The art of physician communication

by Steven Robinson, RN

Most physicians want to provide an accurate written picture of their patients, and many believe that they document effectively and consistently. However, when queried by a CDI specialist, physicians often require help to understand exactly what needs to be further explained in their documentation and why.

This presents an opportunity for the CDI specialist to explain CMS’ inpatient prospective payment system (IPPS) documentation regulations and the effect physician documentation has on data collection and reported patient care. It is Maxim’s belief that CDI specialists, hospitals, and physicians share a common goal—to accurately reflect true patient acuity, which includes MS-DRG relative weight, severity of illness (SOI), and risk of mortality (ROM).

As many CDI specialists know, physicians often struggle with regulatory methodology compliance mandated by CMS and the AHA to demonstrate accurate patient SOI. MS-DRGs, APR-DRGs, AP-DRGs, and APS-DRGs are examples of payment bundling systems that categorize coded diagnoses depicting a severity profile. The physician/documentation disconnect comes when the physician’s perceived “complete and accurate clinical picture” does not equate to the required documentation needed in the IPPS severity profile. As a result, CDI specialists may have difficulty demonstrating how clinical documentation can directly affect:

» The physician’s individual, practice, specialty, and hospital current and future SOI/ROM profiles and process acuity (case-mix index, CC capture rates, diagnostic ratios, etc.)
» Placement of the patient in the appropriate venue of care according to medical necessity guidelines (i.e., qualifying for inpatient vs. outpatient vs. observation status)
» Accurate reimbursement for the care provided and resources consumed

If physicians can grasp the fundamental purpose behind the CDI specialists’ questions, they will be more understanding of the CDI process, more deliberate in the documentation they provide, and more accepting of the queries generated by CDI staff.

Build relationships proactively

To enlist the cooperation of the physician, a personal introduction will go a long way. CDI specialists should be sincere, confident, and cooperative when initiating a relationship with the physician.

Relationships are built through trust in what is said and actions that are observed, and physicians are great observers. CDI specialists should be sure their actions are always professional with physicians, fellow colleagues, and the patient population. In addition, the more succinct and targeted CDI staff can be with physicians, the more they will entrust them with their time.

Gaining physician cooperation requires the CDI specialist to be strategic. Sometimes it takes several attempts for CDI specialists to clarify a diagnosis or garner documentation on a particular case. The physician may respond, but may not do so completely or with adequate specificity. In such instances, CDI specialists should follow up with the physician by providing direct education (factual, prepared, and intentional information) and by providing focused communication demonstrating how documentation clarity can influence profile accuracy and more appropriate E/M levels. Such actions represent what Maxim considers an industry best practice.

Private, one-on-one discussions reviewing case examples of CDI process outcomes (CC/MCC capture, principal diagnosis, principal procedure influence, severity profiles, and E/M level changes) can be a successful method to help build a strong IPPS foundation and educate physicians.

The goal is to create a relationship in which the physician seeks out the CDI staff once he or she finds value in the CDI work. Valued communication is information that the physician cannot get elsewhere, including profile results, comparative study data, specific rules around documentation, and E/M facts that coincide with DRG queries.

Be prepared when talking with a physician about a specific patient’s documentation. Physicians need to understand that the CDI specialists’ questions are legitimate and that
their responses will influence their private practice as well as the SOI/ROM for the patient. Therefore, it is best to have the medical record readily available to directly point out documentation that is not complete.

Furthermore, talk facts. If you have scheduled a meeting with a physician concerning a specific issue (e.g., query response rates, specific CC/MCC capture rates, or specific criteria surrounding a diagnosis), use internal comparisons of colleague data (with names omitted). Use recent internal metrics reports, including DRG reports, query reports, and PEPPER reported data, that can help the physician gain a greater understanding of the potential benefits of documentation clarity.

The best action plan does not dwell on the past. If you schedule a meeting, be proactive and think about the next step in the discussion. Have your suggestions for improvements in place, but be open to modification.

**Employ multifaceted educational tactics**

There are many ways to address and educate physicians about documentation best practices. They include:

» **Grand rounds.** Build credibility by discussing specific cases from a CDI perspective while making rounds with the physician. CDI staff can explain how specific documentation can help justify resources, demonstrate a higher SOI/ROM, and improve patient care.

» **Posters.** Visual posters on performance grab attention. Display a poster in the nurses’ or physicians’ lounge describing documentation for specific diagnoses that frequently creates challenges for your physicians.

» **Group meetings.** Schedule data report presentations for physician sub-sectional meetings that demonstrate successes and challenges (physician names are usually omitted in these presentations). Physicians tend to respond positively to clearly illustrated trends.

Participation of the CDI specialist in patient care rounds, clinical patient care teams, or patient conferences are all avenues to teach medical staff about specific documentation that affects the patient’s SOI. Grand rounds, patient care conferences, and resident lectures are of benefit to the CDI specialist, too: They can help enrich the specialist’s knowledge of disease and appropriate diagnosis classifications.

Introduce documentation education in meetings, lectures, and medical staff presentations that are already on the schedule. Ask to be involved in identified medical education gatherings. In private or community hospitals, CDI staff can take advantage of medical staff interactions by requesting to be put on the agenda for medical and surgical sectional meetings and medical staff quarterly meetings.

In addition, consider scheduling one-on-one meetings in the physician office or office staff meetings. Offer to round with physicians and review their documentation with them.

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### 16 questions to assess physician communication effectiveness

Honest answers to the following questions can help evaluate the current state of your physician communication process:

1. What actions should we take to employ effective CDI communication with physicians?
2. What can we do to assist hospitals and physicians with accurate profiles?
3. What am I doing to stimulate better communication with my physician staff?
4. Is my communication fresh and new?
5. Who among my physician staff supports my CDI efforts?
6. Am I able to be a consultant to physician staff regarding CDI?
7. Do physicians approach me with questions, or am I always going to them?
8. How many hospitalists does my hospital employ?
9. Are hospitalists receptive?
10. Have hospitalists become my advocates?
11. What process metrics are being measured, and are they reported back to the physician groups?
12. Which metrics are being reported to physicians?
13. Are action plans written around the metrics? Why/why not?
14. Do I have a monthly/quarterly dashboard that I can depend on?
15. What are my dashboard metrics, and do I refresh them? If so, how often do I do this, and who do I share them with?
16. How are metrics outside my objective benchmarks acted on?
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**Identify physician trends**

Identify trends by tracking data and the issues that are illustrated by that data. These trends may affect more than one physician; alternatively, you may uncover a consistent issue with a physician that warrants group interaction.

CDI managers and their team should evaluate CDI operational process metrics and CDI physician query process metrics each month at the beginning of a new CDI program, and then on a quarterly basis once the CDI process is finalized.

**Physicians like to see, acknowledge, and be acknowledged for their specific contributions to the CDI process.**

Physicians like to see, acknowledge, and be acknowledged for their specific contributions to the CDI process. CDI leadership should display and present CDI process results, including CC and MCC capture, case-mix index changes, mortality and SOI changes, changes in principal diagnosis, and physician communication query statistics to physicians during medical staff and section meetings to reinforce successes and acknowledge physicians’ hard work.

Review any trends in physician metrics with each physician privately. Furthermore, if the metrics indicate a lack of change or progress, it is important to make physicians aware of the situation to help motivate them to work toward an understanding and reach for benchmark goals. (See “16 questions to assess physician communication effectiveness” on p. 17.)

**Use different tactics for different types of physicians**

Give physician leaders information about how documentation improvement can help them. Once they understand the importance of CDI, they will lead by example and train future generations of physicians on the importance of appropriately documenting care for their patients.

In an academic healthcare facility, residents generally dominate medical record documentation, at least in the written medical record. However, if residents do not have strong written documentation skills, their responses to CDI queries may not always be accurate and complete. Most residents are not aware of CDI methodologies or the importance of addressing diagnoses/procedures in a compliant manner. Provide specific examples of resident cases and outcomes to demonstrate the benefits of improved documentation.

Some resident programs allow the concepts surrounding documentation accuracy to be taught in their classes, and hospitals are involving residents more and more in their CDI programs. One Texas hospital system invites residents to learn inpatient and outpatient coding applications by employing them as coders, allowing them the option to moonlight in the HIM department as opposed to the ER.

You should also focus your CDI education on hospitalists. Usually, hospitalist groups comprise a relatively small number of physicians who are responsible for providing care to a large percentage of the inpatient population. Typically, hospitalists are willing to embrace learning opportunities.

Hospitalist groups may also be receptive to patient care rounds and educational sessions on specific disease documentation.

**Ask the right question the first time**

CDI specialists need to ask questions of the physician when appropriate and warranted, but those questions must be compliant and non-leading. In turn, physicians must be willing to cooperate with the CDI query process.

Questions submitted by the CDI specialist should always be valid, clear, legitimate, and complete (but concise). If questions are easily understood and display an applicable snapshot of the supporting clinical evidence, the CDI program will achieve a higher percentage of physician responses.

Maxim agrees with the AHIMA Practice Brief “Managing an Effective Query Process,” published in the October 2008 *Journal of AHIMA*. The brief states, “The entire record should be reviewed to determine the specific reason for
the encounter and conditions treated.” It also states, “The importance of consistent, complete documentation in the medical record cannot be overemphasized.”

You should incorporate the following components into each query:

- Clinical indicators: signs, symptoms, and clinical evidence that could support a definitive diagnosis
- Treatment plans: medications, treatments, and prescriptions to treat or identify diagnoses
- Clinical monitoring: serial labs, x-rays, vital signs, neurochecks, or any serial/repeated diagnostics
- Physician questions: Ask about diagnostic options pointing to the clinical indicators and treatment plans

When a query is depicted correctly, it paints a picture of the patient’s quality of care and allows the physician to choose a diagnostic statement using the clinical indicators identified.

**Evaluate the physician communication process**

Hurdles and challenges exist in physician education, monitoring, and tracking, but you can support your hospital metrics outcomes as well as the physician’s profile through effective communication with the medical staff. Maxim’s clients state that their CDI specialists’ ability to communicate with inpatient physicians is gradually becoming easier and that physicians are becoming more approachable.

As more and more hospitals implement CDI initiatives, many physicians have become professionally involved in the CDI process as physician champions or advisors. Others are more involved in utilization review, quality, case management, and HIM committees.

Remember that it is always necessary to offer physicians education on documentation compliance. CDI specialists should support physicians by providing queries as needed and by continually making them aware of changing rules and regulations regarding documentation compliance.

CDI is an involved process, and it can be challenging to produce the results you desire. However, collaborative communication between the CDI specialist and physician is not only the first step, but the “concurrent step” to success.

**About the author**

Steven Robinson, RN, has successfully managed CDI services for more than 200 acute healthcare hospitals, medical centers, and health systems over the past 19 years. An RN and physician assistant with a master’s degree in health management, Robinson currently serves as the senior director of CDI at Maxim Health Information Services (MHIS) in Cleveland.

Prior to working at MHIS, Robinson served as vice president of clinical consulting services at a CPA healthcare firm acquired by 3M, senior vice president of clinical consulting at HP3, and director of forensic healthcare consulting at KPMG, LLP. He is committed to providing clients across the country with quality CDI services.

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