Welcome to OHSU

Snapshot of your role in supporting excellent patient care documentation.

Clinical Documentation Information Program & Specialists

As an academic medical center, we have multiple types and levels of staff that have a role in documentation of the care we provide to our patients.

- Program implemented in late 2004, to improve physician documentation by capturing the highest level of specificity of reportable conditions / diagnoses of our patient population
- Physician and mid-level provider documentation reflects the quality of care, the severity of illness, risk of mortality, supports medical necessity, appropriate reimbursement and is compliant with all regulatory requirements regardless of the impact on reimbursement
- Complete, concise, compliant documentation can reduce compliance risks, minimize OHSU’s vulnerability during external audits, and support medical necessity criteria
- The concurrent documentation review process is conducted by the Clinical Documentation Specialists, for the defined patient populations and payer mix; Current CDI Specialists: Eileen Pracz RN @ 418-4023, Evelyn Murphy RN @ 494-3294, Sandra Nelsen RN @ 494-1705 and Tom Kauffman RN @494-0688
- Charts are reviewed for clear, concise, complete and compliant documentation

The following is a summary of key documentation issues and how the process impacts your documentation workflow

I. The review process

- The information gathered during the concurrent review is evaluated by the Clinical Documentation Specialists for clinical indications, diagnostic terminology and treatment plans [medications and procedures] for consistency.
- Documentation which is ambiguous, conflicting, incomplete or non-diagnostic may need to be clarified by the concurrent Clinical Documentation Specialist Staff.

II. Clarification & Query Process

- A concurrent query / clarification process will be conducted by the CDI specialist as needed and goes to members of the treatment team taking care of the patient [the author of the issue needing clarification] and to the attending provider via the In-Basket function in Epic IHR
- It is expected that if you receive a In-basket message [Documentation Clarification is the title of the entry], you will read and act on the query / clarification request by taking the following steps:
  o Documenting the appropriate [agreed] diagnosis or clarification in a progress note, operative note and / or discharge summary by adding an addendum or writing a new note
  o If the provider does not agree with the query / clarification question, a reply to the sender of the query is needed stating that they disagree
  o The query process will be monitored, evaluated and communicated to appropriate groups as a basis for establishing benchmarks, education tools and presentation to interested groups.

III. Key Concepts

In order to support the most efficient review of notes by all end users of the electronic medical record the following concepts guide documentation

- Select the most appropriate category for your note
  Common types: H & P, Procedure, Progress Note, Significant Event, Consult, D/C summary
- If copy & pasting from prior notes, only information / data that is pertinent to the current admission should be added to a new no Create a current active [hospitalization] problem list and maintain it as the admission continues, updating it as new or resolved problems occur
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Purpose:

The purpose of this policy is to define clearly a process of supervision and responsibility for all aspects of the surgical patient’s care at OHSU that simultaneously provides safe and effective patient care and ensures appropriate, progressive responsibility that contributes to the education of all learners in the hierarchy and culminates in their ability to enter the unsupervised practice of surgery.

General Statement:

Each patient admitted to a surgical service at University Hospital, seen in the Outpatient Department or Emergency Room, or seen in consultation by surgery shall have an attending faculty surgeon designated who is responsible for that patient’s care.

The attending surgeon will supervise and be responsible for all aspects of the patient’s care and subsequent follow-up and may delegate aspects of that care to surgical residents commensurate with each resident’s level of skill and experience.

The residents are aggregated into teams of individuals with varied experience forming a hierarchy from post-graduate year one (intern) through senior year or chief resident and also including non-physician, licensed, independent practitioners who may share responsibilities for patient care and may supervise residents on specific services.

Although interns may care for patients and write orders, all major changes in patient condition and changes in treatment must be communicated through the chain of command of the service. The attending surgeon shall be kept informed of all such changes in the patient’s condition or management.

If an attending surgeon is out of town or otherwise unavailable, he/she must identify another faculty member to be responsible for each patient and communicate that change to the resident team caring for the patient.

Principles:

Supervision

All patient care provided by resident/fellow physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety and ensure high quality education. That supervision is graduated depending on patient acuity and the resident/fellow’s level of responsibility. Four levels of supervision are recognized:

DIRECT SUPERVISION (DS): the supervising physician is physically present with the resident/fellow and the patient.
INDIRECT SUPERVISION WITH DIRECT SUPERVISION IMMEDIATELY AVAILABLE (IS-DSIA): the supervising physician is present in the hospital/clinic and is immediately available to provide Direct Supervision. The supervisor may not be engaged in any activities (such as a patient care procedure) which would delay the response to a resident/fellow requiring direct supervision.

INDIRECT SUPERVISION WITH DIRECT SUPERVISION AVAILABLE (IS-DSA): the supervising physician is not required to be present in the hospital/clinic, or may be in-house but engaged in patient care activities, but is immediately available through telephone or other electronic modalities and can be summoned to provide Direct Supervision.

OVERSIGHT (O): the supervision is available to provide review of patient procedures/encounters with feedback provided after care is delivered.

Availability of Supervising Physicians: Faculty call schedules are structured to assure that support and supervision are readily available to residents/fellows on duty. Residents/fellows must know which attending physicians are on call and how to reach them. Backup must be available at all times through more senior residents/fellows and appropriately credentialed attending physicians.

Progressive Resident Responsibility:
As they advance in the training program, residents/fellows are given progressive responsibility for care of patients. Graded responsibilities for each level of training are described specifically below. The determination of a resident’s ability to provide care to patients with more responsibility or to act in a teaching capacity is based on the resident’s demonstrated clinical experience, judgment, knowledge, and technical skill. It is the decision of the supervising physician to designate which activities the resident/fellow will be allowed to perform within the context of the assigned levels of responsibility.

Roles and Responsibilities:

Program Director:
It is the responsibility of the Program Director to develop written guidelines governing supervision of residents/fellows and to establish categories of all activities according to graduate levels of responsibility and appropriate levels of supervision.

Supervising Physicians:
All patients are the direct responsibility of attending physicians and those individuals are responsible for the quality of all clinical care services provided to their patients. When the attending staff physician accepts a resident/fellow on the service, he/she becomes the physician responsible for the supervision of the resident/fellow’s patient care.

Supervising physicians will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care and the experience, judgment and level of the training of the supervised resident/fellow. This responsibility is exercised by observation, consultation and direction. Fulfillment of such responsibility requires personal involvement with each patient and each resident/fellow who is providing care as part of the training experience. Supervising physician may use their discretion in allowing residents/fellows to
perform certain procedures without direct supervision. The supervising physician is expected to provide the resident with timely instruction, advice, support and feedback, including a comprehensive, written evaluation at the end of the rotation or training period.

Supervising physicians are also responsible for determining when a resident is unable to function at the level required to provide safe, high quality care to assigned patients. In these circumstances, he/she must notify the Program Director of any deficiencies in medical knowledge, patient care, interpersonal communications, systems-based practice, practice-based learning or professionalism consistent with their level of training. In addition the supervising physician must have the authority to adjust duty hours as necessary to ensure that patients are not placed at risk by fatigued or impaired residents/fellows.

Residents/Fellows
Each resident/fellow is responsible for communicating significant patient care issues to the supervising physician and such communication must be documented in the medical record. Individual residents/fellows must be aware of their limitations and not attempt to provide clinical services or procedures for which they are not trained.

PGY-1
First year residents will have mandatory attendance at a series of teaching conferences aimed at addressing basic clinical situations and appropriate management. Examples of topics covered include hypotension, low urine output, cardiac dysfunction and respiratory distress. Additionally, PGY-1 residents will have a Patient Management Skills Log which will be completed in the first 3 months of their internship. Interns will be observed and monitored for the successful management of hypotension, hypertension, oliguria, anuria, cardiac arrhythmia, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndrome. They must be signed off on management of these patient issues by a more senior resident or attending. Direct supervision (DS) will be provided at all times for PGY-1 residents until the Program Director has documented their ability to provide care with indirect supervision. Junior or senior level residents or the attending of record will be present in the operating room, hospital or clinic at all times to be physically present and oversee procedures or complex patient care issues. When interns have been cleared for management of complex issues or procedures, they will be monitored by indirect supervision with direct supervision immediately available at all times (15-DS1A).

PGY-2
PGY-2 level residents will begin in a supervising role for interns. They are instructed that they must limit their supervisory roles to situations and procedures for which they have met any available objective criteria and have attained the level of comfort which will best ensure safe and effective patient care. Direct supervision will be provided for at least the critical portions of all OR surgical procedures and for invasive procedures for which the resident is not yet competent. PGY2 residents must communicate with the appropriate supervising faculty for any significant change in a patient’s status requiring an invasive intervention, more intensive
level of monitoring, or transfer to a higher level of care. The ensuing level of supervision by the supervising physician will be determined by the nature of the problem.

PGY-3

PGY-3 level residents will continue in a supervising role for interns and PGY2 level residents. They are instructed that they must limit their supervisory roles to situations and procedures for which they have become experienced and have attained the level of comfort which will best ensure safe and effective patient care. Direct supervision will be provided for at least the critical portions of all OR surgical procedures and for invasive procedures for which the resident is not yet competent. PGY3 residents must communicate with the appropriate supervising faculty for any significant change in a patient’s status requiring an invasive intervention, more intensive level of monitoring, or transfer to a higher level of care. The ensuing level of supervision by the supervising physician will be determined by the nature of the problem.

PGY-4

Residents act as leaders of their respective services and must be familiar with all aspects of their patients’ care. They will keep the attending surgeon appraised of the patients’ progress and all changes in their care.

Residents are expected to respond to consults in a timely fashion and review all patients with the attending before implementing treatment or disposition plans. After discussing plans for treatment, residents may perform procedures without direct supervision if they are comfortable and experienced with these procedures and it is approved by the attending physician. Residents are expected to request immediate supervision if they are not comfortable. For any patient who requires a procedure in the operating room, there will be direct attending supervision. Residents are expected to attend clinics with their assigned attending, see patients independently, and discuss proposed treatment plans with the attending before implementing care. Residents are expected to have an attending present or immediately available for any OR case.

PGY-5

Residents are expected to round on every patient daily, make decisions regarding the clinical situation and patient care, and communicate daily with the attending before implementing significant changes. Residents are expected to be familiar with and independently implement the routine treatment protocols for specific high volume cases. Residents are expected to respond to consults in a timely fashion and review all patients with the attending. Basic treatment plans or disposition may be implemented independently by the resident.

For any patient who requires a procedure in the operating room, there will be direct attending supervision though residents are expected to function as the operating surgeon and make all intra-operative decisions. Residents will be expected, at times, to take more junior residents through cases. Residents are expected to attend clinics with their
assigned attending, see patients independently, and discuss treatment plans with the attending. Residents are expected to have an attending present or immediately available for any OR case. Residents are expected to provide instruction to more junior residents and students and to run rounds. Residents are expected to perform administrative functions such as creating the call schedule for the residents without faculty supervision.