Appendix C: Ongoing Education Plan

Save to myBoK

An annual plan for ongoing education can be developed and started at the beginning of each calendar or fiscal year, or with the annual employee evaluation. The manager of the CDI team or designee can be required to ensure each education topic is offered to the employee during the year. It is important to have the ability to track the employee's training. An area can be created, as in the example below, for the employee to sign off and date the time in which the training was completed.

Employee Name:			
Education Topic (see some examples listed below)	**Frequency (see some examples listed below)**	**Title of Training**	**Date and Signature**
Review of Top 10 MS-DRGs for Organization • Review Top 10 • Review those without CC or MCC	**Twice a Year**		
How to Read Documentation (see some examples listed below) • Review chart order • Review EHR for: ◦ Demographic information ◦ Emergency department (ED) notes ◦ History and Physical ◦ Consultation notes ◦ Operative notes ◦ Progress notes ◦ Physician orders ◦ Laboratory and radiology findings ◦ Other ancillary as needed ▪ Respiratory therapy	**Annually**		

▪ Wound therapy ▪ Nursing notes and flowsheets ▪ Other ◦ Accuracy of Problem List ◦ Medication Administration Flow Sheet (MAR)				
Documentation Roles (see some examples listed below) • Physicians ◦ Problem list ◦ Consultations ◦ ED notes ◦ History and physical ◦ Progress notes ◦ Orders ◦ Procedure notes ◦ Interventional notes ◦ Discharge notes • Administrative/hospital staff ◦ Patient demographics ◦ Guarantee account ◦ Coverage/payer information ◦ Financial counseling • Clinical Hospital Staff ◦ Intake notes ◦ Medication administration ◦ Flow sheets ◦ Dietician notes ◦ Ancillary notes ◦ Wound care notes ◦ Social services/case management ◦ Spiritual care ◦ Laboratory ◦ Radiology • Clinical Documentation Improvement professionals ◦ Physician queries • Coding professionals	**Annually**			

◦ Physician queries ◦ Final code assignment			
Documentation Used for Clinical Code Assignment (see some examples listed below) • Progress notes: ◦ To detect complications and/or secondary diagnoses for which the patient was treated and/or procedures performed. • History and physical: ◦ To identify any additional conditions, such as history of cancer or a pacemaker in situ. • Discharge summary: ◦ Code diagnoses and procedures that are listed on discharge summary and meet the definition of a codable diagnosis. • Consultation report: ◦ To detect additional diagnoses or complications for which the patient was treated. • Operative reports: ◦ Scan to identify additional procedures requiring coding. • Pathology reports: ◦ Review to confirm or obtain more detail (note: coder must continue to verify and obtain confirmation of any diagnoses from this clinical	**Annually**		

documentation with the attending physician). • Laboratory: ◦ Use reports as guides to identify diagnoses (i.e., types of infections) or more detail (note: coder must continue to verify and obtain confirmation of any diagnoses from this clinical documentation with the attending physician). • Radiology: ◦ Use reports as guides to identify diagnoses or more detail (i.e., type of fracture) (note: coder must continue to verify and obtain confirmation of any diagnoses from this clinical documentation with the attending physician). • Physician's orders: ◦ To detect treatment for unlisted diagnoses, the administration of insulin, antibiotics, sulfonamides (may indicate treatment of diabetes), and respiratory or urinary infections that should be confirmed by the coder. • Nutritional assessments • MAR ◦ Validate treatment and medication ordered was provided.				
Review Common Diagnoses (see examples below)	**Twice a year**			

- Sepsis, Systemic Inflammatory Response Syndrome (SIRS), Shock, urinary tract infection (UTI)
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines
    - Treatment
- Cancer and Metastatic Cancer
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines
- Anemia
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines
- Diabetes and Manifestations
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines
- Gastrointestinal System
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines
- Protein Calorie Malnutrition
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines
- Respiratory Failure
    - Clinical Definition
    - Body System
    - Clinical Indicators
    - Coding Guidelines

• Renal Failure
  ◦ Clinical Definition
  ◦ Body System
  ◦ Clinical Indicators
  ◦ Coding Guidelines
• Pneumonia
  ◦ Clinical Definition
  ◦ Body System
  ◦ Clinical Indicators
  ◦ Coding Guidelines
  ◦ Treatment				

Physician Queries (see examples below)
• Managing an effective concurrent querying process
  ◦ Overview of query process
  ◦ Completeness
  ◦ Clarity
  ◦ Consistency
  ◦ Precision and content
  ◦ Concurrent versus Retrospective
• Guidelines for querying the physician
  ◦ When to query a physician
  ◦ When NOT to query a physician
  ◦ Compliance guidelines
  ◦ Verbal versus written queries
• Writing a physician query
  ◦ General guidelines
  ◦ Template format
  ◦ Communicating to the physician
  ◦ Reviewing physician response, comments
• Query management
	Annually			

◦ Managing physician responses ◦ Managing queries not answered at discharge ◦ Review query follow up process			
CDI Metrics (see examples below) • Identify program metrics ◦ Productivity rates ▪ Qualitative ▪ Query opportunities ▪ Query compliance ▪ Quantitative ▪ Review rate ▪ Query rate ▪ Query response rate ▪ Query validation rate ▪ Retrospective query rate ▪ Denial rate	**Twice a year**		