Core-CDI

Diagnostic Excellence- When Your Thoughts Truly Matter

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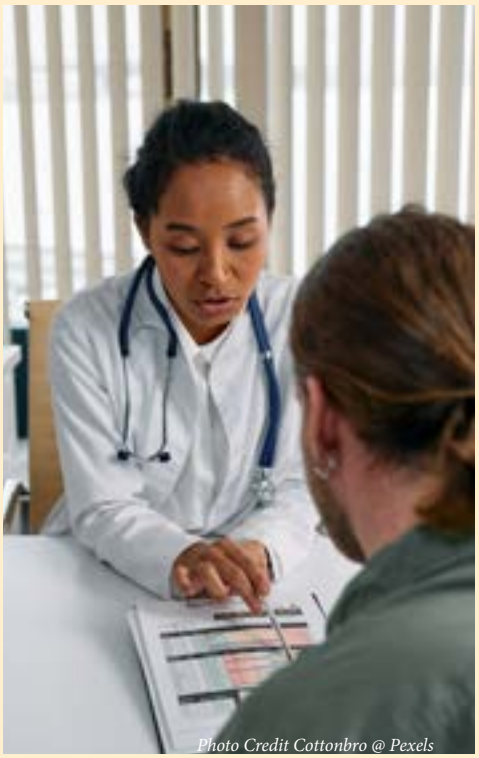

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Back in the day, outside reviewers and payers took your word for it when you documented a patient's diagnosis or diagnoses within the chart. The physician's words truly mattered when it came to diagnosing and treating the patient. Unfortunately, those days are long gone with payers requiring "clear clinical evidence of the diagnosis, particularly with the diagnoses of sepsis, acute hypoxemic respiratory failure, Type II MI to name just a few. Clear clinical evidence of these common hospitalizations for these types of diagnoses does not require a thesis or extensive amount of additional clinical documentation. Instead, it often requires less documentation, just clear, consistent, contextually correct, and concise documentation.

Steps to Take to Construct a Complete and Accurate Note

1) First and foremost, physicians should adhere to the following practice in all clinical documentation, whether it be a History & Physical, Progress Note, Consult Note or Discharge Summary. William Osler, the father of modern medicine who was the Co-Founder of the first residency program at John Hopkins Medical School, sums it up nicely with the quote: "A good physician treats the disease, the great physician treats the patient with the disease." The fundamentals of documentation begin with the patient, telling, describing, showing, painting, and reflecting the patient's clinical condition starting with the patient's Chief Complaint and History of Present Illness. This is critical to starting your documentation on the right foot, this is where the clinical picture closely approximates with your clinical impression as part of the "A" portion of the SOAP note. The clinical acuity of the patient gathered from your observation and interview of the patient as recorded serves as the starting point for explaining and substantiating your acute diagnosis(es) within the assessment. Every acute diagnosis or provisional diagnosis must be traceable directly back to the clinical picture as painted by you in the documentation within the History of Present Illness. Avoid overlooking any detail in the recording of the patient's clinical acuity as you gather information as part of the HPI.

2) Pay particular attention to the physical exam where inconsistences with the patient's presenting signs and symptoms as recorded in the HPI, the Constitutional part of the exam, and Assessment crop up. Case in point, a diagnosis of Acute Hypoxemic Respiratory Failure documented in the Assessment when the Constitutional Part of the Exam states "Alert, Oriented x 3 in no acute respiratory distress." If the patient is currently being managed with supplemental O2, be certain to include this fact in the Constitutional Part of the Exam. Also be


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certain if you are utilizing the drop-down menus in the EHR to record your findings in the Exam to insure you do not inadvertently enter information contrary to the patient's actual findings. Another example is under Respiratory portion of the physical exam a recording of "Lungs CTA bilaterally" when elsewhere in the ER documentation notes rhonchi, rales, and wheezes. If the patient received breathing treatments in the ER and the lungs are somewhat clear, once again make a notation of this fact in the Respiratory portion of the Physical exam.

3) Recording the Assessment is where the rubber meets the road, where you capture your clinical judgment and medical decision making. Crucial to record in your Assessment is not only the acute diagnosis(es), provisional diagnosis and the chronic conditions that impact complexity in managing the acute condition(s) but also your clinical rationale, thought processes and reasoning for arriving at these acute diagnosis(es). It simply is not enough from a clinical perspective to have the labs appear in the record without noting the abnormal labs, abnormal radiology findings, or other abnormal workup results that you utilized in formulating a provisional or definitive acute diagnosis(es). These specific findings must be acknowledged in the assessment as part of each acute/provisional diagnosis(es). Other pertinent information utilized in formulating a diagnosis should be included in the assessment. Taking just an extra minute to express and record your assessment with clinical thoughts and clinical rationale will go a long way in alleviating much of the second guessing on the part of the payer's medical directors of your diagnostic conclusions which often results in additional work on the part of the hospital in appealing and overturning these second-guessing denials.

In conclusion, a well-orchestrated H & P or progress note that captures the essence of the patient story with your assessment and plan of care that includes a clear History of Present Illness/Interval History, Physical Examination, and Assessment with Plan of care that is reasonable, rationale with recording of your clinical judgment and thought processes is the best approach to clinical documentation. By doing so, you will be following the advice of Sir William Osler, A Great Physician Treats the Patient with the Disease!


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