# *Ahima Clinical Documentation Improvement Toolkit*

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
The Complete Guide to CDI Management Cheryl Ericson, MS, RN, CCDS, CDIP Stephanie Hawley, RN, BSN, ACM Anny Pang Yuen, RHIA, CCS, CCDS, CDIP Managing a CDI department can be a daunting task for new and seasoned managers alike. The Complete Guide to CDIManagement provides CDI program managers and directors with insight into the most common issues associated with implementing, staffing, running, and growing a CDI department. The book also covers core skills such as auditing and metrics, and it provides strategies for overcoming challenges related to electronic records, changing regulatory landscapes, and resource limitations. The Complete Guide to CDI Management incorporates the deep expertise of multiple authors with varied backgrounds who have come together to share their firsthand knowledge. From reporting structures and productivity measurement to defining a mission and physician engagement, this definitive resource addresses the wide array of issues facing CDI managers and directors in today's hospital environment. Table of Contents About the Authors Introduction Chapter 1: An Introduction to CDI for the New Manager History of Coded Data The Medical Coder The Prospective Payment System Adding "Severity" Into the DRG Methodology CDI Basics Summary Chapter 2: Growing a CDI Department The Traditional Role of CDI CDI Review Population Principal Diagnosis Assignment Types of DRG Reviews Quality Focus Summary Chapter 3: Developing Relationships Sharing the Mission Physician Engagement Obstacles to Developing a Physician Relationship Leveraging Queries as an Educational Tool The Art of Clinical Validation The Query Format Query Templates Fostering a Relationship With Coding Networking Summary Chapter 4: Department Structures and Staffing Expectations Department Structures Staffing/Hiring Physician Advisor Creating a Career Ladder Continuing Education CDI Department Meetings Evaluations Credentialing Initialing vs. Revitalizing Summary Chapter 5: Demonstrating the Return on Investment Measuring Success Productivity and Sample Metrics Summary Chapter 6: Challenges and How to Overcome Them Organization Issues Resource Issues Summary Appendixes Appendix A: Resources
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.

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.

2021 CDI Pocket Guide

The Medical-Legal Aspects of Acute Care Medicine

Registered Health Information Administrator (RHIA)

Cancer Registry Management

Guide to Clinical Documentation

Forecasting Informatics Competencies for Nurses in the Future of Connected Health

BESTSELLING GUIDE, UPDATED WITH A NEW INFORMATION FOR TODAY'S HEALTH CARE ENVIRONMENT Health Care Information Systems is the newest version of the acclaimed text that offers the fundamental knowledge and tools needed to manage information and information resources effectively within a wide variety of health care

organizations. It reviews the major environmental forces that shape the national health information landscape and offers guidance on the implementation, evaluation, and management of health care information systems. It also reviews relevant laws, regulations, and standards and explores the most pressing issues pertinent to senior level managers. It covers: Proven strategies for successfully acquiring and implementing health information systems. Efficient methods for assessing the value of a system. Changes in payment reform initiatives. New information on the role of information systems in managing in population health. A wealth of updated case studies of organizations experiencing management-related system challenges.

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

The Updated and Extensively Revised Guide to Developing Efficient Health Information Management Systems Health Information Management is the most comprehensive introduction to the study and development of health information management (HIM). Students in all areas of health care gain an unmatched understanding of the entire HIM profession and how it currently relates to the complex and continuously evolving field of health care in the United States. This brand-new Sixth Edition represents the most thorough revision to date of this cornerstone resource. Inside, a group of hand-picked HIM educators and practitioners representing the vanguard of the field provide fundamental guidelines on content and structure, analysis, assessment, and enhanced information. Fully modernized to reflect recent changes in the theory and practice of HIM, this latest edition features all-new illustrative examples and in-depth case studies, along with: Fresh and contemporary examinations of both electronic and print health records, data management, data privacy and security, health informatics and analytics, and coding and classification systems An engaging and user-friendly pedagogy, complete with learning objectives, key terms, case studies, and problems with workable solutions in every chapter Ready-to-use PowerPoint slides for lectures, full

lesson plans, and a test bank for turnkey assessments A must-have resource for everyone in health care, Health Information Management, Sixth Edition, puts everything you need at your fingertips.

CPT(R) 2022 Professional Edition is the definitive AMA-authored resource to help healthcare professionals correctly report and bill medical procedures and services.

Case Studies in Health Information Management

SAFER Electronic Health Records

ICD-9-CM Official Guidelines for Coding and Reporting

Clinical Documentation Improvement (CDI) Made Easy, 2nd Edition

Health Information Management

Key Capabilities of an Electronic Health Record System

Health Care Finance and the Mechanics of Insurance and Reimbursement stands apart from other texts on health care finance or health insurance, in that it combines financial principles unique to the health care setting with the methods and process for reimbursement (including coding, reimbursement strategies, compliance, financial reporting, case mix index, and external auditing). It explains the revenue cycle in detail, correlating it with regular management functions; and covers reimbursement from the initial point of care through claim submission and reconciliation. Thoroughly updated for its second edition, this text reflects changes to the Affordable Care Act, Managed Care Organizations, new coding initiatives, new components of the revenue cycle (from reimbursement to compliance), updates to regulations surrounding health care fraud and abuse, changes to the Recovery Audit Contractors (RAC) program, and more.

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 Important Notice: The digital edition of this book is missing some of the images or content found in the physical edition. An introductory computer literacy text for nurses and other healthcare students, Introduction to Computers for Healthcare Professionals explains hardware, popular software programs, operating systems, and computer assisted communication. The Fifth Edition of this best-selling text has been revised and now includes content on on online storage, communication and online learning including info on PDA's, iPhones, IM, and other media formats, and another chapter on distance learning including video conferencing and streaming video.

The Provider Query Toolkit: A Guide to Compliant Practices provides a comprehensive analysis of query guidelines and easy-to-follow strategies to improve query processes. This valuable resource, perfect for both the new CDI specialist and those looking for a refresher on CDI query fundamentals, examines recent changes in coding and payer nuances, denial trends, query compliance, and quality programs impacting the CDI specialist.

Improving Diagnosis in Health Care

The Provider Query Toolkit

Safety Assurance Factors for EHR Resilience

An Evidence-based Handbook for Nurses

Exam Preparation

Principles and Organization for Health Information Services

**The book provides clear guides on how to perform the vital duties required in obtaining accurate, quality, complete, and specific documentation from the providers so as to reflect the quality of care, severity of illness and risk of mortality of admitted patients during their encounter to the hospital or inpatient rehab. The book is a "must have" for every CDIS or anyone involved in clinical documentation. The book has current ICD-10-CM/PCS update with pertinent information on the 2018 Official Coding Guidelines for Coding and Reporting, Coding Clinic advice, Pay for Performance,**

**sample queries, various disease processes by MDCs, CDI strategy for success in inpatient rehab, rehab impairment group codes and categories, list of all the surgical and MS-DRGs, and much more. Remember, if it was not documented and documented accurately, it never happened.**

**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.**

**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.**

**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.**
**2022 CDI Pocket Guide**
**Notes from the Field**
**The CCDS Exam Study Guide**
**Health Informatics: Practical Guide for Healthcare and Information Technology Professionals (Sixth Edition)**
**Medical Language for Modern Health Care**
**Management of a Strategic Resource**

*CDI Companion for Physician Advisors: Notes From the Field Claude "Trey" La Charit, MD, CCDS When it comes to clinical documentation, physician advisors have a range of important responsibilities, from query escalation to denials management and everything in between. With all these tasks on their plate, physician advisors are constantly pulled in different directions, making it hard to make the best use of their time. CDI Companion for Physician Advisors: Notes From the Field is designed to help physician advisors structure their time properly and carry out their CDI duties effectively and efficiently. This book will help physician advisors: Find their feet in the CDI role Identify tools to provide effective documentation education for physicians and CDI staff Engage medical staff in documentation improvement efforts Understand common documentation deficiencies for difficult diagnoses such as sepsis, heart failure, and kidney disease Work with their CDI team to tackle advanced record reviews in areas such as quality, audit defense, and outpatient HCCs Figure out how to best structure their time to carry out CDI duties About the author: Claude "Trey" La Charit, MD, CCDS, is a hospitalist with the University of Tennessee Medical Center (UTMC) and a past ACDIS Advisory Board member. He serves as the physician advisor for UTMC's clinical documentation integrity program, coding, and Recovery Auditor response. La Charit is a regular contributor to CDI Journal, co-author of the Physician Advisor's Guide to CDI, and a co-lead instructor for the popular Physician Advisor Boot Camp.*

*The Medical-Legal Aspects of Acute Care Medicine: A Resource for Clinicians, Administrators, and Risk Managers is a comprehensive resource intended to provide a state-of-the-art overview of complex ethical, regulatory, and legal issues of importance to clinical healthcare professionals in the area of acute care medicine; including, for example, physicians, advanced practice providers, nurses, pharmacists, social workers, and care managers. In addition, this book also covers key legal and regulatory issues relevant to non-clinicians, such as hospital and practice administrators; department heads, educators, and risk managers. This text reviews traditional and emerging areas of ethical and legal controversies in healthcare such as*

*resuscitation; mass-casualty event response and triage; patient autonomy and shared decision-making; medical research and teaching; ethical and legal issues in the care of the mental health patient; and, medical record documentation and confidentiality. Furthermore, this volume includes chapters dedicated to critically important topics, such as team leadership, the team model of clinical care, drug and device regulation, professional negligence, clinical education, the law of corporations, tele-medicine and e-health, medical errors and the culture of safety, regulatory compliance, the regulation of clinical laboratories, the law of insurance, and a practical overview of claims management and billing. Authored by experts in the field, The Medical-Legal Aspects of Acute Care Medicine: A Resource for Clinicians, Administrators, and Risk Managers is a valuable resource for all clinical and non-clinical healthcare professionals.*

*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.*

*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.*

*CDI Companion for Physician Advisors*

*CPT Professional 2022*

*Patient Safety and Quality*

*Clinical Documentation Improvement Specialist's Handbook*

*A Practical Approach for Health Care Management*

*Certified Documentation Improvement Practitioner (CDIP) Exam Preparation*

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. Nursing informatics has a long history of focusing on information management and nurses have a long history of describing their computer use. However, based on the technical advances and through the ongoing and consistent changes in healthcare today, we are now challenged to look to the future and help determine what nurses and patients/consumers will need going forward. This book presents the proceedings of the Post Conference to the 13th International Conference on Nursing Informatics, held in Geneva, Switzerland, in June 2016. The theme of the Post Conference is Forecasting Informatics Competencies for Nurses in the Future of Connected Health. This book includes 25 chapters written as part of the Post Conference; a result of the collaboration among nursing informatics experts from research, education and practice settings, from 18 countries, and from varying levels of expertise – those beginning to forge new frontiers in connected health and those who helped form the discipline. The book content will help forecast and define the informatics competencies for nurses in practice, and as such, it will also help outline the requirements for informatics training in nursing programs around the world. The content will aid in shaping the nursing practice that will exist in

our future of connected health, when practice and technology will be inextricably intertwined.

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 errors â €"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.

Medical Language for Modern Health Care, Second Edition, uses Contextual Learning Theory to introduce medical terminology within a healthcare environment. Chapters are broken into lessons that introduce and define terminology through the context of A & P, pathology, and clinical and diagnostic procedures/tests. Each 2-page spread covers one topic at a time, offering contextual content, a Word Analysis and Definition Table, and exercises all in one place. Word Analysis and Definition Tables provide a color-coded guide to word parts and combining forms, as well as definitions and pronunciations. With unfolding patient case studies and documentation, students are introduced to various roles in the healthcare environment, illustrating the real-life application of medical terminology in modern health care while facilitating active learning. Now available with LearnSmart: Medical Terminology and Connect Plus+, students and instructors can access all their course materials in one place. Connect Plus+ provides market-leading content, a proven course architecture, and unmatched flexibility to help students apply the principles in the textbook. LearnSmart is the only individualized, diagnostic study tool that creates a specific learning plan for each student, adapting as they progress through content.

Legal and Ethical Standards for Nurses, 4th Edition
The Complete Guide to CDI Management
Health Information - E-Book
The Clinical Documentation Improvement Specialist's Guide to ICD-10
The Clinical Documentation Improvement Specialist's Complete Training Guide
Ethical Health Informatics

**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**

**Uncover the latest information you need to know when entering the growing health information management job market with Health Information: Management of a Strategic Resource, 5th Edition. Following the AHIMA standards for education for both two-year HIT programs and four-year HIA programs, this new edition boasts dynamic, state-of-the-art coverage of health information management, the deployment of information technology, and the role of the HIM professional in the development of the electronic health record. An easy-to-understand approach and expanded content on data analytics, meaningful use, and public health informatics content, plus a handy companion website, make it even easier for you to learn to manage and use healthcare data. Did You Know? boxes highlight interesting facts to enhance learning. Self-assessment quizzes test your learning and retention, with answers available on the companion Evolve website. Learning features include a chapter outline, key words, common abbreviations, and learning objectives at the beginning of each chapter, and references at the end. Diverse examples of healthcare deliveries, like long-term care, public health, home health care, and ambulatory care, prepare you to work in a variety of settings. Interactive student exercises on Evolve,**

**including a study guide and flash cards that can be used on smart phones. Coverage of health information infrastructure and systems provides the foundational knowledge needed to effectively manage healthcare information. Applied approach to Health Information Management and Health Informatics gives you problem-solving opportunities to develop proficiency. EXPANDED! Data analytics, meaningful use, and public health informatics content prepares HIM professionals for new job responsibilities in order to meet today's, and tomorrow's, workforce needs. EXPANDED! Emphasis on the electronic health care record educates you in methods of data collection, governance, and use. NEW! Chapter on data access and retention provides examples of the paper health record and its transition to the EHR. NEW! Focus on future trends, including specialty certifications offered by the AHIMA, the American Medical Informatics Associations (AMIA), and the Health Information Management Systems Society (HIMSS), explains the vast number of job opportunities and expanded career path awaiting you.**

**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**

**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.**

**Text and Review**

**Documentation Guidelines for Evaluation and Management Services**

**Medical Coding ICD-10-CM**

**Registries for Evaluating Patient Outcomes**

**Letter Report**

**ICD-10-CM Code Book, 2021 Spiral Edition**

*Aimed at health care professionals, this book looks beyond traditional information systems and shows how hospitals and other health care providers can attain a competitive edge. Speaking practitioner to practitioner, the authors explain how they use information technology to manage their health care institutions and to support the delivery of clinical care. This second edition incorporates the far-reaching advances of the last few years, which have moved the field of health informatics from the realm of theory into that of practice. Major new themes, such as a national information infrastructure and community networks, guidelines for case management, and community education and resource centres are added, while such topics as clinical and blood banking have been thoroughly updated.*

*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.*

*Promotes verbal and written communication strategies that nurses can use to effectively meet the individualized needs of an increasingly diverse patient population in an effort to enhance patient-provider communication across the entire continuum of care.*

*Introduction to Computers for Healthcare Professionals*

*Providing Person-Centered Care*

*A Quickstudy Laminated Reference Guide*
*A User's Guide*
*Health Literacy in Nursing*
*A Guide to Compliant Practices*