Ahima Clinical Documentation Improvement Toolkit

Healthcare Information Management Systems
Legal and Ethical Standards for Nurses, 4th Edition
Clinical Informatics Study Guide
Workbook to Accompany Conquer Medical Coding 2018
Registered Health Information Administrator (RHIA)
Principles and Organization for Health Information Services
Principles and Practices for Hospitals and Central Registries
ICD-10-CM Official Guidelines for Coding and Reporting - FY 2021 (October 1, 2020 - September 30, 2021)
SAFER Electronic Health Records
An Applied Approach
2021 CDI Pocket Guide
Providing Person-Centered Care
From Research to Implementation
Advances in Patient Safety
Effective Management of Coding Services
Design and Implenation
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Healthcare Information Management Systems Amer Health Information Management
This important volume provide a one-stop resource on the SAFER Guides along with the guides themselves and information on their use, development, and evaluation. The Safety Assurance Factors for EHR Resilience (SAFER) guides, developed by the editors of this book, identify recommended practices to optimize the safety and safe use of electronic health records (EHRs). These guides are designed to help organizations self-assess the safety and effectiveness of their EHR implementations, identify specific areas of vulnerability, and change their cultures and practices to mitigate risks. This book provides EHR designers, developers, implementers, users, and policymakers with the requisite historical context, clinical informatics knowledge, and real-world, practical guidance to enable them to utilize the SAFER Guides to proactively assess the safety and effectiveness of their electronic health records EHR implementations. The first five chapters are designed to provide readers with the conceptual knowledge required to understand why and how the guides were developed. The next nine chapters focus on the underlying informatics concepts, key research activities, and methods used to develop each of the guides. Each of these chapters concludes with a copy of the guide itself. The final chapter provides a vision for the future and the work required to ensure that future generations of EHRs are designed, developed, implemented, and used to improve the overall safety of the EHR-enabled healthcare system. Taken together, the information provided in this book should help any organization, whether large or small, implement its EHR program and improve the safety and effectiveness of its existing EHR-enabled healthcare systems. This volume will be extremely valuable to small, ambulatory physician practices and larger outpatient settings as well as for hospitals and professors and instructors charged with teaching safe and effective implementation and use of EHRs. It will also be highly useful for health information technology professionals responsible for maintaining a safe and effective EHR and for clinical and administrative staff working in EHR-enabled healthcare systems.

Legal and Ethical Standards for Nurses, 4th Edition Government Printing Office
Get more out of your HIM course with Schnering/Sayles/McCuen's CASE STUDIES IN HEALTH INFORMATION MANAGEMENT, 4th Edition! More than a collection of fascinating case scenarios, this versatile worktext gives you experience applying theories from the classroom to practices in the modern health care environment. Case studies explore major HIM topics, including current issues in health data management, health care privacy and ethics, information technology, revenue management and compliance, leadership, project and operations management, quality and performance statistics. A quick-reference correlation grid to current RHIA and RHIT domains and competencies helps you focus on specific areas for certification exams -- maximizing your study time. It's the perfect companion for any HIM course. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.
Clinical Informatics Study Guide Springer Science & Business Media
Health Informatics (HI) focuses on the application of Information Technology (IT) to the field of medicine to improve individual and population healthcare delivery, education and research. This

extensively updated fifth edition reflects the current knowledge in Health Informatics and provides learning objectives, key points, case studies and references.

Workbook to Accompany Conquer Medical Coding 2018 Quickstudy Reference Guides

Physicians play vital roles in the overall quality of patient care. However, HIM professionals and clinical documentation improvement specialists also share essential roles in the healthcare system as guardians of PHI and advocates for continuity of care through consistent documentation and accurate code assignment. Clinical documentation improvement specialists (CDIS) are responsible for the communicative aspects of the process, often serving as a liaison between the provider and the coder. The CDIS ensures that the medical record is complete, there is clinical validation to support diagnoses, and that the medical record is consistent without conflicting or obscure documentation. HIM professionals share some of the responsibility of CDIS in addition to abstracting data from the medical record and assigning the appropriate codes to accurately report the patient's clinical picture.Without the two teams working hand in hand to improve the medical record's documentation, billing errors could ensue, and the quality of patient care is at risk. The process is very detailed and requires a clinical and coding mind to work efficiently. More organizations are calling for their CDIS to learn the fundamentals of coding and for their coders to review the medical record with clinical eyes. Which is whythisresource proves invaluable! Whether you're already skilled in HIM but want to add CDI expertise to your resume, or an existing CDIS looking to update your coding skillset this publication will be of good use to you!

Registered Health Information Administrator (RHIA) John Wiley & Sons

Get more out of your lessons with CASE STUDIES IN HEALTH INFORMATION MANAGEMENT, 3rd Edition! More than a collection of fascinating case scenarios, this versatile worktext helps you apply theories to practices in the modern healthcare environment. Case topics cover everything from data management and security to compliance and statistics, while a handy correlation grid highlights the latest RHIA and RHIT domains and competencies to help you prepare for certification exams. The prefect companion for any HIM textbook or simply a reliable desk reference, CASE STUDIES IN HEALTH INFORMATION MANAGEMENT, 3rd Edition offers realistic forms and spreadsheets to develop your skills, deepen your understanding of the HIM role, and lay the groundwork for your professional success. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.

Principles and Organization for Health Information Services Springer

Your new CDI specialist starts in a few weeks. They have the right background to do the job, but need orientation, training, and help understanding the core skills every new CDI needs. Don't spend time creating training materials from scratch. ACDIS' acclaimed CDI Boot Camp instructors have created The Clinical Documentation Improvement Specialist's Complete Training Guide to serve as a bridge between your new CDI specialists' first day on the job and their first effective steps reviewing records. The Clinical Documentation Improvement Specialist's Complete Training Guide is the perfect resource for CDI program managers to help new CDI professionals understand their roles and responsibilities. It will get your staff trained faster and working quicker. This training guide provides: An introduction for managers, with suggestions for training staff and guidance for manual use Sample training timelines Test-your-knowledge questions to reinforce key concepts Case study examples to illustrate essential CDI elements Documentation challenges associated with common diagnoses such as sepsis, pneumonia, and COPD Sample policies and procedures

Principles and Practices for Hospitals and Central Registries HC Pro, Inc.

To practice nursing effectively today requires a sound understanding of the legal system and the laws specifically affecting nurses. Legal and Ethical Standards for Nurses is filled with practical information, covering topics such as delegation, documentation, professional liability insurance, regulatory issues, advance directives and many others! While these are exciting and challenging times for nurses clinically, they are equally challenging legally. It is, therefore, increasingly important that each nurse learn how to protect herself and her nursing license. The 4th Edition includes an expanded discussion of healthcare fraud and the False ClaimsTo practice nursing effectively today requires a sound understanding of the legal system and the laws specifically affecting nurses. Legal and Ethical Standards for Nurses is filled with practical information, covering topics such as delegation, documentation, professional liability insurance, regulatory issues, advance directives and many others! While these are exciting and challenging times for nurses clinically, they are equally challenging legally. It is, therefore, increasingly important that each nurse learn how to protect herself and her nursing license. The 4th Edition includes an expanded discussion of healthcare fraud and the False Claims Act, information about the HITECH Act has been added, and there is a section about the impact of HIPAA on the use and disclosure of protected health information. Issues with new technologies, such as electronic communications and medical records, are also addressed. And there is a new chapter on staffing issues, including handling questionable assignments and mandatory overtime, as well as a discussion of Allow-natural-death orders. All chapters include the update on applicable laws and case law. Act, information about the HITECH Act has been added, and there is a section about the impact of HIPAA on the use and disclosure of protected health information. Issues with new technologies, such as electronic communications and medical records, are also addressed. And there is a new chapter on staffing issues, including handling questionable assignments and mandatory overtime, as well as a discussion of Allow-natural-death orders. All chapters include the update on applicable laws and case law.

ICD-10-CM Official Guidelines for Coding and Reporting - FY 2021 (October 1, 2020 - September 30, 2021) Lulu.com

This books provides content that arms clinicians with the core knowledge and competencies necessary to be effective informatics leaders in health care organizations. The content is drawn from the areas recognized by the American Council on Graduate Medical Education (ACGME) as necessary to prepare physicians to become Board Certified in Clinical Informatics. Clinical informaticians transform health care by analyzing, designing, selecting, implementing, managing, and evaluating information and communication technologies (ICT) that enhance individual and population health outcomes, improve patient care processes, and strengthen the clinician-patient relationship. As the specialty grows, the content in this book covers areas useful to nurses, pharmacists, and information science graduate students in clinical/health informatics programs. These core competencies for clinical informatics are needed by all those who lead and manage ICT in health organizations, and there are likely to be future professional certifications that require the content in this text.

SAFER Electronic Health Records PHC Publishing Group

Develop the skills you need to effectively and efficiently document patient care for children and adults in clinical and hospital settings. This handy guide uses sample notes, writing exercises, and EMR activities to make each concept crystal clear, including how to document history and physical exams and write SOAP notes and prescriptions.

An Applied Approach Lulu.com

Clinical Documentation Improvement for Outpatient Care: Design and Implementation is an all-inclusive guide to establishing and enhancing CDI programs for the outpatient amd professional fee setting.

2021 CDI Pocket Guide National Academies Press

Commissioned by the Department of Health and Human Services, Key Capabilities of an Electronic Health Record System provides guidance on the most significant care delivery-related capabilities of electronic health record (EHR) systems. There is a great deal of interest in both the public and private sectors in encouraging all health care providers to migrate from paper-based health records to a system that stores health information electronically and employs computer-aided decision support systems. In part, this interest is due to a growing recognition that a stronger information technology infrastructure is integral to addressing national concerns such as the need to improve the safety and the quality of health care, rising health care costs, and matters of homeland security related to the health sector. Key Capabilities of an Electronic Health Record System provides a set of basic functionalities that an EHR system must employ to promote patient safety, including detailed patient data (e.g., diagnoses, allergies, laboratory results), as well as decision-support capabilities (e.g., the ability to alert providers to potential drug-drug interactions). The book examines care delivery functions, such as database management and the use of health care data standards to better advance the safety, quality, and efficiency of health care in the United States.

Providing Person-Centered Care Springer Nature

Now in its second edition, The Clinical Documentation Improvement Specialist's Guide to ICD-10 is the only guide to address ICD-10 from the CDI point of view. Written by CDI experts and ICD-10 Boot Camp instructors, it explains the ICD-10 documentation requirements and clinical indicators of commonly reported diagnoses and the codes associated with those conditions. You'll find the specific documentation requirements to appropriately code a variety of conditions. The CDI Specialist's Guide to ICD-10, 2nd edition, not only outlines the changes coming in October 2014, it provides detailed information on how to assess staffing needs, training requirements, and implementation strategies. The authors-an ICD-10 certified coder and CDI specialist-collaborated to create a comprehensive selection of ICD-10 sample queries facilities can download and use to jumpstart ICD-10 documentation improvement efforts. Develop the expertise and comfort level you'll need to manage this important industry change and help your organization make a smooth transition. The Clinical Documentation Improvement Specialist's Guide to ICD- 10, 2nd ed. is part of the library of products and services from the Association of Clinical Documentation Improvement Specialists (ACDIS). ACDIS members are CDI professionals who share the latest tested tips, tools, and strategies to implement successful CDI programs and achieve professional growth. Member benefits include a quarterly journal, members-only Web site, quarterly networking conference calls, discounts on conferences, and more. WHAT'S NEW? Completely revised to accommodate changes in ICD-10 implementation dates Dozens of targeted ICD-10 physician queries Updated ICD-10 benchmarking reports BENEFITS Sample ICD-10 queries Specificity requirements and clinical indicators by disease type and body system Staff training and assessment tools

From Research to Implementation Debolsillo

Updated for 2018 ICD-10 CM (International Classification of Diseases, Clinical Modification) guidelines, this 6 page laminated guide covers core essentials of coding clearly and succinctly. Author Shelley C. Safian, PhD, RHIA, CCS-P, COC, CPC-I, AHIMA-approved ICD-10-CM/PCS trainer used her knowledge and experience to provide the largest number of valuable facts you can find in 6 pages, designed for you to find answers fast with color coded sections, and bulleted lists. A must for students seeking coding certification and a great desktop refresher for professionals for classifying and coding diagnoses, symptoms and procedures recorded in conjunction with hospital care. 6-page laminated guide includes: General Coding Conventions & Official Guidelines Instructional Notations Chapter-Specific Official Guidelines Selection of Principal Diagnosis Reporting Additional Diagnoses Diagnostic Coding & Reporting Guidelines for Outpatient Services Steps to Coding Diagnoses Using the ICD-10-CM Manual Documentation of Complications of Care Rules of Compliance External Cause Codes Sequencing Multiple Codes Correctly What to Code & What Not to Code The Process of Abstracting Medical Coding ICD-10-PCS Selection of Principal Procedure ICD-10-PCS Coding Conventions ICD-10-PCS Sections & Subsections Medical & Surgical Section: Guidelines Obstetrics Section: Guidelines New Technology Section: Guidelines ICD-10-PCS Terms

Advances in Patient Safety HC Pro, Inc.

The use of mobile and wireless technologies to support the achievement of health objectives (mHealth) has the potential to transform the face of health service delivery across the globe. A powerful combination of factors is driving this change. These include rapid advances in mobile technologies and applications, a rise in new opportunities for the integration of mobile health into existing eHealth services, and the continued growth in coverage of mobile cellular networks. According to the International Telecommunication Union (ITU), there are now over 5 billion wireless subscribers; over 70% of them reside in low- and middle-income countries. The GSM Association reports commercial wireless signals cover over 85% of the world's population, extending far beyond the reach of the electrical grid. For the first time the World Health Organization's (WHO) Global Observatory for eHealth (GOe) has sought to determine the status of mHealth in Member States; its 2009 global survey contained a section specifically devoted to mHealth. Completed by 114 Member States, the survey documented for analysis four aspects of mHealth: adoption of initiatives, types of initiatives, status of evaluation, and barriers to implementation. Fourteen categories of mHealth services were surveyed: health call centres, emergency toll-free telephone services, managing emergencies and disasters, mobile telemedicine, appointment reminders, community mobilization and health promotion, treatment compliance, mobile patient records, information access, patient monitoring, health surveys and data collection, surveillance, health awareness raising, and decision support systems.

Effective Management of Coding Services Jones & Bartlett Publishers

This User’s Guide is intended to support the design, implementation, analysis, interpretation, and quality evaluation of registries created to increase understanding of patient outcomes. For the purposes of this guide, a patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes. A registry database is a file (or files) derived from the registry. Although registries can serve many purposes, this guide focuses on registries created for one or more of the following purposes: to describe the natural history of disease, to

determine clinical effectiveness or cost-effectiveness of health care products and services, to measure or monitor safety and harm, and/or to measure quality of care. Registries are classified according to how their populations are defined. For example, product registries include patients who have been exposed to biopharmaceutical products or medical devices. Health services registries consist of patients who have had a common procedure, clinical encounter, or hospitalization. Disease or condition registries are defined by patients having the same diagnosis, such as cystic fibrosis or heart failure. The User's Guide was created by researchers affiliated with AHRQ's Effective Health Care Program, particularly those who participated in AHRQ's DEcIDE (Developing Evidence to Inform Decisions About Effectiveness) program. Chapters were subject to multiple internal and external independent reviews.

Design and Implenation National Academies Press

Addressed to practitioners of healthcare administration, the book looks beyond traditional information systems. This text suggests how information systems can bring a competitive advantage to hospitals and other healthcare providers. Its viewpoint is neither technical nor clinical. Rather it is concerned with the role and the use of information in the provision of healthcare. The text is divided into several reader-friendly units, which allows the reader to quickly select only what he wants to study in depth. Divided into two sections, one dealing with support for the private practitioner, the other with managing an institution, the material spans a wide array of types of computers. This provides valuable instructional information for nurses, physicians and administrators using the computer as a tool for providing quality medical care.

A User's Guide F.A. Davis

Ethical Informatics is an invaluable resource for HIM, the healthcare team (nursing, physical therapy, occupational therapy et al.), information technology (IT) students (associate, baccalaureate and graduate) and practitioners. Each chapter includes ethical "real life" scenarios, a discussion of the issues, and a decision-making matrix for each scenario that facilitates an understanding of ethical ways to respond to the problem and actions that would not be considered ethical.

Case Studies in Health Information Management Springer Publishing Company

Getting the right diagnosis is a key aspect of health care - it provides an explanation of a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem. According to Improving Diagnosis in Health Care, diagnostic errors-inaccurate or delayed diagnoses-persist throughout all settings of care and continue to harm an unacceptable number of patients. It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, providing unnecessary or harmful treatment, or resulting in psychological or financial repercussions. The committee concluded that improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative. Improving Diagnosis in Health Care a continuation of the landmark Institute of Medicine reports To Err Is Human (2000) and Crossing the Quality Chasm (2001) finds that diagnosis-and, in particular, the occurrence of diagnostic errorsâ€"has been largely unappreciated in efforts to improve the quality and safety of health care. Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity. Just as the diagnostic process is a collaborative activity, improving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policy makers. The recommendations of Improving Diagnosis in Health Care contribute to the growing momentum for change in this crucial area of health care quality and safety.

Tips and Tools for Building a Program F.A. Davis

Clinical Documentation Improvement Specialist's HandbookHC Pro, Inc.

Health Literacy in Nursing Clinical Documentation Improvement Specialist's Handbook

Improving documentation is no easy task CDI professionals have never had one easy-to-read, inclusive reference to help them implement a CDI program, understand the fundamentals of ICD-9-CM coding, query physicians, and encourage interdepartmental communication. In theory, physicians should document their entire thought process, including ruling conditions in and out. But it's not that simple, and in light of MS-DRGs, it requires significant physician education and retraining. You need a blueprint for success.. Your blueprint has arrived! At last, here is a guide for CDI specialists. The Clinical Documentation Improvement Specialist's Handbook is your essential partner for creating a CDI program, staffing your program, querying physicians, and understanding how documentation affects code selection and data quality As a CDI specialist you need answers now In light of Medicare Severity DRGs (MS-DRG), detailed documentation and accurate capture of complications and comorbidities (CCs) has made the CDI specialist's role more important and more demanding than ever. This handbook will enhance your ability to gather the right information the first time--and every time Author Colleen Garry, RN, BS, has compiled case studies that document best practices and reference several different CDI models so that you can select the one that's right for your hospital's CDI success. In addition, you'll be privy to an executive summary of HCPro's exclusive CDI survey that solicited more than 800 responses. Learn how other hospitals are handling CDI and choosing the model that works best for them. * work with physicians to obtain detailed, appropriate documentation * maintain compliance when performing physician queries * convey return on investment for a CDI program Customizable CD-ROM included Your copy of The Clinical Documentation Improvement Specialist's Handbook includes a CD-ROM loaded with all of the working tools you'll find in the book. Among them

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