



## Documentation Education Hospital Sales Training for Physicians

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Imagine this seemingly perfect business model. Your company, diversified in both goods and services, offers lifelong customer support services, at a fee. You have sales representatives who sell for "free," (no salary requirements and no commissions, all profits go to the company), and you have long lines of new and existing consumers clamoring for your business. Your target market would be everyone who breathes, (and technically, some who don't), and your ultimate value is enormous to your customers.

Your sales reps close on sales with almost no effort, and best of all, they are entrusted by the customers to write up the purchase order leaving the decision what to actually purchase almost entirely up to the judgment of the sales representative. Rarely does a customer object or change an order.

There are just a few troublesome points.

1. Often the customer is unable, or unwilling, to pay the invoice after receiving the goods and/or services.
2. Often the actual sale price is independently determined by a third party, whose object is to conserve capital. Furthermore, because of contractual agreements, your company may actually operate at a loss.
3. Your principal sales representatives, although skilled at sales, often simply forget to write up the order by which you bill.

Welcome to the wacky world of healthcare business. When viewed from a *sales perspective*, healthcare is laughable. If you were to run most companies in this fashion, you'd soon be out of business --- partially explaining some of the problems faced by hospitals today.

Factors such as patients who can't or won't pay hospital bills and third party payer contractual relationships are common topics for hospital administrators, but through education of the hospital sales representatives, elements of ineffective sales behavior can be changed to improve profitability.

From a sales perspective, all the income generated to a hospital come through the signature of a physician. Without the sales of goods and services approved with a physician signature, a hospital generates no patient care revenue. Hospital and Non-hospital employed physicians alike are sales representatives of hospitals --but a very unique type of sales representative.

Non-hospital employed physician "sales-reps" are not paid employees of hospitals. They receive no commission from hospitals or no benefits. While tokens of goodwill and esteem are common, they, by compliance regulations, are limited to just tokens and not real revenue streams. In fact, physicians generate personal income using a totally different billing system than hospitals. Hospitals use the DRG coding system while physicians use CPT codes.

Most physicians and hospitals fail to recognize the areas of overlap between these two systems, but the area of overlap is not in a strict income sense. Furthermore physicians are free to choose which hospital competitor to deliver the sale to. Hospital employed physicians, while perhaps more





likely to sell the employer hospital first, often have little incentive, (if salaried), to effectively help the hospital bill correctly after closing the sale.

Most companies dependent on ongoing sales will invest large sums of money in sales training. Hospitals invest in "training and orientation" for almost every new employee and follow this up with ongoing in-services to keep employees up to date, but fail to give similar benefits to the physician sources that drive hospital cash flow. In my hospital, the investment to fully train a ward secretary easily reaches into thousands of dollars. However for physicians who drive the revenue flow of hospitals, "new physician orientation" is typified by the one I received by my hospital. My "hospital orientation" consisted of hands on instruction in using a fire extinguisher, what the various "color codes," meant, (blue is cardiac-pulmonary arrest, red is fire, and I can't remember if green or yellow was the color for infant abduction...or was that for the disaster drill?), where the cafeteria was located, and how to use the dictating system.

Sure, hospitals show physicians the "instructions for use" for the dictating system, but they never include "recommendations for *optimal dictated content*." That's the missing element, education for physicians in hospital sales. Physicians don't respond well to "training," but are lifelong learners who understand the importance of education. While training provides the "how's and what's," education enlightens on the "whys," that will stay with physicians long after they've forgotten the proper code color for a nursery infant abduction alert. By understanding the larger picture of how physician documentation plays such a vital role for hospital and physician success in the "business of medicine" environment, informed physicians will become self-starters for future learning.

From a sales perspective, physicians are already masters of selling. Neil Rackham's book, *SPIN Selling*, was the culmination of years of research in the science of sales. In his book, the reader learns that there is an enormous advantage in understanding the fundamental difference between selling low ticket items with high ticket items. Medicine and healthcare is a high ticket item. The S.P.I.N. model advanced by Neil Rackham starts the seller asking the potential buyer questions and discussions concerning **S**ituational, **P**roblem, **I**mplication finally culminating in precise identification and clarification of the **N**eeds of the potential buyer.

When I read *SPIN Selling*, I was struck by the fact that this is what we physicians do everyday with our patients. For example, take this one sided conversation and watch it *SPIN*.

S: "Good morning Mrs. Jones, what symptoms have you been experiencing?...I see, you've been having chest pain...What seems to bring it on? Does this happen at a special time of the day or night? Are there associated symptoms with the pain? What makes it better or worse? What medications are you on, and have they seemed to help? Is it getting worse? How is this different from what you've experienced before?"

P: Well, chest pain can come from a number of reasons. Some are harmless and others can be quite dangerous. This obviously could present a significant problem, perhaps even life threatening. Have you noticed any shortness of breath when you have this pain? Does the pain move anywhere? Have you noticed pain in your legs when you're walking as well as in your chest? Have you experienced any lightheadedness with this chest pain?

I: "I see Mrs. Jones; let me say what I'm hearing you tell me. This problem really is limiting what you can do. It is occurring more and more, and perhaps is getting worse. You're unable to even walk to the mailbox without trouble, from both your chest and leg pain and it's really limiting what you like to do, especially with your grandchildren, and I know how important that is to you. Obviously, we want to avoid a catastrophic life threatening problem.





N. "Well, yes, we actually can help you with these problems. First we'll need to do some diagnostic studies, some as an outpatient, in the office or hospital, and then we may want to admit you for further evaluation or treatment to get you back to enjoying life more fully. How does that sound to you?...Great, we'll get started right now." -- Effectively closing another sale to a soon to be satisfied patient/customer.

Most physicians use the SPIN selling approach automatically. We ask basic background questions to size up the situational circumstances and complaints of the patient. We then ask questions of the patient that will uncover problem areas that may not even be recognized by the patient. Then, with the patient understanding the true implications of the problem and the potential disastrous consequences of ignoring the problem, we offer a solution. And close the sale.

Then, as physicians, we sabotage the sale we just made for the hospital. For our own part, physicians have made "our sale," in terms of E&M coding and actually anticipate future E&M codes to be used. But with the potential profits available to the hospital from the patient care, by not understanding what specific documentation is necessary for the hospital to be reimbursed, we fail to document and the hospital suffers because the full measure of payment from a given patient is never realized.

Part of the problem exists because of the dichotomy between physician and hospital coding systems. After all, what incentive does a physician have to ensure complete and accurate documentation for hospitals? Physician reimbursement is not dependent on what is documented "for the hospital."

In reality, physician documentation of multiple diagnoses has direct financial repercussions not only for hospital DRG payment but also direct impact on the compliance correct E&M CPT. There are three key components to a CPT code, the documented history component, the physical exam component and the medical decision making component. Medical decision making is determined by another three components. Risk, as determined by AMA/HCFA/CMS documentation guidelines, the amount of data to order or review, and the **number of medical diagnoses** or management options. DRG coding and E&M coding therefore share a point of commonality that effectively motivates *educated* physicians to correct documentation from *their own benefit*, not that just of the hospital.

It's not just money that motivates physicians to improve documentation. Most physicians don't appreciate the direct effect proper hospital documentation has on their own severity of illness (SI) index. Physicians typically are uninformed about how hospital Case Mix Index (CMI) is determined directly by their documentation as reflected in primary and secondary diagnoses and procedures, as well as the value Co-morbid Conditions and Complications, (CC's) have on accurate DRG representation. An increase awareness of how inpatient physician documentation has direct "quality" measurement on admitting physicians as well as the overall hospital, will serve as a reason physicians can again embrace to effect positive change.

By educating physicians, the true sales representatives of hospitals, hospitals will reap a potentially huge ROI. Linking DRG and E&M coding systems through the point of commonality, documentation of multiple diagnoses, allows improvement of documentation to be perceived as a win-win situation for hospital and physician alike. There is a symbiotic relationship between hospitals and physicians when it comes to documentation. By educating physicians, physician beliefs about documentation, compliance, HIM, concurrent coding initiatives, Case Mix Index will change and in turn, improve results. This, in part, is what "behavioral medical economics" is about.

