

Clinical Documentation Improvement and Data Analytics Combine to Improve Patient Safety

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Healthcare professionals have all been subjected to mountains of information urging them to amplify quality care and patient safety. Everyone who works in healthcare, including health information management (HIM) professionals, must strive to advocate and serve these two areas. Patient safety is an evolving path connecting every member of the healthcare team. The medical record is the chief communication tool used to provide safe and efficient patient care and allow for appropriate reimbursement of services and equipment.

This article will focus specifically on the link between the clinical documentation improvement (CDI) specialist and the data analyst. The data analytics team must rely on the fact that the data they review is an accurate reflection of the patient encounter. Linking accurately coded data to pertinent clinical information is the primary focus of most CDI teams. By working directly with physicians and coders, CDI specialists help interpret, communicate, and educate the healthcare team to produce a clear and precise reflection of the care and progress of each patient encounter.

Precise Documentation Is a Must

The clinical staff within an organization are responsible for direct patient care and must document assessments, decision-making processes, and patient outcomes for translation of the medical record into specified coded diagnoses and procedures. Consistent and precise documentation in the medical record produces favorable results and enhances information gathering processes for analysis and process change. Data integrity is directly related to the input of information in the medical record as well as the interpretation of the consolidated documentation. Direct care providers record the essential foundation of documentation for data analysis. Provider communication with the clinical documentation specialist team through queries and education of coding guidelines and specificity requirements for accurate coding produces favorable patient outcomes and focused data analysis of benchmarked data.¹

More than a keystroke, the information in the medical record tells the story of the patient encounter. Quick access to positive and negative outcomes is essential for healthcare providers when determining the continuity of care and creating safe evaluation and treatment modalities. Federal and state guidelines mandate that physicians, and in some states nurse practitioners and physician assistants, have ultimate responsibility for accurate documentation and control over the content of the medical record.²

CDI Team Vet Documentation for Care and Cost

The CDI team performs inpatient and outpatient reviews “to ensure that physicians provide the most complete, clear, reliable, timely, legible, and precise documentation consistent with the clinical findings in the medical record.”³ CDI strives to combine clinical and coding knowledge to substantiate correct DRG assignment and reporting of a secondary diagnosis. Concurrent reviews help align patient information within the medical record for clarity and consistency, which facilitate coding accuracy. Additionally, the CDI team communicates verbally or electronically with clinical providers to educate them on the need for clear, concise, and specific documentation to facilitate proper coding for patient quality and safety. Clinical validation may occur during the patient stay, or retrospectively. CDI pulls data from a variety of entry points in the medical record to confirm supporting documentation of a diagnosis. Monitoring for clinical validity within the medical record to support the professional judgment of providers allows for further study of patient safety and quality outcomes.⁴

Facilities or departments may determine critical areas of interest for focused CDI reviews based on quality indicators, length of stay, mortality, readmissions, or other benchmarked data. For example, CDI could conduct a targeted study to determine how patient length of stay affects the occurrence of pressure ulcers, ultimately improving the standard of care for this

population. Identifying links between activity levels, nutritional status, and the presence of comorbid conditions helps carve new procedures, enhance documentation practices, and improve nurse/provider communication while identifying the need for improvement or confirming best professional practice. In this way, patient safety outcomes are reflected by the efforts of the CDI specialist working with physicians and coders to ensure appropriate capture of primary and secondary diagnoses for every patient at every encounter. CDI specialists work to sort through the complex medical record with concurrent or retrospective reviews to determine the most appropriate code selection.⁵

The CDI team may include previous direct care providers, experienced coders, or a combination of both. This team approach yields quality documentation that will positively reflect on patient safety scores. Record reviews and physician queries resolve questions of causal relationships. For example, did a medication cause an adverse effect in a patient because of dosing, underlying medical conditions, drug interactions, or intolerance to the substance? When examining why patients fall in the hospital, this in-depth study could prevent future falls.

The goal of concurrent or retrospective documentation reviews by the CDI specialist enhances patient safety by ensuring the first line of defense with consistency and accuracy within the patient record.⁶ Data analysts can then create descriptive databases and produce statistical information with correct information, thus enhancing patient safety outcomes.

Data Analytics Team Searches for Significance

Data analysts compile large volumes of information to determine significant outcomes of care that may influence future treatment modalities or avoid potentially dangerous situations by identifying patterns and trends.⁷ Precise data entry by clinical staff at the bedside leads to more specified clarification of clinical documentation by CDI professionals, resulting in clean data for statistical analysis. Decision-making processes begin with benchmarking data to determine trends, correlations, or variances within a specific population.

Coded data can be sorted and arranged with ease, allowing the data analyst to apply calculations. Information can be evaluated within an organization with a prescribed timeline or compared with reported data from archived databases with selected significance. In this way, healthcare professionals may not only establish new plans of care but determine the effectiveness of change. Benchmarking is the driving force to assess the effectiveness or need for improvement of performance and quality standards.⁸ Since the advent of the electronic health record (EHR) system, a streamlined approach to data management has paved the way to new opportunities to improve patient outcomes. Accurate data entry provides the groundwork for reporting and analyzing vast quantities of information using a systematic approach.

Consolidated data entry provides an efficient manner in which chart reviews are conducted for coding or auditing, and data is extracted for analysis or reporting. Identifying and monitoring patterns within the healthcare delivery system provide guidance for system development, business management, and medical decision-making. Operational system alerts and enhanced order entry procedures can be established as a result of proper reporting of concise data. The Office of the National Coordinator for Health IT (ONC) was created in 2004 to “spur the widespread adoption of the interoperable EHR within 10 years.”⁹ Advanced education can be developed to facilitate a deeper understanding of the importance of accurately and precisely capturing appropriate diagnosis and procedure codes from provider documentation.

Connecting for Improved Patient Safety

The future of healthcare quality and safety can best be determined by the complete and accurate interpretation of the quality information in the patient record to include treatment modalities, patient safety indicators, and response to care including outpatient follow-ups and quality measures.

Patient safety and quality care is the responsibility of all healthcare professionals. The patient record remains the most prominent method of communication between healthcare providers to include direct patient-specific care as well as understanding quality measures and performance outcomes to improve the management of population health initiatives.¹⁰ From facility and provider communication for each patient encounter to the analysis of coded data, clinical documentation specialists provide another link to quality and safety.

Notes

1. Johns, Merida L. Enterprise Health Information Management and Data Governance. Chicago, IL: AHIMA Press, 2015.
2. Abdelhak, Mervat H. et al. Health Information Management of a Strategic Resource, 5th Edition. St. Louis, MO: Elsevier, 2016.
3. Fahrenholz, Cheryl G. et al. Documentation for Health Records. Chicago, IL: AHIMA Press, 2013.
4. Abdelhak, Mervat H. et al. Health Information Management of a Strategic Resource, 5th Edition.
5. Ibid.
6. Johns, Merida L. Enterprise Health Information Management and Data Governance.
7. White, Susan. A Practical Approach to Analyzing Healthcare Data. Chicago, IL: AHIMA Press, 2016.
8. Ibid.
9. Johns, Merida L. Enterprise Health Information Management and Data Governance.
10. Ibid.

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