dr. Dombro recommends the following bibliographical references for further study:

- https://www.medicare.gov/hospitalcompare/search.html?
- https://www.qualityreportingcenter.com/wp-content/uploads/2017/09/VBP-IQR-HACRP_HAI_Webinar_Slides_vFINAL508.pdf

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Designation of Credit

Physicians

The Texas Health Resources designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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