Clinical Documentation Improvement

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Sources: AHIMA CDI Toolkit · Bowman (2013) · O'Malley et al. (2005) · WHO Data Quality Guide

WEEK 1 · TOPIC 1

What Is Clinical Documentation?

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> **"Clinical documentation is the foundation of every health record in every setting."**

Clinical documentation is:

- Any **manual or electronic notation** made by a clinical care provider
- The written story of who the patient is, what's wrong, what was done, and what happens next

It can be:

- Paper notes & registers
- Electronic health records
- Discharge summaries
- Nursing assessments

WEEK 1 · TOPIC 1

Who Uses the Health Record?

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Direct Care

- Physicians
- Nurses
- Allied health professionals
- Case managers

Beyond the Bedside

- Coders & HIM professionals
- Researchers
- Insurers & payers
- Government & regulators
- Public health agencies
- Patients & families

One record. Many users. Many purposes. That's why it must be complete.

The Golden Rule of Documentation

"If it is not written down, it did not happen."

The Problem:

Physicians are often **not trained on proper documentation skills**. This creates large gaps between what the provider *knows* and what gets *written*.

Example:

A provider thinks "urinary tract infection" but writes "**bacteremia**". Coders can only code what is written. The code, the severity, and the reimbursement are all wrong.

The WHO confirms the same problem globally:

> *"Poor, inaccurate and incomplete documentation has a substantial impact on data quality. It also has an impact on the process of health care and has potential financial consequences."*

WEEK 1 · TOPIC 2

Why Documentation Matters

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✅ Good Documentation Helps:

- Doctors assess severity
- Nurses give safe care
- Case managers plan discharge
- Researchers study outcomes
- Leaders plan & fund services
- Coders assign accurate codes

❌ Bad Documentation Causes:

- Medical errors
- Repeated tests
- Poor follow-up
- Weak research data
- Coding denials
- Underfunding

Where Do Errors Come From?

O'Malley et al. (2005) — The Coding Process Flowchart

Errors enter at **every stage** between the patient's actual disease and the final code:

1 Patient doesn't share all symptoms

2 Clinician misinterprets or omits information

3 Record is incomplete or uses vague terms

4 Coder assigns wrong code from poor documentation

> *"Many sources of error are interposed between a person's disease (as it is in truth) and the word label applied to it by a clinician, and between the diagnosis and the code applied by a coder."*
> *— O'Malley et al.*

The Global Perspective — WHO Data

Causes of Poor Documentation in Developing Countries (WHO)

- Poorly designed data collection forms
- Lack of training in interviewing and recording
- Delay in recording data — not captured at the point of care
- Lack of understanding of data quality requirements
- Pressure of workload — documentation is not a priority

67%

of diagnoses were missing or incorrect on the front sheet

52%

of surgical procedures were missing or incorrectly documented

Source: Jones 1993, cited in the WHO Data Quality Guide

What Is CDI?

> *CDI is "the process an organization undertakes that will improve clinical specificity and documentation that will allow coders to assign more concise disease classification codes."*

CDI Goals (from the AHIMA Toolkit):

- Capture patient severity of illness (SOI) and risk of mortality (ROM)
- Identify and clarify missing, conflicting, or nonspecific documentation
- Support accurate coding and appropriate reimbursement
- **Promote health record completion — which promotes patient safety**
- Improve communication between the healthcare team
- Improve documentation to reflect quality and outcome scores

Case Study: "The Missing Diagnosis"

📋 **SETTING: PUBLIC TERTIARY HOSPITAL IN NIGERIA · PAPER RECORDS**

A 52-year-old woman is admitted for shortness of breath and leg swelling.

The doctor writes: **"Heart failure"**

No cause listed. No severity. No type.

The nurse records: swollen legs, difficulty breathing when lying flat.

The case manager can't plan discharge. A researcher later **excludes this patient** from a heart failure study.

What's Missing?

- What *type* of heart failure? (systolic? diastolic?)
- What *severity*? (acute? chronic? decompensated?)
- What *caused* it?
- What is the ejection fraction?

The CDI Fix

❌ **BEFORE CDI**

"Heart failure"

✅ **AFTER CDI**

"Acute decompensated congestive heart failure with reduced ejection fraction"

🖍️ Exercise: Your Turn

Give an example of a poorly written diagnosis you've seen (or could imagine seeing) in a patient chart. Then rewrite it using the three elements below.

1. **Write a vague diagnosis** — nonspecific, missing key details (e.g., "Infection," "Breathing problem," "Kidney disease")
2. **Rewrite it** using all three elements:

- 🔹 Cause
- 🔹 Severity
- 🔹 Clinical Indicators

💬 Discussion (after exercise):

- What information was missing in your "before" diagnosis that a coder would need?
- How would a researcher be affected if your vague diagnosis appeared in a dataset?
- Which of the three elements is most commonly missing in practice?
- What could be done at the point of care to help providers document with this level of specificity *from the start* — so that retrospective chart review becomes less necessary?

WEEK 1 · CLOSING

Week 1 Takeaways

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"Documentation is part of patient care."

Remember:

- Clinical documentation is the **foundation** of everything — care, coding, research, planning
- If it's not written, it didn't happen
- Poor documentation is usually a **training problem**, not a character problem
- CDI exists to **bridge the gap** between what the provider knows and what is documented