Building Hospital-Physician Bridges

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On a recent trip to San Francisco, I leaned the Golden Gate Bridge is not named for its orange vermilion color; rather this famous bridge spans the Golden Gate Strait. The Golden Gate Strait is the mile wide channel from the Pacific to San Francisco Bay and is characterized by 400 feet deep, bone chilling, shark infested, deadly waters with treacherous currents. Not unlike healthcare today.

If not for a single point of commonality, a single structural pier stretching hundreds of feet from above the water down to the seafloor, the bridge could not connect San Francisco and Marin County.

How wide is the gap separating your hospital from your physicians? In the increasingly competitive business of healthcare, physicians and hospitals equally struggle with diminishing reimbursement, increased government and third party payer scrutiny, seemingly endless compliance issues, and increasing overhead expenses. Most predictions point to a healthcare future of dire, not golden, straits. It would be prudent if physicians and hospitals could learn to connect and work together to overcome these obstacles to financial and clinical success.

There is a single point of commonality, a central pier that will support a bridge to span the physician-hospital gap; physician documentation of multiple medical diagnoses. Hospitals and physicians are symbiotic not only in their roles of taking care of patients, but also in the importance documentation determines for mutual success.

Hospitals, not physicians, generate income from the DRG system by diagnoses, and if additional diagnoses, documented by physicians, qualify as Co-morbid Conditions or Complications (CCs), the DRG is weighted higher. But how do you motivate physicians to list diagnoses for "hospital benefit"?

Physicians generate income from the CPT coding system. 85% of all billed CPT codes are Evaluation and Management (E&M) codes. Compliance correct E&M codes take into account the "medical necessity" element of Medical Decision Making as outlined in AMA/CMS coding guidelines. A critical element of Medical Decision Making is the "number of diagnoses or management options."

If physicians are educated in E&M coding and understand the importance of documentation of multiple medical diagnoses in deriving the compliance correct CPT code, the same physician documented diagnoses may serve to function as CCs for hospital DRG payments. Physicians are self-motivated for physician correct documentation benefits and hospitals can share those documented diagnoses as well. This illustrates the power and positive results "medical behavioral economics" can have through physician education.

Further education of physicians on hospital DRG impact will demonstrate how DRGs affect not only hospital reimbursement, but also determine the severity of illness (SI) profile of a hospital. When physicians understand that the SI profile of a hospital is simply the summation of individual admitting physician SI profiles, (that are also used to grade physician "quality" by third party payers and other purveyors of healthcare), the SI profile stops being "a hospital number" because it directly impacts individual physicians as well.

Hospitals are dependent on physician documentation to generate the profits necessary to sustain operation. Unfortunately, education of physicians for this critical role is appalling. The orientation and training cost for a low level new hospital employee eclipses the "orientation" of a physician in most hospitals. In my own hospital, "orientation" as a new attending physician consisted of being taught how to work a fire extinguisher, (the high point of the experience), what do in case of fire, nursery kidnappings, cardiac arrests, and the location of the cafeteria; all in about an hour. I was also *trained* how to use the hospital dictating system, but I was never *educated* how to use the dictating system for precision documentation driving financial, regulatory, and quality benefits for my hospital. Despite the pivotal nature of physician documentation in determining hospital survival, nursing aids were given more formalized education on how to maximize performance for their jobs.

When hospitals look to improve parameters determined by critically essential physician documentation, an educated physician staff is the starting point to achieve success. Through an investment in physician education, hospitals can build a bridge of understanding and fiscal stability with physicians through shared points of commonality, benefiting hospital and physician alike.

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