

The Clinical Documentation Evaluation Tool (CDET) - Adding value

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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. South Eastern Sydney Local Health District implemented the Clinical Documentation Specialist (CDS) role in 2018 to perform audits of documentation and education to clinicians to improve documentation and subsequently both coding and funding.

The Clinical Documentation Evaluation Tool (CDET) was initially created to support the work of the Clinical Documentation Specialist (CDS), with the scope expanding to include use by clinicians, performance department and management teams. The CDET is a near real-time, interactive business intelligence application displaying admitted patient episode activity data.

The National Casemix and Classification Centre (NCCC) provided advice surrounding appropriate data required within the CDET. Using these recommendations appropriate measures and dimensions were selected, and the data sourced. State and National LOS averages for DRGs were imported and used as a comparison. The data is visualised in QlikSense software, and includes trend charts showing these measures for each month, and pareto charts showing the top categories for each measure for the dimensions described.

Using the CDET, the data enabled the CDS to focus initial efforts on underperforming specialties and DRGs, plan interventions and monitor project impacts on the relative stay index in addition to NWAU and DRG complexity increases over time. The CDET has ongoing use by managers in the planning of initiatives across the Local Health District, with the easily accessible real-time data enabling decision making at the point of meetings, reducing delays in sourcing information from external sources.

The user-friendly interactive interface and visually stimulating displays of data enable valuable information to be presented to meet the needs not only of the CDS, but clinicians, performance department and management teams to monitor performance, activity, patient complexity and the impacts of improvement initiatives.

This paper will present the process of establishment of the CDET tool, explain how the various dimensions and measures are used to generate opportunity and the value.

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>>.