RESEARCH NOTES

Resident education as an avenue for improved documentation

by Howard Rodenberg, MD, MPH, CCDS

If you were to ask me, “What is the single best thing I can do to improve clinical documentation?” my answer would be to go out and get yourself some resident physicians. Beg, borrow, or steal them if you have to, but having residency programs within your healthcare system inevitably gives you a leg up in CDI success.

Why are residents so critical to your ultimate success? It’s because they’re a blank slate, without any preconceived notions of what CDI is or how it works, and without the baggage that comes with a personal history of “how medicine used to be.” They’ve grown up in an era where administrative input and the EHR are not enemies, but simply background noise. They want to learn, and they see knowledge as growth rather than as the enemy of experience. (Granted, coming out of medical school they think they know something, but it only takes a week or two to make that go away.)

Residents are a captive audience, as the nature of medical teaching means you know where to find them on rounds and conferences. And they want to please—please the attending physicians, nurses, coders, cafeteria staff, housekeeping—anyone who looks like they know what they’re doing, which compared to a resident is everyone.

At Baptist Health, we have the unusual scenario of four adult hospitals that are fully non-teaching, plus a children’s hospital with an academic pediatric residency. The pediatric CDI crew can readily participate in rounds and provide real-time support for clinical staff, as well as attend teaching conferences on a regular basis. (One of the residents’ favorites is “CDI Jeopardy” where the top prize is a $25 gift card to a local grocery store.) In the adult hospitals, we try to catch doctors when and if we can, negotiate for a few minutes of education at a staff meeting each month, and do most of our work via query. You can imagine which approach has proven to be more effective.

In this issue’s research notes, we’ll review a couple of poster presentations from the 2019 ACDIS Annual Conference in Orlando dealing with house staff and CDI.

Proactive daily rounding by a CDI specialist with medical house staff improves accuracy of reported expected mortality

by Corey E. Tabit, Patricia McBride, Amy Krattochvil, Mitchell J. Coplan, James K. Lioa, and Daniel Adelmann; University of Chicago

To fully understand this very clever work, a bit of background is in order. When mortality rates are compared between hospitals, they are not presented as percentages or raw numbers. In order to account for variances in patient populations, it’s more accurate to use an observed versus expected mortality (O:E) ratio. Observed mortality represents the real-life outcomes of care, while expected mortality is a statistic derived from the severity of illness as demonstrated by the diagnoses documented within the medical record. Poor documentation may artificially lower the expected mortality, suggesting patients are less sick than they really are. A lower number for the denominator with a constant observed mortality rate in the numerator causes the overall O:E ratio to rise, reflecting increased mortality and suggesting issues with the quality of care.

This poster proposed that daily CDI rounding with house staff and real-time documentation advice could provide a more accurate reflection of expected mortality. To test this hypothesis, a CDI specialist rounded with a cardiology house staff team and reviewed every note for completeness prior to attending signature. They found that nearly 60% of cases had a meaningful documentation opportunity, and that improved documentation would change the expected mortality risk in 23% of charts. The changes in expected mortality based on improved documentation resulted in a reduction of the
O:E ratio from 1.1 (suggesting care below the norm) to 0.8 (reflecting better than expected outcomes).

The study makes clear that when you have the advantage of daily interactions in a teaching environment, with committed staff and real-time input, you can affect measures of quality. And while the study did not address this as an end point, 58% of the records were found to have at least one CC/MCC opportunity, so there was likely a fiscal impact as well. However, there is a significant resource limitation in that staff time must be provided to review every note produced by a house staff team on a daily basis. It would be interesting to know if there is positive return on investment for this commitment, either in increased revenue or decreased quality penalties.

Could this scheme work in a non-teaching hospital? I think it would, but without a teaching structure that gives you a daily captive audience at specific times and places, it would be an uphill climb. CDI in the academic setting also benefits from limitations on resident workload, protecting time during the day for learning and thought in a way that simply doesn’t exist in the “real world.” Without limits on workloads, and with payment often driven by output rather than salary, hospitalists speed through as many current cases as possible while trying to practice good medicine and still being available for new patients as well as calls from colleagues, floors, patients, families, and even CDI staff. If anyone has a solution, please let the rest of us know.

This work reviewed a “Take 5” curriculum model of CDI education and compared before-and-after measures of educational satisfaction and documentation accuracy to assess the impact of the program. The “Take 5” program included at least five monthly CDI lectures during academic half-days and noon conferences. These meetings were designed to be interactive, using clinical scenarios to demonstrate documentation principles. Just as in the prior presentation, the CDI team clearly took advantage of the resident teaching program’s academic structure to further their educational work.

Residents were administered before-and-after surveys measuring satisfaction with their CDI training. Overall agreement rates with the statement “I have received adequate training in CDI” rose from 18% pre-training to 60% after the educational program. It appears that a second outcome was also evaluated via a CDI or coding quiz; graphics indicate that the “percent correct answer on surveys” rose from roughly 60% to 75% across all postgraduate years.

To be frank, it’s hard to know what “satisfaction” or “accuracy” really means without knowing what’s actually being asked or who’s doing the asking/answering. The poster itself is vague about the exact mechanisms of intervention and assessment. But reading between the lines, it seems that a consistent process of resident education can improve internal measures of CDI comfort and knowledge.

While my intuitive feeling is that residents are valuable to a CDI program, supportive data is hard to come by. Building on studies such as these can help demonstrate that house staff education may be the most valuable CDI tool of all.

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