Documentation Update 2020: Ensuring Compliance - July 28

Date: July 28, 2020  Time: 9:00 AM

Location:
9 to 11 am
Webinar

Registration:
IHA Members: $195 per organization
Non-IHA Members: $250 per organization

*Please note: The registration fee is now for one organization. An organization may have multiple connections for this program at no charge.

This webinar is a must-attend program for any nurse, physician or professional working in healthcare today. Accurate, concise documentation in medical records is key to preventing claims of fraud and abuse, and is also vital if the records are reviewed by the Recovery Audit Contractors (RACs), the Office of Inspector General (OIG), or the Centers for Medicare & Medicaid Services (CMS). Yet many hospitals have seen an increase in documentation challenges within their electronic health records.

Accreditation expert Sue Dill Calloway, RN, MSN, JD, will discuss the importance of documentation to avoid allegations of malpractice, substandard care, accreditation nightmares and denial of reimbursement. She will provide more than 50 recommendations to improve documentation and cover key problematic Joint Commission (TJC) and CMS Hospital Conditions of Participation (CoP) requirements. The program will also identify issues that must be documented in order to be reimbursed by CMS, as well as avoid allegation of fraud, abuse and improper documentation. Finally, you’ll get an overview of the new Medicare Outpatient Observation Notice (MOON) form for 2020.

Offered through the Georgia Hospital Association

OBJECTIVES

At the conclusion of this session, participants should be able to:

- Discuss two recommendations or tips to improve documentation to reduce the risk of liability.
- Explain what should be documented in the assessment of pain.
- Describe that The Joint Commission has the Record of Care chapter which includes many things that must be documented in the medical record.
- Explain the CMS requirement that all orders be in writing in the order sheet even if hospitals use approved protocols.
Discuss that both CMS and TJC have standards that require specific documentation of verbal orders.

WHO SHOULD ATTEND

This program is designed for hospital and health system leaders and staff in:

- Clinical care (i.e. nursing, medical staff, anesthesiologists)
- Quality improvement
- Patient safety
- Risk management
- Health information management
- Legal affairs

SPEAKERS

Sue Dill Calloway, RN, MSN, JD, has been a nurse attorney and consultant for more than 30 years. Currently, she is president of Patient Safety and Healthcare Education & Consulting. She was previously the chief learning officer for the Emergency Medicine Patient Safety Foundation.

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