Changing Medical Culture and Influencing New Ideas: CDI for Medical Students

Tim Weister, RN, MSN, CCDS
Clinical Documentation Improvement Specialist
Mayo Clinic
Rochester, Minn.
Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Identify the importance of including CDI training in the medical school curriculum
  - Select teaching strategies to use with medical students
  - Incorporate content pertinent to medical student training
  - Identify resources that support complete documentation

Overview of Content

- Why provide CDI training to medical students?
- Outline of steps taken developing medical student CDI training
- Provide an overview of training content
- Introduce documentation resources available to providers at Mayo Clinic – Rochester
Mayo Clinic

- Mission: To inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education, and research
- Primary value: *The needs of the patient come first*
- Every year, more than a million people come to Mayo Clinic for care
  - All 50 states and 150 countries

Mayo Clinic – Rochester

- Staff physicians and scientists – 2,158
- Residents, fellows, students – 2,899
- Allied health staff – 29,166
- Approximately 15,000 hospital discharges per quarter
- 16 full-time CDISs and one full-time analyst
  - Chart reviews by focus area
  - Review of PSIs and expired patients
Mayo Clinic – Rochester’s CDI Training Program

• Medical students to staff physicians
• New providers
• Regular updates per specialty
• Partnership
  – Mayo School of Continuous Professional Development
  – Resident/fellow Education Program Coordinators
  – Mayo Medical School

Background

• Frequent feedback from providers
  – “We were never taught this information”
  – “The way CDI is instructing us to document is different from what we have been taught”
Background

- “Medical schools and residency training programs have a duty to teach proper documentation skills” (Gliatto, Masters, & Karani, 2009, p. 358)
- “Medical students need to learn to write notes just as they would any other skill critical to function as physician” (Hammond et al., 2012, p. 259)
- “Systematic training regarding use of EMRs in medical education, however, remains limited” (Stephens & Williams, 2010, p. 222)

---

Mayo Medical School – Rochester

- In 1917, with a gift from the Mayo brothers, a medical school was founded at the University of Minnesota
- In 1972, Mayo Clinic started its own medical school on the Rochester campus
- Annually
  - 4,700 applicants
  - 50 selected
- Block system curriculum
Questions We Asked Ourselves

- Why present to medical students?
  - Documentation becomes a habit
  - Medical students as CDI champions
- Who to ask?
- When to present the training?
- What content to include?

Our Approval Process

- Operations manager
  - Content and curriculum review
- Dean
  - Final approval
- Course instructor
  - Review and approval of content
- Time and setting
Our Approval Process

- Who to ask?
  - CDI management
  - Operations manager, curriculum director, or dean/vice dean
- Course instructor
- Medical students
- Time and setting

When to Present?

- Second year medical students
  - They have received medical/clinical instruction, and transition to clinicals second year
  - Pre-clinical instruction includes training on composing clinical notes – admission and progress notes
  - Discharge summary training comes later in the second year
Pre-Clinical Block: Themes and Objectives

- Humility
  - Documentation review
  - Audits
- Patient-centered, team-based care
  - Patient access to records
  - Patient access to quality healthcare
- Communication
  - Patient record central to coordinated care

Content to Include Based on Previous Provider Feedback

- Integrate CDI training with scheduled curriculum
  - Clinical notes (admission, progress)
- Introduction to DRG basics and coding, including EMR and present on admission
  - Many providers are unfamiliar with the DRG system
  - Differentiate outpatient billing from clinical documentation improvement
  - Government regulations will likely only increase
Content to Include Based on Previous Provider Feedback

- Your documentation makes a difference: quality data
  - Why include information on quality data?
    - Growth of internal/external quality data down to the provider level
    - Patients are savvy healthcare consumers
    - Reimbursement becoming linked to outcomes

- Documentation specificity, guidelines, and tips
  - Why include information on documentation specificity?
    - Include ICD-10 details now
    - Impacts of specificity on DRG, LOS, SOI/ROM, and reimbursement
    - Resources for clinical documentation
Outline of Medical Student CDI Training/Content

- Why clinical documentation is important
- Medicine under the microscope

Introduction to Coding and EMR Basics

- Define start/stop dates for inpatient stays
- Define present on admission and notes that establish present on admission
- Encoder images displaying POA indicator for each coded diagnosis
Documentation and Quality Data

• Mortality index, severity of illness
• Table illustrating how documentation improves SOI, LOS, DRG, and reimbursement

Admission Notes

• What information to include
• Review diagnoses to include in past medical/surgical history
• Image of EMR illustrating where to document pertinent information in the admission note
Teaching Strategies: Case Scenarios and Audience Response

- Teaching strategies for medical students
  - Lecture: icebreaker, visuals such as tables and screenshots of the medical record
  - Case scenarios: examples add realism
  - Audience response system: keeps learners engaged and thinking
    - Pre/post-test
    - Combine scenarios with audience response

Admission Note Example

- Statement why the patient is being admitted
- Pertinent history surrounding admission
- Updated medication list
- Update allergies
- Past medical/surgical history to include only resolved diagnoses and prior procedures
- Update social/family history
- Include only current vitals
Admission Note Example

• Include updated physical findings if obtained during the visit

• I/R/P: Include all current, chronic and possible diagnoses to be treated, evaluated, or monitored during the hospital stay

• Diagnosis section can be pulled in from the I/R/P

Admission Scenario

• An elderly female is admitted to the ED with nausea/vomiting, midline abdominal pain, and CT shows acute small bowel obstruction. Patient complains of urinary frequency and burning the past few days. She has CHF, HTN, and LE edema. History includes Rt THA in 2000 and Rt breast CA s/p mastectomy in 2002. VS: BP 148/50, p. 85, T 36.6, R 22, BMI 38.6.
Admission Note: Putting It All Together

- Past medical/surgical history
  - R THA in 2000
  - R breast cancer s/p mastectomy in 2002
- Impression/report/plan
  - Small bowel obstruction
  - Congestive heart failure
  - Hypertension
  - Lower extremity edema
  - Obesity, BMI 38.6
  - Possible UTI

Diagnosis Specificity: Your Documentation Makes a Difference

- Display table illustrating impact of SOI, LOS, DRG assignment
- Include end coder images of coded scenario diagnoses
Importance of Specificity Table

<table>
<thead>
<tr>
<th>Admission diagnoses:</th>
<th>I/R/P:</th>
<th>I/R/P:</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Acute small bowel obstruction</td>
<td>#1 Acute small bowel obstruction s/p multiple segment small bowel resection</td>
<td>#1 Acute small bowel obstruction s/p multiple segment small bowel resection</td>
</tr>
<tr>
<td>#2 CHF</td>
<td>#2 Chronic systolic heart failure (CC) due to ischemic cardiomyopathy</td>
<td>#2 Exacerbation of chronic systolic heart failure (MCC) in the presence of postoperative fluid overload</td>
</tr>
<tr>
<td>#3 HTN</td>
<td>#3 ABG: 7.30/88/49/26</td>
<td>#3 Respiratory acidosis (CC)</td>
</tr>
<tr>
<td>#4 LE edema</td>
<td>#4 Positive 4.5L</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement example: $10,000</td>
<td>Reimbursement example: $15,000</td>
<td>Reimbursement example: $30,000</td>
</tr>
<tr>
<td>Estimated LOS: 4.4 days</td>
<td>Estimated LOS: 7.3 days</td>
<td>Estimated LOS: 11.9 days</td>
</tr>
</tbody>
</table>

Roadblocks to Complete Documentation

- The provider believes documentation specifics are not important to the plan of care
  - Heart failure versus chronic systolic heart failure; delirium versus delirium in senile dementia
- The provider believes the diagnosis is stated
  - Sepsis scenario
    - 85-year-old male with fever, chills, pulse 109, BP 78/40 persistent despite fluids and vasopressors
- Clinical terms differ from coding terms
  - Urosepsis versus sepsis due to UTI
Documentation Tips and Tricks

- Link home medications to a diagnosis
- Use of probable/likely to reflect complexity
- Ruling diagnoses in/out as more information becomes available
- Stating acuity, cause, and manifestations
- Diagnoses are not captured from labs, pathology, etc.
- Others

Conclusion: Medical Student CDI Training

- Review of key concepts
- Provide students with documentation resources available
  - Posters
  - Guides
  - Brochures
  - Templates (admission/progress)
- Demonstrate resources
- Evaluation
Presentation Conclusion

• Partnership and collaboration with your medical school
• Documentation is a habit – create good habits early on
• Medical students as CDI champions

References

Thank you. Questions?

weister.timothy@mayo.edu

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the workbook.