Power of Persuasion: Proven Strategies Inspire Physicians to Improve Documentation

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Tired of haranguing physicians about the importance of clinical documentation? Our expert's strategies will improve documentation and make physicians happy, too.

Clinical documentation is the foundation for the codes that serve as links between patient care and payment, individual patients and public health data, and much more. The physician is responsible for providing the documentation that the coding professional uses to translate clinical information into these measurable values. And the more complete, accurate, and reliable the physician's documentation, the more complete, accurate, and reliable the coder's final product will be.

Several resources stress the importance of complete and accurate physician documentation, including the Official Guidelines for Coding and Reporting and the *Code of Federal Regulations*.[1, 2] But what HIM professionals need is a strategy to engage physicians in a collaborative effort to provide this information. In short, the physicians need to want to improve documentation. In this article, we'll explore what motivates physicians and how HIM professionals can take advantage of those drives to improve clinical documentation in their organizations.

What Do Physicians Care About?

To formulate a strategy for obtaining physician support for improved documentation practices, every HIM director, coding manager, and coder should first ask themselves, "What do physicians in our organization care about?"

There are certain concepts that are probably important to all physicians, but it's important for you to first determine if certain events in your hospital or community are capturing physicians' attention right now. For example, has a hospital in your region recently been acquired by a for-profit corporation? Has a new group of surgeons been recruited by your administration? These are all things that can affect the way physicians are thinking. Ultimately, the way to achieve complete and accurate documentation is to find the answer to the question, "How can we tie what physicians care about to clinical documentation improvement?"

In informal surveys conducted with physicians across the nation, we have been able to put physicians' priorities into the following categories:

Their Patients

Physicians dedicate themselves to the practice of medicine because they want to help sick people become healthy and healthy people remain healthy. If HIM professionals can illustrate for physicians how their documentation practices affect their patients, this will have a positive effect.

In a documentation improvement educational session with a group of oncologists at a community hospital, I reviewed the common DRGs into which their patients were assigned and how these cases were weighted and reimbursed under the DRG system. One of the oncologists became angry that his patients, whom he believed were the sickest in the hospital, appeared to be grouped into fairly low-weighted DRGs. A discussion followed in which the physicians were truly engaged in learning about what documentation they could provide that would make a difference in how their patients' records were coded. Focusing on the patients and how the physicians' documentation makes their patients look is a good first step in your strategic plan.

Their Medical Practice

Most physicians today are still in private practice, meaning that the physician is self-employed or a member of a self-employed group. These physicians may be the most difficult to reach in the continuing quest for improved documentation. However, if you illustrate how good documentation practices in the hospital can affect the physicians' private practices, they will begin to take notice.

Ask your evaluation and management (E/M) coding expert to design a coding session for physicians that will demonstrate how improved diagnostic documentation in the patient's record can affect the level of medical decision making in the E/M code assigned to the patient for professional fee billing.

Their Reputation

Physicians care about how they are perceived by their peers and the community in which they practice. Community physicians derive their livelihood through patient referrals and other physicians. Given that, tactfully using physician profiling can motivate physicians to improve their practices either individually or as a group or specialty.

In one hospital, the cardiology department was continually profiled as having the greatest opportunity for improved documentation, which meant many cardiologists were poor documenters. The case mix index analysis was shared monthly with the medical staff. Finally, the chief of cardiology vowed at one meeting that their specialty would be the lowest on the list of "poor documenters" by the end of the quarter. He worked diligently with this department and month by month, the cardiology group's documentation improved. In this case, the impetus behind better documentation was how these physicians compared to their peers, not whether the hospital was reimbursed more accurately.

New Technology

Most physicians want access to the best technology to treat their patients. If the hospital is willing to share financial information with interested physicians, it can be demonstrated that a healthy financial bottom line, made possible through more complete documentation, can result in access to better tools for physicians.

This strategy may only work with certain physicians in a community setting who are either very interested in financial projections for their own reasons or find financial, analytical information interesting. However, this strategy can be very successful for the hospital that employs physicians. In this sense, the physician's bonus dollars or budget for equipment can be tied into favorable documentation audits or query response rates.

Avoiding Malpractice Allegations

Every physician wants to avoid medical malpractice allegations, especially in parts of the country where malpractice premiums have increased two- or three-fold in the past two years. Here, the HIM professional can link risk management with good documentation practices. It is important to illustrate the connection between complete clinical documentation and patient care quality, which has a direct link to possible malpractice.

In addition, your HIM department can also conduct specific seminars on documentation and risk management for the physician. Most medical malpractice insurers have programs that will provide at least a minimal reduction in physicians' medical malpractice premiums if they attend a certain number of educational sessions that address risk management. Inquire with the bigger carriers in your region about whether they would be willing to include your sessions as incentive for the physicians to attend.

Healthcare Data and Ratings

The wealth of healthcare data available to consumers today shines a new spotlight on physician documentation. Patients have several sources from which to gain information about providers, including state hospital associations for state-specific reports, HealthGrades (www.healthgrades.com), DoctorQuality (www.doctorquality.com), Solucient (www.solucient.com), and numerous other Web sites. This data is derived from MEDPAR and other publicly available data sources.[3] The data that is

used to determine mortality and complication ratings is your hospital's coded data, which, of course, springs from the physician's documentation. In hospitals that tend to be rated low on the mortality analyses on these sites, it's common that the physicians provide very sparse documentation, especially for secondary diagnoses. Patients with more (valid) secondary diagnoses will have a higher probability of mortality in general than patients with one or no secondary diagnosis.

How Can HIM Professionals Make a Difference?

HIM professionals have developed several effective strategies to change physician attitudes toward improving documentation. Try one or more of the following proven strategies to boost awareness of the importance of documentation:

Dinner and a Query

In one organization, the HIM department transformed the retrospective query process into a monthly event that physicians look forward to attending. In this 500-bed hospital, records with incomplete documentation at the time of coding are audited monthly. Retrospective queries are divided up by physician. Then, physicians with one or more queries are invited to a meeting with several of their query peers where, in return for responding to the queries via a late entry progress note, they receive a nice meal in one of the hospital's best rooms. There, physicians are presented with a stack of records that have been carefully combed through by HIM professionals. They can focus on the clinical documentation that led to the query because it is specifically tabbed and highlighted by the coder in careful preparation for this process. Many physicians look forward to these meetings and have said that they have learned a lot from the process. Interestingly, there are very few repeat attendees, which may mean the query sessions are effective educational tools.

Go Public with Data

By sharing publicly available data about your hospital with physicians on a regular basis, you'll remind them of the important role their documentation plays in such data. If this becomes a regular practice, it can become very positive.

Spotlight a Key Metric

Most hospitals have key metrics that are shared with the hospital management team. Key metrics usually include monthly case mix index, average length of stay, and census numbers. The case mix index could be a key metric that is shared with the medical staff to focus on documentation improvement. However, it may actually be more effective to share a metric that is physician documentation-specific. Some key metrics that other hospitals share include concurrent physician query response rate, concurrent documentation audit change rate, and potential for case mix improvement based on improved documentation. All these metrics can be shared as one number, or by specialty or physician group.

Target Your Education

As noted above, there is great value in providing educational sessions to physicians on documentation improvement and risk management. Your organization should require a minimum number of continuing medical education (CME) credits related to documentation improvement each year. Further, advertisements for documentation improvement CME sessions should clearly state the purpose of such sessions, so physicians are continually reminded about the importance of sound documentation practices.

Make Learning Easy

In addition to offering CME credits on documentation improvement, make the sessions easy for physicians to attend or obtain. For example, offer sessions on cassettes, CDs, or via the Internet.

Talk Doctor to Doctor

To get the greatest success out of any documentation improvement program, recruit a physician employee to assist in the education and query process, because physicians generally relate best to other physicians. The physician liaison can be

involved in the retrospective query process, communicating with physicians when there are specific documentation issues that require intervention, conducting educational sessions, and developing and approving coding and query guidelines. Additionally, he or she can serve as a key member of the management team tracking clinical documentation improvement metrics by physician, physician group, or specialty.

The presence of a physician peer in the documentation improvement process will improve the effectiveness of your program fivefold and the return on his or her salary will likely be obtained within the first few weeks of his or her appointment.

Know Your Audience

Nagging your physicians won't yield the quality of documentation coders need to assign the correct codes. But by examining what motivates physicians, HIM professionals can design documentation improvement strategies that inspire physicians to embrace these efforts.

Notes

1. ICD-9-CM Official Guidelines for Coding and Reporting, 2002. Available at http://www.cdc.gov/nchs/data/icd9/icdguide.pdf.

2. 42 CFR 412.46

3. MEDPAR is the publicly available patient data set that contains all Medicare inpatient claims data by calendar year.

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