



@twitterhandle

## The role of AI in Clinical Documentation

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## What is it

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# The patient story

Diagnoses, procedures, laboratory, medications, medical decision making, treatment plans, subjective descriptions and objective findings.



## The goal

Complete,  
Accurate,  
Specific

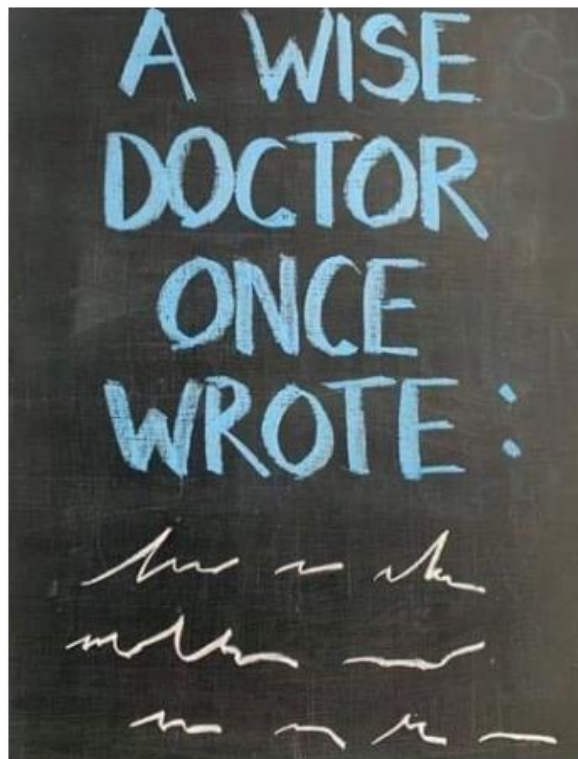
documentation in the medical record to reflect the patient's true complexity of illness and accurate hospital quality profiles

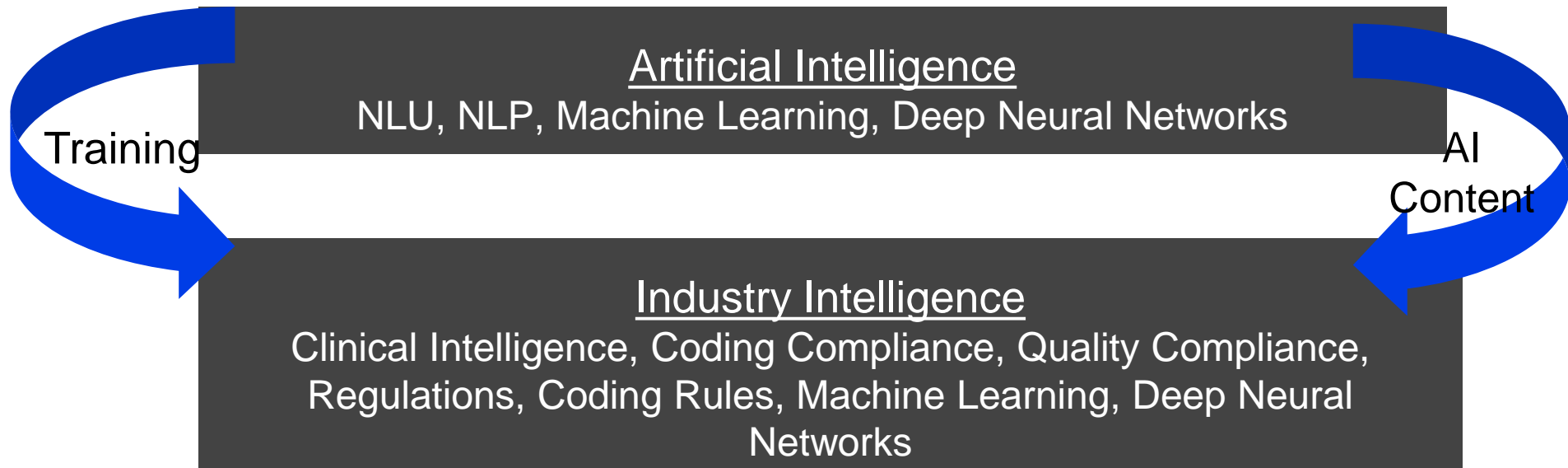


## The uses

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- Patient care
- Clinical decision support
- Patient outcomes and quality of care
- Hospital metrics
- Case mix complexity
- Reimbursement
- Third party

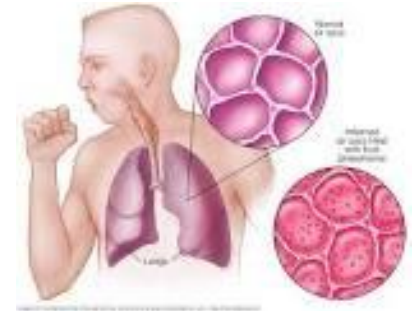






## Technology

- Clinical point of care
  - 3M CDI Engage
    - Pneumonia
      - Documentation of pneumonia and antibiotic therapy without documentation of the type of pneumonia.
    - RSV
      - Documentation of RSV without documentation of RSB bronchiolitis or pneumonia





## CDI Engage

- Each edit/nudge follows a standard format with unique
  - Requirement
  - Evidence
  - Defining logic
  - Default messages



## Technology

- Clinicians
  - Nudges appear in line with the EHR workflow in real time, generated by NLU reasoning over the documentation.
  - This means common documentation gaps are resolved proactively and before the note is saved in the medical record



## Technology

- For the CDI teams and Clinical Coders:
  - The NLU can prioritise worklists – these are customizable and can uncover episodes with the most opportunity.
  - There is visibility to the real time nudges provided to the clinician
  - The NLU generates evidence sheets to support documentation queries



## Prioritisation of CDI worklists

- CDI Team are able to prioritise episodes with the greatest opportunity to clarify documentation
  - Evidence without documentation
  - Documentation without evidence
  - DRG (Diagnosis related group)
  - Clinical unit
- Autogenerated worklist
  - Prioritised by focus of department



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Thank You