Improvement in Coding Accuracy of Diagnoses & Procedures through Multidisciplinary Collaboration

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Introduction
Complete and accurate documentation of the disease and procedure coding is crucial to vividly reflect on the heavy workload and complexity of the clinical effort of an healthcare institution being engaged in. QEH is one of the topmost among all public acute hospitals in terms of service workload and complexity (as the tertiary centre of various clinical services). Apart from utilization of electronic patient record, further efforts are required to improve the coding data quality in an institution of such a large scale as QEH.

Objectives
To improve accuracy and completeness of clinical coding data.

Methodology
Risk factors of suboptimal coding data capture were identified through series of audit of discharged episodes since 2009. Multidisciplinary collaboration effort was engaged in different communication channels to raise clinicians' awareness. Clinicians were also provided with various support, included quick reference toolkit (e.g. cue cards), orientation and training sessions, review of discharge summaries by senior clinicians, on-site support by medical record staff and off-site support on CMS interface (Disease Classification Coordinator). Coding accuracy was the main outcome measure for comparison before and after interventions.

Result
The overall coding accuracy for diagnoses and procedures was shown to have improved from 81.0% and 76.3% in 2013/2014 to 88.7% and 80.8% in 2016/2017, respectively. Compared 2016/2017 to 2013/2014, the maximum increase in accuracy
rate for 'Principal Diagnosis' in an individual clinical department reached 33.3% and the maximum increase in coding completeness in an individual department was observed to be 1.2%.