How Clinical Documentation Essentials for the Hospital Resident helped one teaching hospital

Many years after the implementation of clinical documentation improvement (CDI) programs, the biggest challenge for CDI is still physician engagement. According to a recent survey conducted by the Association of Clinical Documentation Improvement Specialists (ACDIS), physician engagement is still the number one problem facing CDI specialists.

“Physicians have never been taught documenting for coding based reasons; they’ve always been taught documenting for clinical reasons,” says Timothy N. Brundage, MD, CCDS, medical director of Brundage Medical Group, LLC, in Redington Beach, Florida, and one of the co-authors of the Clinical Documentation Essentials for the Hospital Resident e-learning course.

While every CDI program has a query process in place, that alone will not directly change your physician engagement and knowledge numbers. “If you were to give a query to a physician, they may answer that query in the way that you wanted, but the physician will make the same mistake over and over again,” Brundage says. In order to truly educate residents as to the benefit of accurate documentation and coding, they need more than just a query. They need in-depth education and training.

Course content

Enter Clinical Documentation Essentials for the Hospital Resident. “This course gives them a little bit of DRG background, a little understanding of documentation and coding, quality, and how quality is tracked, how physician metrics are tracked, and a little understanding of clinical criteria to make diagnoses and what words to use when making that diagnosis,” Brundage says about the outline of his course. “Each section is a short educational section. Some focus on coding, some on policies, some on coding guidelines, some on clinical criteria separated by body system.”

While a query in itself will not help educate and engage residents, continued comprehensive educational efforts will. “Our course is written by practicing physicians, for practicing physicians,” Brundage says. “Without education, you won’t move forward.”
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**Audience**

So, how does the *Clinical Documentation Essentials for the Hospital Resident* course fit into residents’ already busy schedules, and why would they want to participate?

“They have to first become comfortable with the fact that documentation is important and then prioritize it,” Brundage says. As a whole, however, the course only takes about three hours to complete—an easily attainable timeframe.

As the course is taught by physicians, it approaches CDI from a perspective any physician would be interested in. “In my opinion, being a good clinical documenter will not only improve physician metrics, it also improves the quality of care,” Brundage says. If a resident recognizes key clinical indicators, it will help them be more mindful of that patient’s condition and care and therefore document it more closely. “It’s not just about the hospital. It will also improve the resident’s care.”

**Case Study**

The residency program director at a teaching hospital with 400+ beds used *Clinical Documentation Essentials for the Hospital Resident* and found that Dr. Brundage’s course helped improve the facility’s quality scores and reimbursement significantly.

“The results following this training far exceeded expectations,” the facility’s residency director says. “Our facility is fortunate to have the ability to follow data over any given time period, which is important as our residents admit over 5,000 patients each year. Four months after completion of this training, our case mix index, severity of illness, and risk of mortality all increased significantly. One of the most important figures, our case mix index, increased from 1.38 to 1.47 when compared to the previous year. This can equate to more than $2 million dollars in revenue savings simply by documenting appropriately. I would highly recommend this educational tool to all physicians, regardless of training level or experience.”

Though the facility’s improved scores are likely enough reason to attract other facilities to the course, Brundage says that the course is focused on physician education, not directly what it can do for a facility. It provides residents with much needed education on documentation, and the 400+ bed teaching hospital found its residents valued the course and considered it useful.
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“I was familiar with terms such as case mix index and risk of mortality but didn’t realize the importance on my personal performance and its effect on our facility,” says a resident at the teaching hospital. “I was assigned the e-learning course and I found it both educational and efficient. It took me less than three hours to complete and the information was invaluable. The course provided a practical approach and understanding of how important appropriate documentation can be and how to improve on my own personal performance.”

“If you just open your mind to the possibility of learning a little about documentation to improve code capture, then this course will be very valuable to your physicians and your hospital as a whole,” Brundage says.

FOR MORE INFORMATION

To learn more about Clinical Documentation Essentials for the Hospital Resident or to purchase, please visit: https://hcmarketplace.com/clinical-documentation-essentials-for-the-hospital-resident