TITLE: The Missing Link – Clinical Documentation

Introduction

The value of casemix is dependent on the many factors that underpin it; codes, costing, funding – all datasets that have their own nuances, rules and determinants but the key to it all is the quality of the clinical documentation used to determine these datasets. Clinical documentation needs to be complete and accurate for the success of a quality casemix program. Codes cannot be assigned, and costs cannot be allocated if the patient story is not documented completely and accurately. So how do we determine the quality of the documentation in the clinical records in relation to casemix outcomes.

Methods

3M partnered with a leading tertiary hospital in Australia in a project to understand the quality of the clinical documentation in the context of maximizing casemix complexity. This project reviewed the clinical content of the medical record in relation to its completeness for clinical coding purposes.
Using a 3M methodology to determine a sample of 200 recent episodes of care. Both both overnight and multiday length of stay episodes were included. A manual review was undertaken by a team of coding experts to determine the accuracy of the assigned Diagnosis Related Group (DRG) for each episode. Where a DRG change was found an indicator as to the reason for the change was noted.

Results

The casemix index (CMI) of the sample prior to the review was determined and compared with the post review results.
The review determined a 2.3% Casemix Index increase was possible at 100% realization. To meet this goal it would require that 100% of episodes of care were reviewed in a 12 month period and that all the queries generated as a result of the review were agreed to by the Clinicians. As much as 3M have a conservative approach to queries requiring the support of Clinicians it is unlikely that all queries would be agreed to. This leaves us with a more realistic result of perhaps a 75% or even a 50% realization meaning a CMI increase of somewhere between 1.2% (50% realization) or 2.3% (100% realization). To meet this outcome it was determined that there be a minimal increase in CDI staff and that there be additional training for the CDI specialists and clinical teams responsible for the documentation.
Extensive training was undertaken for the CDI (Clinical Documentation Improvement) team and several Clinician training sessions were held. As this was during the COVID pandemic all training was held remotely.

Conclusions

Data was gathered for the following financial year detailing the financial implications of each of the DRG changes instigated by the CDI team. These results realized a CMI increase of 1.6% which represented a 69% realization rate from the original study.

The results of this project indicate that it is possible to predict a financial opportunity, based on a representative record review, that may be possible with an improved CDI program. An improvement in clinical documentation is not only a positive for financial outcomes and benchmarking but all datasets that feed into a casemix system which we rely on for the management of our healthcare systems.