CORE CDI

March News- Relevancy

CDI Tip of the Month:

A fully engaged forward thinking CDI program will embrace a strong commitment to continuous quality improvement. Continuous quality improvement entails elements such as insuring compliant queries, identifying clinical scenarios conducive to diagnosis clarification, enhancing DRG correlation assignment between Coding and CDI. Don't overlook tremendous opportunities for continuous quality improvement in actual documentation completeness and effectiveness. A worthwhile place to start is taking a deep dive into medical necessity and clinical validation denials as well as DRG down-codes. Unequivocally, there are always ongoing opportunity for documentation improvement beyond diagnoses reporting. Become familiar with what drives these denials and address proactively with feedback to physicians, sharing actionable knowledgeable ideas to enhance the quality of the documentation in the spirit of denials avoidance.

Additional CDI Resources!

Time Consuming EHR

Cloning-A Bad Habit

Visit Core-CDI.com for more

The Electronic Health Record-A Two-Edged Sword

The adoption of the electronic health record is widespread with 90% of hospitals and health systems and upwards of 80% of physician office practices utilizing the computerized record. Tangible material benefits abound with the use of the EHR including legibility, enhanced security although this has not obviously materialized with all the security breaches, enhanced access and availability and promotion and achievement of time saving documentation capabilities. The notion of time savings for physicians in documentation associated with the EHR must be called into question when various observational studies including one published in a 2017 Annals of Family Medicine journal highlighting the fact that each weekday, physicians spent an average of 5.9 hours out of an 11.4-hour workday working in the EHR. According to the article that consisted of 4.5 hours during clinic times and 1.4 hours after work. Clerical and administrative tasks such as documentation, order entry, billing and coding and system security, accounted for 44 percent of the total EHR usage time. About one-third of the time was spent on medical care EHR tasks such as chart reviews and problem lists, while inbox management took up 24 percent of family physicians' time. (Annals of Family Medicine-Tethered to the EHR) Obviously, physician face-to-face time with the patient is significantly curtailed with potential quality of care suffering given time is a precious physician commodity

Basics of Documentation- The standard of documentation from a CDI Perspective

Read article here

Change your outlook of chart review to be proac