

From  TrendLeader  
Connections

## Building Physician Engagement

By Jimmy Udall, Principal, Rule 4 Consulting

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**H**aving an engaged medical staff is crucial to the success of many hospitals. Unfortunately, many organizations lack a clear outline of how to accomplish this and suffer as a result. I was recently involved in a project that tackled this issue and learned a framework for physician engagement that can be applied to any organizations struggling with this issue.

### Framework for MD engagement

1. Engage as many physicians as possible from the start of the project.

Before the hospital ever hired our firm as consultants, we were engaged with the medical staff to get its permission to move forward. We spent time with all key physicians understanding their concerns and issues with the hospital. We observed them in their offices and followed them as they interacted with the hospital. We talked with their staff and even their patients to get a better understanding of their perspective before we attempted to make any changes. By honoring their work without preconceptions we were able to build trust from the start of the project.

2. Create a coherent voice for the physicians.

Physicians can have disparate interests, but in order to act and partner effectively with the hospital they need to have a coherent voice that can lead to concerted action. We worked to foster physician leadership at the hospital and to arm these physician leaders with the facts that they needed to organize their peers. In doing so we gave physicians the tools they needed to have an ongoing dialogue with the hospital for issues critical to both and we ensured that we had a critical mass of physicians up to date on market challenges, comparative outcomes and the need for collaborative action.

3. Deal in facts.

If you're trying to work through issues with anyone, especially a scientific-minded group of people, it's important to have data that helps clarify the issues. Having the facts about the issues at hand was a key component to our work and something on which we spent considerable time. When the physicians showed interest in a hospitalist program we investigated the costs, benefits and challenges through research and talking with other hospitals. When they complained that the turnaround time for radiology tests was too long we found out how long it was and reported back. This helped build a relationship based on a shared understanding of facts and help reduce blame and anxiety. We also tried to bring issues that we had heard about through the rumor mill out in the open and encourage open dialogue and transparency. This took the wind out of rumors and innuendo and brought us back to the land of the real and factual.

4. Follow through.

There are two points to be made here: First, if you say you'll do something – do it. Pretending you have a handle on something when you don't can lead to distrust or a loss of credibility. Be honest. If you don't know something, it's perfectly acceptable to say "I don't know...but I'll find out and report back." Second, get ready to improve things once the group has identified them as problems. Dialogue is important, but unless it leads to concerted action and improvement, it's insufficient. Have the tools on hand to improve processes, culture, leadership or any other sticking points you and your organization may have in the eyes of the physician leadership.

*(Continued...)*

## Building Physician Engagement (Continued)

### Case Study: Surgery

After organizing a group of physicians using this framework it quickly identified problems that it needed to work through with the hospital. One of the key sticking points was the surgery department at the hospital. According to the group, the OR too often made poor use of physician's time through poor processes which caused delays. So much so that a number of surgeons had taken cases to nearby hospitals whose ORs were more efficient. Others were threatening to do the same. One physician confided that he had to take cases to a new OR in a hospital that in his mind shouldn't even exist, simply because it didn't waste so much of his time. Clearly the surgeons were frustrated, but we were pleased that they believed enough in the process to bring forth such a vital issue.

The physicians' groups agreed to start in the OR and upon our recommendation we focused on start times, with emphasis on the first case of the day. We engaged the OR staff in much the same way that we engaged physicians and because the leadership of the hospital was behind this effort we quickly made progress on start times. In trying to stick with the facts, we had regular updates to the physician group on our progress and we began to see results. We were also interested in the sustainability and continuation of these efforts after we the consultants had left. The staff had to believe in this work and carry it forth on their own, just as the physicians would with their engagement. Toward this end we engaged everyone in the OR from the front line staff to the director of the department. The results of our work follow and with each passing month the start times continue to improve.

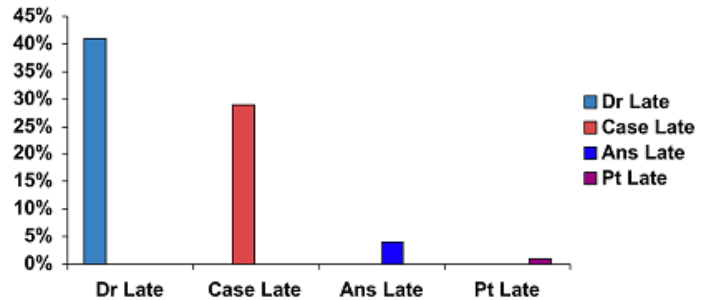
After the OR had made a significant improvement to start times it became clear that a substantial source of delays were the physicians themselves. The charts on the right show the period after we had made improvements in the OR, but before we engaged physicians in the improvements.

Because we had clear data it allowed us to look from the same vantage point. This common viewpoint gave us the framework to later ask the doctors their ideas for improvement with their piece of the problem: surgeons not showing up on time. By presenting the facts and opening the lines of communication the hospital and physicians were able to make progress on a key sticking point together.

A similar situation played itself out with radiology turn

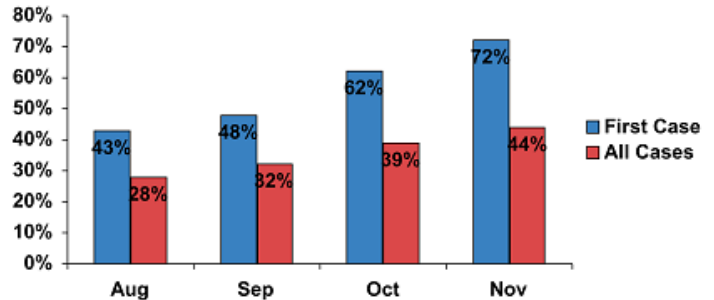
### Reason for Delays

Reason for Delays



### On-time Start Improvement

On-time Surgery Start Trend



around times, laboratory turn around times, connections between women's services and the major obstetrics clinic and other areas of physician-hospital collaboration. In all these areas we were able to use the same framework successfully to improve outcomes for patients, physicians and the hospital.

This project was not without its challenges and the collaboration is far from perfect, but because both the collaboration and improvements continue, I'm confident that the hospital will be in a better place a year from now than it is today.

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## Improving Clinical Documentation

By Wendy Frieling, MD, MMM, Chief Medical Informatics Director, PHNS

Most hospitals realized long ago that if they didn't have accurate clinical documentation, then coders couldn't accurately capture the work that was done and thus money was being left on the table, often lots of money.

Hospitals also realized that if clinical documentation was not complete enough to support medical necessity or to substantiate claims, then they risked losing money and paying penalties. In the new era of the Recovery Audit Contractors (RAC), pay for performance (P4P), ICD-10, CMS bundling of payments and potential healthcare reform, it is more important than ever to be sure that the clinical documentation in your facility is as accurate and complete as possible.

In June 2008, the [results of the three year RAC demonstration project](#) were published. That report pointed out that \$10.8 billion via Medicare and \$12.9 billion via Medicaid were overpaid in 2007. It also concluded that the RAC program was quite cost effective, from which we can conclude that the RAC and similar programs are here to stay. Many of us are already experiencing the pain of having RAC auditors come to call and the Medicaid Integrity Contractors (MIC) are just getting started. Our government believes that the amount it overpaid in 2008 far exceeds the 2007 amount.

We know from the RAC demonstration project that the majority of the overpaid dollars were for services that did not meet CMS' definition of medical necessity. If we train our physicians to be better documenters of medical necessity, we avoid a lot of this headache before it starts to develop. CMS has a specific definition of medical necessity (services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member), but that definition is often subject to a lot of interpretation. Only a physician can legally determine medical necessity.

We physicians weren't taught in medical school and residency to try to game the system by treating people that don't need treatment and, for the most part, we are

all decent human beings just trying to do the right thing – so why is so much money being taken back because treatment given wasn't medically necessary? It is because we are also not taught in medical school and residency to document what we do in a thorough manner that complies with complex governmental documentation requirements. There is almost an unwritten understanding among we physicians that "patient care is the most important thing that I do, and documenting the care and filling out other paperwork is beneath me." While we have pretty good evidence to confirm that good documentation is paramount for patient safety and quality of care, we still have a hard time getting past the tendency to document in vagaries that have been ingrained in us.

How can we improve clinical documentation? Incorporating the basics of a CDI program into graduate medical education is a must. The key to inspiring clinicians to change their bad documentation habits is a good clinical documentation improvement (CDI) program that demonstrates to clinicians that their documentation is the foundation for a lot more than coding and billing. The same documentation, whether paper or electronic, that is the foundation for a patient's DRG is also the foundation for the physician's mortality statistics, P4P reports, quality reports and more.

As we move from ICD-9 to ICD-10, physician documentation needs to rise to a new, much higher level of specificity. ICD-10 doesn't allow us to code vague diagnoses. We need to specify left or right side, acute or chronic, etc. Details in documentation are essential for a smooth transition to ICD-10.

As CMS pushes us toward value driven healthcare and accountable care organizations, physicians will need to work more efficiently with each other and with the their hospitals. Concise, accurate clinical documentation is key!

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## Fixing the Doctor Shortage

There is still a possibility that some form of healthcare overhaul will pass in Congress. The likely change will come in the form of expansion of insurance coverage for millions of Americans. The unanswered question is will the newly insured have a physician to care for them.

Writing in *The Wall Street Journal*, Darrell G. Kirch, MD, president and CEO of the Association of American Medical Colleges, explains that our nation currently faces a shortage of physicians expected to worsen as the number of people over age 65 (who use more than twice the healthcare of younger adults) doubles. Even with significant changes to the healthcare delivery system and improved prevention, the United States will face a shortage of more than 125,000 physicians in the next 15 years – a daunting problem considering that we only train about 27,000 new doctors a year. In addition, the U.S. Department of Health and Human Services (HHS) estimates that at least 16,000 more primary care physicians are needed today.

While U.S. medical schools are working to increase their classes by 30 percent, these new medical school graduates will not increase the nation's overall supply of physicians, or even have a residency position in which to train, unless the government lifts the cap on residency training slots it pays for that was imposed as part of the Balanced Budget Act in 1997.

The doctor shortage affects primary care as well as many medical specialties, even without an expansion of health insurance. According to HHS, overall demand for physician services will increase an estimated 22

percent between 2005 and 2020, while the number of primary care physicians will increase by only 18 percent during this period. Worse, the supply of some doctors (such as urologists and general surgeons) is expected to shrink over this period despite the government's assessment that the need for almost all types of physicians will continue to grow. Researchers have suggested that only one specialty, general pediatrics, will have a supply of physicians greater than the demand for their care.

The U.S. health work force has been rightly criticized because the percentage of physicians in primary care is lower than in most of the developed nations to which we often compare our health system. This is a problem many see as directly related to poor reimbursement for primary care services. Yet the number of formally trained family physicians doubled between 1985 and 2004, and we still remain without enough doctors in primary care and many other medical fields.

The physician shortage is, in part, a result of expectations in the 1990s that managed care and primary care would greatly drive down the need for physicians, particularly specialists. However, these expectations fell short against the rising needs of an aging, growing population that has high expectations of its healthcare system.

Dr. Kirch writes that Congress is right to expand insurance to as many Americans as possible. But it also has a responsibility to ensure that the nation is cared for by more than an insurance card and an answering machine.

### About



PHNS provides IT services for hospitals, other healthcare providers and businesses. PHNS' IT services include application hosting, co-location and managed services; electronic off-site data back-up and data vaulting; business continuity solutions; disaster recovery services; and systems integration services. PHNS also provides comprehensive business process solutions for hospitals including admitting, HIM (including medical record management and storage, transcription, coding, release of information and electronic medical record services) and revenue cycle services. PHNS creates business-healthy hospitals by improving operations, enhancing technology and increasing cash on hand, which allows hospitals to focus on their core competency – patient care. PHNS has approximately 1,670 customers, including approximately 400 hospital IT and business process customers and approximately 1,270 IT customers. PHNS is headquartered in Dallas, Texas. See [www.phns.com](http://www.phns.com) for additional information about PHNS.