Delivering Outcomes: Clinician documentation Improvement Project

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Quality and consistency of clinical documentation has significant implications for hospital funding. Clinician documentation that does not conform to coding standards may result in missed opportunities to code all possible diagnoses and interventions encountered by a patient during their acute hospital stay. This may result in episodes being coded at a lesser complexity within a Diagnostic Related Group (DRG) or lower National Weighted Activity Unit (NWAU). Research has documented the correlation between poor clinical documentation and subsequent missed revenue[1, 2], with some estimates including local audit quantifying this at up to 10% of episodes having opportunity for improved coding outcomes resulting from complete clinical documentation.

A major teaching hospital in Sydney undertook an external coding audit of two-hundred episodes of care to identify deficiencies and opportunities for change. This audit identified opportunities to enhance the documentation as part of better reflecting care decisions and adequately reflecting the casemix of patients being cared for at this hospital. Also, significant to this exercise was the potential increase of (NWAU) value based on the Australian Refined Diagnosis Related Group (AR-DRG) classification changes.

In response, to these findings, the Clinical Documentation Improvement (CDI) project was established at the facility including the recruitment of a Clinical Documentation Specialist (CDS) who commenced training in July 2018. The primary functions of the CDS is to perform audits of documentation and education to clinicians to improve documentation and subsequently both coding and funding.

A diverse team of managers, clinicians and the CDS collaborated to implement a sustainable program, with the aim of identifying issues and implementing strategies to improve clinical documentation. Following an analysis of the data, the project team identified a specialty as an initial focus area. The National Casemix and Classification Centre (NCCC) was engaged in the education of the CDS and establishing data measures for an evaluation.

In the short time the role of the CDS working with the project team and the clinical staff have already made substantial gains.

This paper will highlight the process, engagement, activities undertaken and outline the outcomes achieved. The outcomes have included improved documentation, better representation of patient acuity, increase NWAU value, the establishment of

electronic resources to support querying and the clinical leadership and engagement that contributed to the success.

1. Cheng,P, Gilchrist, A, Robinson, K and Paul, L 2019, 'The risk and consequences of clinical miscoding due to inadequate medical documentation: a case study of the impact on health services funding', *Health Information Management Journal',* vol. 38, no. 1, pp. 35-46, <https://pdfs.semanticscholar.org/09e3/2f147f5752339a9f530cbc7641d1448cb47c.pdf>.
2. Chin, N, Perera, P, Roberts, A and Naggapan, R 2013, 'Review of medical discharge summaries and medical documentation in a metropolitan hospital: impact on diagnostic-related groups and Weighted Inlier Equivalent Separation', *Internal Medicine Journal*, vol. 43, issue 7, pp. 767-771, <https://onlinelibrary.wiley.com/doi/abs/10.1111/imj.12084>.