How to Successfully Talk to Doctors About CDI

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Utilize effective communication to engage physicians in constructive queries
  – Discuss effective written and verbal queries

Why Is This So Hard?

• Doctors are ...
  – Much too busy
  – Impatient
  – Anxious—under a black cloud of doubt
  – Insistent upon things making sense
  – Afflicted with acquired ADD (or ADHD)
  – Afflicted with PTSD
  – Confused about who you are or what you want
  – Unclear as to what coding is
1. **Assume Complete Ignorance**

   - First rule: Doctors know nothing about CDI until you tell them.
   - Second rule: Assume no one has ever mentioned it!
     - Didn’t they learn this in medical school?
     - Didn’t they learn this in residency?
     - Hasn’t the hospital educated them?
     - Don’t they get this in orientation?

2. **Begin With a Personal Introduction**

   - Introduce yourself every time you meet a physician until they begin to call you by name
     - Who are you?
     - What do you do?
     - Why do you do what you do?
     - Explain the rules regarding the WAY queries are worded!

3. **Face-to-Face Encounters**

   - Do as much as you possibly can face-to-face with the provider
   - Build a relationship (especially with your hospitalists)
   - Sympathize and agree—it’s disarming
   - Recognize their frustration
**Poorly Answered Query**

- Attending physician admits patient with an acute GI bleed
- Attending states “Hb is 6, ordered 2 units PRBCs stat!”
- Query to attending:
  - Please clarify why this patient received a stat blood transfusion
  - Physician states: “Because the patient would otherwise have died!”

**4. Choose Your Words Carefully**

- Try to think like a doctor
  - When you ask for “clarification” for a problem that is crystal clear ...
  - It confuses physicians
    - “Colleen, the evidence speaks for itself!”
    - “Why are you asking me if this patient has renal failure? He’s on dialysis, for heaven’s sake!”
    - “Didn’t you see the radiologist’s (or pathologist’s) report?”
    - What more do you need?”
    - “It’s so obvious!”

**Be Aware That Doctors Are Frustrated With Queries**

- “Tell me what you want me to say!” is a frequent response
  - Doctors think their documentation is perfect
  - They don’t want to hear they did something “wrong”
  - They don’t like to be questioned
  - They feel picked on
    - “Do you read every specialist’s note and then query ME about it?”
    - “Ask the admitting doc if it was present on admission!”
    - “I’m not the cardiologist, ask him!”
5. Control the Conversation

- Simplify
  - If you need a diagnosis, ask for it!
- Tell them how to get fewer queries!
  - Coders can’t code from lab values
  - Coders can’t code from radiology reports
  - Medicare rewards specificity
    - Insufficiency vs. failure
    - Acute, chronic, acute on chronic
  - Every query is a learning opportunity

6. Get Rid of Acronyms and “Slanguage”

- POA (power of attorney)
- CDI (central diabetes insipidus, C. diff infection, color doppler imaging ...)
- CC/MCC (CC is chief complaint, MCC Merkel cell carcinoma, mutant colorectal cancer suppressor gene)
- DRG (drug)
- Move a DRG (sell drugs faster)

  Doctors don’t know these acronyms, so don’t use them in conversation or in a query

How to Get Your Queries Answered

- Go in person and ask for help
  - Doctors love to help
- Be patient but persistent
  - Don’t accept a “non-answer”—query again
- Move up on their “triage list”
- Make it easy
  - Pop-up message now in place
  - Laminated tip card, pen, smart phrases, newsletters, signs, etc.
- Add consequences
  - A consequence for unanswered queries
    - Escalation path—use it, no exceptions
Be Short and to the Point

Example of a query that is too long and difficult to follow:

Yellow Team Hospitalist:

Patient admitted via direct fil. IRT was called and the IRT staff documented: "The patient is in acute respiratory distress, diaphoresis, using accessory muscles, tachypnea and unable to speak. J3 edema lungs sounds have crackles through out after 40 mg of IV Lasix. Bipap was started. CXR results show interstitial edema and an enlarged azygos vein which suggests congestive failure." Last echocardiogram done 02/14/13 shows EF 35% with "Todd concentric left ventricular hypertrophy" (please clarify the following)

1. Please clarify the condition that prompted the IRT call and need for Bipap
2. Please clarify the condition that prompted the IRT call and need for Bipap
3. Chronic respiratory failure
4. Acute respiratory insufficiency
5. Hypoxia
6. Other

A2. Patient has chronic diastolic CHF listed as a diagnosis on H&P. As the patient is now resolving IV Lasix: Please clarify the current CHF acuity
1. Decompensated CHF
2. Chronic CHF
3. Other, please specify
4. Other, please determine

In order to capture the patient's severity of illness and risk of mortality, all diagnoses with significant findings that have been treated during the course of this admission must be documented in the progress notes and on the discharge summary.

The Physician’s Answer:

• “Volume overload after IV fluids and blood transfusion.”
  – What does (s)he think you are asking? (probably got to the word “edema”)
  – Did this physician read the choices?
  – Did (s)he see the second question?

The Same Query Rewritten

Dr. Soled, [address him by name since it is going into his chart]

1. What diagnosis do you believe prompted the rapid response call and the need for Bipap in this patient?
   a. Acute respiratory failure
   b. Acute diastolic failure
   c. Chronic diastolic failure
   d. Other, please specify
   e. General felt clinically determined

2. The IRT states the patient has chronic diastolic CHF but is currently receiving IV Lasix. What diagnosis best describes his CHF?
   a. Acute diastolic CHF
   b. Chronic diastolic CHF
   c. Acute LV systolic failure
   d. Other, please specify
   e. General felt clinically determined

Pertinent clinical info:

- Patient is a 65-year-old male admitted with acute MI, developed acute respiratory distress, diaphoresis, using accessory muscles, and unable to speak. In J3 edema was noted and crackles heard throughout lungs after 40 mg of IV Lasix. Patient required Bipap.
- CXR results: interstitial edema and an enlarged azygos vein suggesting CHF. Last echo 02/14/13 shows EF 35%
  with mild concentric LV hypertrophy.

Sign your name, title, and PhD.
QTIP

- Don’t be afraid, doctors don’t bite.
- It isn’t personal—really. It’s just another demand.
- So what if a doctor is mad—so what?
  - Why are they mad? Refer to slide 2.
  - Watch out for the “older” ones.
    - Culture shock!
    - Computers, keyboarding …
  - Doctors move on—use their ADD to your advantage.

Moving On …

- Holding a grudge is like drinking poison and expecting the other person to die!

The Problem

- The physician is the problem (not always)
  - Can’t read their handwriting
  - They don’t know the rules
  - Forgot to document things that happened
  - Refer to labs instead of conditions
  - Use adjectives instead of diagnoses (cachetic)
The Answer

- The physician is the answer
  - But doesn’t know the question
  - Only the physician can make the diagnosis
  - If the physician doesn’t say it, it doesn’t exist

... and if you don’t teach them, they’ll never say it!

The Power

- Knowledge is power
- If you have the knowledge, then you have the power
  - Must pass that knowledge on
  - Convey the importance—what’s at stake?
  - Empower them

Educate, Educate, Educate

- Ask for 10 minutes regularly at team meetings or department meetings
  - Present large-impact diagnoses
  - Get performance data
  - Compare them to their peers (very competitive)
- Give examples of how documentation affects SOI, ROM, LOS (after you have explained these acronyms)
- Show them what it means to “move a DRG”
- Tell them the appropriate way to answer the query
  - Progress note / reply to inbox / d/c summary?
The Good, The Bad, and The Ugly

• The query is our product
  – It should deliver the desired result
• Following this slide are some of the query templates we were using at Salem Health
  – Let’s look at each one through a physician’s eyes.
  – What can you do to make the query more successful?

Questionable ARF Query Template

Acute renal failure query template
Medical record documentation for this patient states: (insert physician/chart diagnosis documented with chart clinical indicators)

Acute renal failure has been documented. Do you agree with the diagnosis of acute renal failure?
• Acute renal failure present and being treated
• Acute renal failure ruled out
• Unable to clinically determine
• Other, please explain

If you agree, please substantiate this diagnosis by giving the specific supporting clinical indicator(s) in your response as listed below with underlying cause (or suspected cause) if possible:
• Increase in serum creatinine of >/= 0.3 mg/dl
• Abrupt (within the past 48 hrs) reduction in kidney function
• Previous creatinine not available for comparison, a reduction of creatinine after treatment of 33%
• Other, please explain

Please reference Dr. O’Brien’s smart phrase .CENARF
Clinical indicators for acute renal failure referenced from Salem Health definitions
Thank you.

The Bad

• Problematic for several reasons:
  – First, the choices are inconsistent with the question, and where was it documented and by whom?
    • When asking for agreement, give appropriate choices
    • If you refer to documentation, be specific
  – Second, never ask physicians to give clinical indicators
  – Third, make sure the question is clear—what are we asking for?
    • The clinical indicators had not been present, hence the query …
Edited Version

Dr. So&so,
I need your help to code this chart correctly. I see that acute renal failure was documented in the chart (by Dr. XXX) but per *Salem Health Standard definitions, the clinical indicators do not appear to be present (may want to add BUN/Cr here). Which diagnosis do you believe is most accurate?

* Acute renal failure was not present
* Acute renal failure was present
* Other, please explain
* Cannot be clinically determined

Additional information from patient chart: [add labs, etc.]

Thanks so much for your help.

Your name, title, and ph #

*see Salem Health Standard Definitions in EPIC under “references.”

Questionable AMS Query Template

The patient's record indicates the patient has the following clinical findings: [insert physician/chart documentation: i.e., lethargy/altered mental status]

Please clarify from the following choices if the clinical condition can be further defined by any of the following.

(please insert applicable choices based on clinical indicators)

**Encephalopathy (specify type: metabolic, toxic, septic, alcoholic, anoxic, hepatic, or hypertensive)**
**Acute delirium (please specify, if known, if delirium is due to senile dementia, delirium tremens, or drug or alcohol withdrawal)**
**Acute confusional state due to a drug reaction**
**Mild cognitive impairment**
**Transient alteration of awareness**
**Other, please explain**

Thank you.

Documentation clarification is required for the medical record for this patient to meet compliance, accuracy in coding, and profiling of severity of illness and risk of mortality for this admission.

Disclaimer: In responding to this query, please exercise your expert, independent judgment. The fact that a question is asked does not imply that any particular answer is desired or expected.

Problems

• There are too many options (6) and some are very undesirable
  – Mild cognitive impairment? Adds nothing—take it out!
  – Transient alteration of awareness? Really? What’s that?
  – Don’t ask for clarification if it’s a diagnosis you need
  • Doctors don’t “clarify,” they diagnose

  My advice: Don’t give choices that are not meaningful. Give good, clear choices that you can use.
Dr. Soder,
I need your help to code this chart correctly. Could you please give me a more specific diagnosis for atypical mental status?
1. Acute encephalopathy (brain, metabolic, septic, alcoholic, OI, anoxic, hepatic, hypertensive, etc.—give any that apply)
2. Acute delirium due to... (tardive dyskinesia, withdrawal from a substance, reaction to medication, etc.—give any that apply)
3. Other—please specify
4. Cannot be clinically determined

Additional clinical information (clinical indicators and other pertinent information go here)
Thank you so much for your help.
Your name, year title, your ph#.

Documentation clarification is required for the medical record for this patient to meet compliance, accuracy in coding, and profiling of severity of illness and risk of mortality for this admission.

Disclaimer: In responding to this query, please exercise your expert, independent judgment. The fact that a question is asked does not imply that any particular answer is desired or expected.

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Questionable Malnutrition Query Template

This patient’s record indicates the following: [Insert physiologic/clinical documentation, i.e. BMI, W/F status, dietary consultations, appetite elevation (cachexia), nausea, supplemental feedings, TPN, chronic conditions, i.e. alcoholism, cancer, DM, EOD, medical/psych, failure to thrive, social risks ordered and answered]. If these provide the following criteria a nutritional diagnosis is applicable (see above clinical diagnosis).

*Hospitalized on admission or since hospitalization
*Serious underlying condition
*Significant nutritional risk
*Significant functional impairment

Please refer to So&so’s smart phrase: CENMALNUT

Thank you.

Documentation clarification is required for the medical record for this patient to meet compliance, accuracy in coding, and profiling of severity of illness and risk of mortality for this admission.

Disclaimer: In responding to this query, please exercise your expert, independent judgment. The fact that a question is asked does not imply that any particular answer is desired or expected.

1. Estimates of all or portion of the calculations below are unreliable, the Academy and ASPEN is recommending the diagnosis of malnutrition.

**If energy needs refers to table below**

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...Also Included a Chart!

[Table showing nutritional indices and risks]
The Bad AND the Ugly

- It’s ugly!
  - Much too long—they won’t read it
  - Appears cluttered
- It’s bad!
  - Uses terms doctors don’t know.
    - Protein-calorie is not a medical term
  - What is “nutritional risk without malnutrition???”
    - Take it out if it isn’t useful
  - The chart may be considered educational—different opinions about this ... but we took it out.

Edited Version

Dr. So & So,
I need your help to code this chart correctly. This patient has (list a few of the most compelling indicators). The dietary consultant has stated (list any diagnosis that was stated). Please choose the diagnosis you believe is most consistent with the patient’s condition:

1. Malnutrition (mild, moderate, severe)
2. Cachexia only
3. Malnutrition is not present
4. Other (please specify)
5. Cannot be clinically determined

Additional clinical information (like NPO status, appetite stimulant, TPN, alcoholism, cancer, etc.)
Thank you so much for your help,
[Sign, title, ph#]

Dr. O’Brien’s smartphrase: cenmalnut may be useful for documentation purposes and/or the EPIC tab in "references."

A Standard Template Provides

- Standard work
  - A standard format reduces variation
  - Improves compliance
  - Promotes understanding
- A recognizable product
  - Physicians will immediately know what they have
  - Less confusion
- Ease of use
  - More likely to get answered if easy
Miscellaneous Queries

• For miscellaneous queries we made a generic query template
  – Same format
  – Same recognizable quality
• Your expertise is still required to personalize every query for the patient and the physician
• Ask yourself what would you most need to know in a doctor’s shoes
• Give clear choices
• Avoid useless or confusing choices

Additional Tips

• Only query when you must!
  – Don’t query
    • Anemia if the Hb is 12.5
    • Acute renal failure if the creatinine is 1.0
    • If the answer makes no difference
      – Pick your battles
      – Don’t re-query just because you don’t like the answer

More Tips

• Multiple questions or multiple queries?
  – We asked and our docs chose multiple questions
    • Doctors hate queries, so fewer queries might be better
    • Query fatigue is real
  – Give the number of questions up front in bold type
  – Clearly separate the questions
  – Make the choices obvious
    • Limit to just a few choices plus “other” and/or “cannot be clinically determined” when possible
Thank you. Questions?

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 program guide.