Shadowing Physicians for Documentation Improvement

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Strike when the ink is wet.

That is the motto of the clinical documentation improvement specialists (CDSs) at Shands Hospital, based in Jacksonville, FL. They routinely "shadow" physicians as part of their clinical documentation improvement program (CDIP), seeking clarification in real-time and making recommendations for how physicians can fine-tune documentation to enable more accurate coding.

CDIPs are popular in healthcare facilities looking to capture better documentation. Physicians know the documentation they need for treatment and continuity of care, but CDSs are anticipating additional detail that will later produce more complete and accurate coding. A more thorough description can enhance reimbursement and more correctly reflect the facility's quality of care indicators.

Officials at Shands and other facilities using this technique say they get more out of their CDIPs when documentation specialists are present with physicians in real-time, not querying later via e-mail or paper forms left in the chart. But some challenges, like time management and physician buy-in, also come with the successes.

How It Works

In many CDIPs, documentation specialists resolve queries after physicians have taken part in the patient encounter and recorded their documentation. Typically CDSs pick up the chart from a nurses' station and review for documentation clarification. If a question arises or chance for clarification is spotted, the CDSs may leave a paper query form in the chart for the physician to answer next time, e-mail the physician, or seek a face-to-face discussion.

CDIPs that use physician shadowing get more out of their program through direct, real-time documentation improvement efforts, says Michelle Dragut, MD, CCS, physician advisor for clinical documentation improvement at Shands Hospital. Dragut also helps implement CDIPs as a physician advisor for the Florida Hospital Association.

"This is real-time interaction with the physician pen. When the ink is still fresh," Dragut says-"on-the-spot interaction with the physician, when the case is fresh in their mind and they are in the process of making decisions."

The shadowing program pairs CDSs with physicians as they make their rounds and evaluate each patient's status for the day. After each patient encounter, the CDS and physician discuss the recently added documentation in the chart regarding the patient's diagnoses and treatment and potential DRG assignment.

At Shands, four CDSs-including Dragut-accompany physicians several times a week. The shadowing isn't random. The CDIP staff identify physicians who have a history of under-documenting in the chart. New hospitalists or residents are also good candidates. CDSs additionally review current patient charts for cases and conditions that are historically under-documented.

Once these cases and physicians are identified, the CDSs familiarize themselves with the physicians' cases and current documentation, then shadow the physicians during rounds, discussing their documentation immediately after it is written in the chart.

"You read the chart right after it is written and engage in a discussion right then," Dragut explains.

In the Room or in the Hall?

Most CDSs do not enter the patient's room with the physician. Instead they wait until the patient encounter is over and review the physician's documentation outside of the patient's room. This gives physicians space to practice medicine, and it offers patients additional privacy that could be compromised if a nonclinical CDS was in the room, Dragut says.

However, some facilities do encourage CDSs to be present in the patient room, according to Paula Frost, RN, CTR, clinical documentation improvement specialist at the Reading Hospital and Medical Center, in Reading, PA. Reading Hospital's newly launched "Concurrent Educational Rounding Initiative" has CDSs enter the patient's room with hospitalists in order to fully understand the encounter and pick up on missed documentation opportunities.

"Opportunities for increased severity documentation might be available at this level," Frost says. "It is possible the physician might not document something that was discussed or reviewed for one reason or another, but the CDI specialist would recognize the information as an opportunity for clarification, degree of severity of illness, or accuracy of documentation."

CDSs at Shands, an academic hospital, participate in case discussions between residents and attending physicians. They attend these meetings, review documentation, and evaluate the opportunities for a better way to express the severity of a illness in a case or other factors.

Hospitalists, attending physicians, and residents are the physicians usually shadowed by CDSs, though community physicians can also take part in the shadowing program.

Shadowing is only part of the CDS role at Shands. CDSs also do the more traditional CDIP work of querying through paper notes left in the chart. However, since the CDSs at Shands are on the floor-or "battlefield of documentation"-90 percent of their day, Dragut notes, they can always approach a physician with a paper query to have it answered on the spot.

Training and Orientation

For those facilities with limited CDIP resources, physician shadowing does not have to be an everyday aspect of the program. Shadowing may be used during CDIP orientation as a way to directly educate physicians on what is expected from the program.

At Catholic Healthcare West, a 40-hospital system based in San Francisco, physician shadowing was used when CDIP were introduced in the system's hospitals. Gloryanne Bryant, RHIA, CCS, CCDS, conducted the shadowing several times between 2003 to 2006 while working as the senior director of coding and HIM compliance at Catholic Healthcare.

After giving her CDIP orientation presentation to a facility's hospitalists, Bryant asked for CDIP shadowing volunteers who would like suggestions on improving their documentation.

This shadowing program was only done at the implementation level. Each individual hospital in the Catholic Healthcare West network did implement a CDIP throughout 2008, but used the traditional methods of paper, e-mail, and face-to-face querying.

During her shadowing experiences, Bryant would bring along her ICD-9 book and a laptop in order to reference specific DRGs and classification codes that could be linked to the physician documentation.

"The physicians actually were very enlightened, very positive, and said they would like to do this again," she says.

Now as the regional managing director of HIM at Kaiser Foundation Health Plan Inc and Hospitals, based in Oakland, CA, Bryant is getting ready to implement CDIPs in 20 of Kaiser's northern California region hospitals. Both the implementation and actual daily CDIP work in the hospital will contain documentation improvement physician shadowing, she says. The program is referred to as Clinical Documentation Integrity, or CDI. The shadowing will be done by CDI staff and physicians who have a strong knowledge of coding and quality measures. The CDI educating physicians will work in tandem with CDI staff who are both RNs and HIM coding professionals.

Demonstrating the "Common Goal"

Documentation improvement shadowing is a way to bring the clinical and coding sides together, Bryant says.

"[Shadowing] shows the real life, real-time impact of the pen, or keystroke, to capturing patient's severity, acuity, and risk of mortality," she says. "It gives insight into the link between the documentation and the coding classification system, details that are in a separate world from the clinical world. It pulls the two sides or efforts together to see the common goal."

Physicians and CDSs see many benefits from the direct interaction. Physicians learn firsthand the type of documentation necessary for their treatment and diagnoses to be clearly recognized and coded. CDSs get to participate in the patient care experience and can better understand the gap between doctors' day-to-day clinical language and the ICD-9-CM code-able lingo, Dragut says.

Shadowing also gives physicians and CDSs a chance to answer each other's questions immediately. Written queries can be misunderstood or set aside for a future time. Paper forms and e-mail limit back-and-forth discussion. But a face-to-face conversation can clearly sort out what both parties need or do not understand.

Just the fact that CDSs are visible and active on the floor serves as a reminder to all physicians that specific documentation is necessary, Frost says.

During shadowing, CDSs can educate physicians on the rationale behind a request to document in a particular way. A CDS can better provide the specific reason for a request for clarification-such as a particular documentation affects severity, accuracy, or DRG. This cuts down on the physician impression that they should answer the documentation question "because we asked you to," Frost says.

Time and Buy-in among the Challenges

There are several challenges that come with CDIP physician shadowing. Shadowing is time-consuming, and it lowers the number of chart CDSs can review each day.

The biggest challenge is getting physician buy-in. Physicians may see shadowing as a nuisance, while others may take offense. If the program's intent is poorly communicated, physicians may feel CDSs are questioning their clinical judgment.

Many CDIP shadowing programs start with physician volunteers who serve the "liaison or champion" role. These are usually hospitalists and residents, who have a stronger connection to the hospital and its financial performance, Bryant says.

When physicians are resistant at Shands, Dragut and the other CDSs stress how the program is in the doctors' best interest. Documentation is used for more than just the bill, they explain. It is turned into codes which are then abstracted into data used to judge physician performance and the overall quality of care at a hospital, including case-mix index, severity of illness, and even physician report cards.

"You can do the best patient care in the world, but if you don't do the best documentation, there is no way for the outside world to know that you did your best," Dragut often tells reluctant physicians.

Clinical, Coding, and Communication Skills a Must

Academic hospitals provide a great environment for shadowing. New residents can learn good documentation skills up front through the program. But community hospitals can also implement CDIP shadowing with equal success. Buy-in from C-suite staff and numerous physician champions is necessary for any shadowing program to survive, Dragut says.

In order to effectively shadow physicians in a CDIP, CDSs have to have both a strong clinical and coding background. Of the three CDSs at Shands, two have physician backgrounds and one is an RHIA with 35 years of coding and HIM practice. Reading Hospital employs two RNs as CDI specialists.

HIM professionals with good clinical and coding knowledge are ideal candidates for CDIP shadowing, Bryant says. Strong communication skills are also vital.

"I think that we need to make sure when we are looking at clinical documentation improvement programs that we design them to look for professionals, whether they be nurses, physicians, or HIM professionals that do the CDI work, who have a good, strong communication skill set," Bryant says.

The possible intimidation of working with physicians can be minimal if a CDS has confident knowledge of how codes translate into data and what the data means from a quality perspective. Bryant advises CDSs to study MS-DRGs and HHCs, learn how documentation affects hospital and physician finances, and understand quality reports on sites such as healthgrades.com.

Physician shadowing can be a great experience for a CDS with an HIM background, Bryant says. “Personally, I found it very rewarding to share knowledge and see lightbulbs go on,” she says. “It is quite exciting to see people get it, understand the value in their day-to-day interaction, and then later see it appear in the documentation and see the coded data is actually improving.”

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