Ballarat Health Services
Putting your health first

OFF THE RECORD

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CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

Successful clinical documentation improvement (CDI) programs facilitate the accurate representation of a patient's clinical status that translates into quality reporting, physician report cards, reimbursement, public health data, and disease tracking and trending.

AHIMA (American Health Information Management Assoc)

HOW IS CLINICAL DOCUMENTATION USED?

First and foremost, clinical documentation is used to communicate patient information to a wide audience. During the patient episode medical, nursing and allied health staff will use the clinical documentation as a communication tool between the various clinical groups and specialties. It should ideally inform what the patient's principal diagnosis and comorbidities are, as well as document the indication for any interventions. If for some reason treatment or discharge are delayed then these too should be clearly documented including the cause of this delay and what steps are in place to get the patient back on track. Complications of care should also be clearly documented, outlining how they are being treated and what impact this has on the patient's care.

WHAT IS THE CORRECT PRINCIPAL DIAGNOSIS?

Coding staff are not clinicians so are very reliant on the clinical staff providing the correct principal diagnosis on the discharge summary. The definition that the Australian Institute of Health and Welfare (AIHW) have provided for application by all health services in Australia is

"The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, and episode of residential care or an attendance at the health care establishment, as represented by a code."

This means the the condition listed as principal diagnosis should not be:

- A condition which was not present on admission but which has arisen during the episode of care, for example a patient is admitted for same-day hernia repair and suffers a stroke in recovery. The hernia is still the principal diagnosis and the stroke a complication.
- A symptom which is found to have an underlying cause, for example patient presents with haemoptysis and is later found to have a primary lung cancer. The lung cancer should be the principal diagnosis.
- A vague term that is of little clinical values such as 'functional decline'. We are increasingly seeing this recorded as the principal diagnosis rather than the conditions(s) which are underlying this, such as Parkinson's disease or dementia for example.

Where more than one condition could be considered the principal diagnosis it is fine to list more than one condition in the principal diagnosis field, for example "delirium due to UTI'. However, be aware that we will most likely assign the codes in the order in which they are listed.

THE RIPPLE EFFECT OF POOR/INCOMPLETE DOCUMENTATION

Poor documentation can flow on to impact upon many diverse areas of BHS business, this can include:

- Poor defence in medico-legal issues
- Inadequate funding for patient episode
- Inaccurate performance data (LOS, mortality rates etc.)
- Inefficient service planning at local, state and national levels

To illustrate this an actual example from our BHS documentation. A patient spent **4 days in our critical care unit** with an admission diagnosis of '**dyspnoea**'. They underwent a coronary angiogram and transoesophageal ultrasound which found dilated cardiomyopathy. The principal diagnosis on the discharge summary was **'dyspnoea FI'**.

Coders are not allowed to assume that results in the episode are the cause of a symptom on the discharge summary. In this scenario the coders were forced to code R06.0 *dyspnoea* as the principal diagnosis. This grouped to **DRG E67A *Respiratory signs and symptoms, major complexity*** and the funding for this episode was **$4422**. This DRG (diagnosis related group) does not take the cardiac investigation into account.

The coding team queried the principal diagnosis and it was established that the principal diagnosis should have been '**dilated cardiomyopathy'**. This change in principal diagnosis resulted in **DRG F42A *Circulatory disorders, not adm for AMI, with invasive cardiac investigative procedure, major complexity.*** The funding for this revised diagnosis was **$9369**, nearly $5000 more than that for 'dyspneoa'.

The effect of poor or incomplete documentation is quite often obvious, but the impact on other areas may not be immediately realised. For instance with the example cited, if the Cardiology Unit wanted to make a business case for increased coronary care beds in our Critical Care Unit, the activity for cardiology may be analysed by DRG. In this instance a lot of activity under the cardiology unit may be missed as episodes may be classified into the correct DRGs.

Another impact is on our performance data and how we benchmark against other similar organisations. Again this data is primarily based on either the DRG or the principal diagnosis. If we are reporting 'shortness of breath(SOB)' instead of 'dilated cardiomyopathy' we will have a cohort of 'SOB' patients with a higher than average length of stay, potentially high readmission rates and/or mortality rates.

There are many further uses of this coded data at regional planning levels, state funding and resourcing as well as national programs, our coded data is also passed along to the Australian Bureau of Statistics. It is important that our data reporting is as accurate as possible and this is underpinned by good documentation.

CLINICAL DOCUMENTATION IMPROVEMENT AT BHS

At the moment we do not have a formal clinical documentation improvement program at BHS but are keen to ensure that our documentation and therefore our coded data are as complete and accurate as possible. All members of staff who contribute to the documentation in the record are encouraged to be mindful of this and assist us in capturing through the data accurate evidence of the growing complexity of our patient population.

If you would like further information or have any questions around coding or clinical documentation, please contact:

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