Physicians as Partners

Robert Teague, MD
Vice President, Physician Services

Accepting and preparing the new organization

Steps to get from here to there

Creating a totally new culture with your partners

From independent agents to employee-partners

When it works, here is what you can do
Evolution of the Hospital-Physician Relationship

_Circa 1870-1910_
Hospitals were Largely Charity Organizations

MD's Didn't Work in Hospitals; Trustees Ran the Operations

Enter the Doctors

After 1910
Physicians Discovered “The Workshop”

1920-1940: Rise of Administration

1951: Joint Commission Codifies a Three-Part Governance

Physician Relationships 101: Traditional Relationships

Relationship governed by:
- Medical Staff Bylaws
- Contracts for Services
- Physician Volunteerism

What happened next?
- Joint ventures clinics, ambulatory services, payer contracts, ACO's
- Special circumstances, e.g., RHC, FQHC, provider-based, other
- Employment of small groups and individuals (especially hospital-based)
- Physicians consolidate:
  - Single specialty (including primary care)
  - Ancillary care
  - Multi-specialty
  - IPA – MSO
  - PHO

Hospital bore no risk for MD cost
Hospital and MD often shared risk at first

Hospital now not only bears full MD cost risk, but guarantees it
The Factory and the Retail Outlet Come Together

*Find an example in history of a manufacturer becoming a successful retailer*

- **Family Medicine**
  - Focus on Revenue
  - CASH
- **OB - GYN**
  - Focus on Cost
  - CASH
- **Pediatrics**
  - Hospital—Accrual
- **Outpatient surgery**

It’s Not Simple Alignment with MD Employment

*Why Physicians are a Partner and NOT Only Employees or Acquisitions*

*The physician employment transaction is more like M&A*

- **Business Acquisition**
  - You buy the assets and the means of production
- **Employment**
  - You buy an exclusive right to use the means of production, which usually is replaceable and free to leave
- **Physician**
  - Partner Agreement
  - Physician always owns at least half of the means of production (license), which can leave and compete with you
Define Alignment in the Integrated Operational Model

First steps in putting baby back together

**MD CLINICAL**
- Medical Staff
- Bylaws
- Ambulatory ops
- Service line ops
- Documentation
- EHR utilization
- Overall MD quality

**“CO-OWNSHIP”**
- Growth strategy
- Product strategy
- Financial performance
- Quality reporting
- Quality improvement
- Workflow
- Systems
- Automation
- Coding
- Documentation

**OPERATIONS**
- Hospital ops
- Care delivery
- Ambulatory ops
- Budgets
- Financial ops
- Service line ops
- Procurement
- Marketing
- Systems

**TRANSPARENT INFORMATION FLOW**

Define Integrated Delivery Platform

Baby becomes whole once again

**Primary Care**

**Specialty**

**Procedures**

**Hospital**

- Disease-focused Program Care
- Care Delivery – Quality – Lean
  - Revenue Cycle
- Go-to-Market – Patient Experience
  - Business Integration
- Information Interoperability

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Integrating Physician Practices into Your Business and Clinical Delivery Model

Examples of Increasing Degrees of Integration

<table>
<thead>
<tr>
<th>Disease-focused Program Care</th>
<th>Care Delivery – Quality – Lean</th>
<th>Revenue Cycle</th>
<th>Go-to-Market Processes</th>
<th>Business Processes</th>
<th>Information Interoperability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional approach. No-standards of care. MD-centric. Everything one-off.</td>
<td>Traditional practice arrangement. Independent. Fragmented leadership, if any. No standard processes or reporting.</td>
<td>Practices operate independently.</td>
<td>Physicians and hospital independent to market and sometimes compete.</td>
<td>Fragmented by each individual physician, ancillary, hospital provider.</td>
<td>Systems are separated by each location and function within each location; some practitioners on paper.</td>
</tr>
<tr>
<td>Organized by service line. Practices operated separately. Some processes and personnel shared.</td>
<td>Practice managers meet to begin standard process adoption. Quality measures and operating metrics identified.</td>
<td>Hospital and clinics use same centralized business services and execute processes needed for practices.</td>
<td>Patient has services coordinated by primary contact.</td>
<td>Practices are cognizant of hospital strategy and business plan.</td>
<td>Communications platforms integrated into information systems; unified clinical view across EMRs; standard clinical outcomes reports.</td>
</tr>
<tr>
<td>Service delivery is patient-centric and delivered as a disease program. Full service integration.</td>
<td>Process improvement new cultural. Patient outcomes and experience. Practice leadership is a port of Hospital Executive Staff.</td>
<td>Back end and front desk operations fully integrated. Enterprise is prepared for risk and bundled payment methodologies.</td>
<td>No visible insurance operation for the patient. Use regular feedback to improve.</td>
<td>Single functioning entity; prepared for risk; VBP quality improvement, cross functional efficiency.</td>
<td>Full information exchange; fully developed population data management; robust patient portal.</td>
</tr>
</tbody>
</table>

Physician Alignment

Develop a working definition of the new culture of Integrated Delivery

Values
The principles and standards that form the basis of beliefs and processes

Look for Gaps

Beliefs
The shared understanding of organizational truths that guide action and behavior

Processes
Organizational methods that determine day-to-day operations and behavior

Look for Inconsistency

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Physician Alignment

Alignment through information often requires culture change

Traditional hospital-physician information exchange

Physicians are trained to give “orders”

DECISIONS

PROBLEMS

Clinical

Values = Open communication and inclusion
Beliefs = We believe everyone gets the information they need to be successful
Process = Silos and talking past each other; task focus

CEOs may communicate Top-down

Everything else

GAP?

Physician Alignment

Provide guidance, prioritization, and coordination of approved projects

Executive Steering Committee (exec, MD, other stakeholders)

Provides guidance, prioritization, and coordination of approved projects

Information flow and feedback are multi-directional at an established cadence

Multi-disciplinary nursing/ancillary and other hospital departments

Collaboration

Physician committee assigned physician-specific aspects of project

Workgroups

(Communication, workflow/devices, order sets, training and support and benefits realization/metrics)

One Type of Structure Enhancing Multi-directional Information Flow

Every one gets to talk to everyone else when needed to advance project

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**Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**

**Transition starts 2015 and progresses through 2018**

**CMS Physician Payment based on:**
- Quality
- Meaningful Use
- Resource utilization
- Practice improvement (e.g. Medical Home)

1. No FFS or productivity basis for pay
2. $ flow from CMS without regard for provider productivity
3. There is no particular guidance on “how to pay” providers

**Merit Based Incentive Payment System (MIPS)**

1. MIPS single quality reporting (PQRS, MU, VBM)
2. MIPS uses claims history for utilization comparison
3. In the meantime, up to 9% penalties for non-reporting

**Physician Compensation Tiers (works FFS or alternative)**

**Transition from FFS to MIPS + Shared Savings**

1. **Standard Base**
   - Base salary
   - Salary inclusive of all needed services
   - Negotiate as a package
   - Benefits standard
   - Specialty
   - Time in grade
   - Prior performance
   - Expected production based on wRVU model
   - Market factors vs. business model

2. **Practice Variable**
   - Base on what you want more of
   - Visits (AWV, TCV, CCM)
   - Procedures
   - Revenue
   - Practice success metrics
   - Production costs
   - OK to build the model with wRVUs but show the real metric you want

3. **Health System Variable**
   - Base on system goals
   - MD leadership
   - Medical directorships
   - Quality metrics
   - Patient satisfaction
   - Cost control/lean
   - Use EHR and CPOE
   - Standardization of preferences
Steps to Partner with Physicians for Quality

1. Hire a physician Leader - Chief Medical Executive

2. Leverage medical staff structure - Avoid multiple governance structures

3. Make the Integrated Delivery Platform an enterprise-wide goal with one single enterprise-wide strategy, business plan, quality plan and key performance indicators (KPI’s), and financial KPI’s

4. Get the data you need and develop a written data strategy (sources and uses)

5. Prioritize the most important clinical quality improvement and engage physicians for active problem solving

6. Leverage hospitalists, ED physicians, care/case/utilization management as well as primary care and specialist integration

7. Develop specific transitional care methodology

STRATEGY, LEADERSHIP, GOVERNANCE

What does a Chief Medical Executive do?

It’s a full-time commitment. Some success factors include:

- Reports to the CEO
- Voting member of the Board
- Part of the executive team and participates in all strategy and financial discussions
- Assists with the translation between clinical need and business need
- Responsibilities extend across the entire enterprise: inpatient, outpatient, physician practice
- Leads clinical quality improvement projects
- Leads patient satisfaction projects
- Works with the Chief of Staff or President of the medical staff to achieve governance of the medical staff and assures constructive input to the financial and clinical outcomes of the hospital
- Helps organize the work groups needed for quality assurance at all levels (e.g., any of the important work meetings going on in pharmacy, infection control, EMR, CPOE, etc.)
STRATEGY, LEADERSHIP, GOVERNANCE

What does a Chief Medical Executive do? (cont.)

- Is critical to EMR activities like CPOE, order sets, standardization of orders, templates, standards of documentation
- Is critical for ICD-10 implementation and working with clinical documentation improvement and coding
- Must lead the physician engagement on whatever the hospital needs to be successful—all projects and initiatives
- The CME should be completely aligned to the financial and clinical performance of the hospital including patient satisfaction
- Leads in compliance quality metric reporting of all sorts (core, MU, physician quality, HCAHPS, etc.)
- Develops an approach for population health including data collection and analysis that can be used for ACO participation, etc.
- Leads the development of population and disease registries and intervention strategies
- Leads in the development of treatment guidelines that include both national data and data from your own patient population


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Create a Data Strategy to Engage Clinicians

1. First, get all the data you need – information interoperability – systems, processes, people

2. Work stream #1: Automate all of your quality compliance metric reporting (structured data)

3. Work stream #2: Decide and develop what population and disease/wellness registries you need/want

4. Work stream #3: Engage physicians and clinicians in answering specific quality improvement questions (e.g., how can we shorten wean times from ventilator support?)

5. Worry about unstructured data later

Clinical Data Utilization

*But first, get all the data*

- Patient Portal
- UAMD offices
- Diagnostics
- Plan Claims
- Pharmacy, etc.
- Integrate with External Clinical Data Sources
- Unified View of All Internal Clinical Data
  - EHR #1
  - EHR #2
  - EHR #3
  - EHR #n
- Interoperable State

Healthcare Data Platform

- Data Management
- Mobility
- Security
- Communication
### Example of the “Built out” Clinical Analytics Stack

<table>
<thead>
<tr>
<th>Engagement Tools</th>
<th>Physician Scorecard</th>
<th>In-Patient Quality Reporting</th>
<th>Case Management Analytics</th>
<th>Remote Patient Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytics Solutions</td>
<td>Predictive Modeling</td>
<td>Operational Performance</td>
<td>Risk Modeling</td>
<td>Fraud/Error Detection &amp; Prevention</td>
</tr>
<tr>
<td>Business Intelligence</td>
<td>Disease Registries</td>
<td>Patient Registries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Warehouse</td>
<td>Clinical Data</td>
<td>Financial/Claims Data</td>
<td>Operational Data</td>
<td></td>
</tr>
<tr>
<td>Aggregate &amp; Normalize</td>
<td>HL7</td>
<td>LOINC</td>
<td>CCD</td>
<td>SNOMED</td>
</tr>
<tr>
<td>HIE &amp; Interoperability</td>
<td>Healthcare Integration Engine</td>
<td>Master Patient Index (MPI)</td>
<td>Consent Management</td>
<td>Clinical RLS/Repositories/Registry</td>
</tr>
</tbody>
</table>

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### Population Registries Empower Care Management

- Data arrives from a variety of sources in a variety of formats
- Data is scrubbed, checked for accuracy, normalized, and risk adjusted
- Compared to master directory
- Sorted into Disease Registries

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What Is Your Clinical Data Strategy for Population Health?

- Business analytics
- Optimize service delivery cost
- Automate compliance reporting
- Population-disease registries

- Risk-adjusted data
- Ad hoc query
- Search
- Drill down
- Local evidence-decision support

- Patient portal
- Registries
- Local evidence
- Integrated data

Key Features for Physician Partner in Quality

- To engage physicians for quality:
  1. Give them something important to do
  2. Support them (allow them to fail/learn)
  3. Be prepared to coach them in activities that are unfamiliar
  4. Hold them accountable for the outcomes

- Leverage the current governance structure including the medical staff structure of committees

- Assemble ad hoc expert panels to address specific questions

- Identify and engage ad hoc physician leaders (may not be who you think)

- When looking for a physician leader
  - Identify who wants to help
  - Identify who is willing to learn

- Power of common belief, common purpose, and peer pressure
Communication for Quality

• Be very clear what is needed from physicians
• Simplify the “ask” and make sure that success is obvious
• Don’t provide data unless you are expecting either a judgment or an action
• Sometimes it’s just hygiene
• Enlist physicians early in any quality or process activity for input
• Identify physician objections and barriers and proactively deal with them
• Work with medical leaders and medical staff leadership to determine how to best organize resources to motivate
• Use existing governance when possible
• Give feedback and tie to organization planning and pay incentives

Creating Systematic Care

Engaging physicians in “protocols”

• Physicians should be at the design table
• Standard acuity and reporting methodology must be used
• Data must be risk adjusted by accepted methodology
• Focus on preventing complications – everyone “hates” complications
• Understand where physicians see problems with standards
  Hint: it is generally in areas where they view that they are necessary to assure quality (e.g., procedures, therapeutic choices)
• Half a loaf is better than none – often protocols that deal with process are better accepted (e.g., feeding, mobilizing, insulin, skin care, empiric antibiotics, etc.)
**Critical Pathway Decision Making Matrix Ventilator Assisted Individual (VAI)**

<table>
<thead>
<tr>
<th>Immobile Patient (I)</th>
<th>Nonweanable Patient (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IW</td>
<td>IN</td>
</tr>
<tr>
<td>MW</td>
<td>MN</td>
</tr>
</tbody>
</table>

**Wearable Patient (W)**

- Vent Weaning Protocol
- Oxygen Weaning Protocol
- PMV Protocol
- Skin Protocol
- Bowel Protocol
- Nutrition Protocol
- Immobility Protocol
- Dilantin / Heparin Protocol
- TPN Startup / Conversion Protocol
- Hand / Foot Splint Protocol
- TED Hose Protocol
- Wound Staging Protocol
- External Feeding Protocol
- Aminoglycoside Protocol
- Potassium Replacement Protocol

**Nonwearable Patient (N)**

- Vent Weaning Protocol
- Oxygen Weaning Protocol
- Skin Protocol
- Bowel Protocol
- Nutrition Protocol
- Immobility Protocol
- Dilantin / Heparin Protocol
- TPN Startup / Conversion Protocol
- Hand / Foot Splint Protocol
- TED Hose Protocol
- Wound Staging Protocol
- External Feeding Protocol
- Aminoglycoside Protocol
- Potassium Replacement Protocol

**Weaning Principles**

- **ROPE**
  - No
  - Do not perform
- **DOPE**
  - No
  - Do not perform
Hospital Weaning for VAI
% of patients weaned / year vs average days on vent

Hospital: Oxygen Weaning Protocol to Optimize O2 Use

% of patients weaned per protocol
Hospital: Enteral Feeding Wean per Protocol

Average Number of Acquired Decubitus

Per Nursing Unit by Year
CHF Indicator Change with Transitional Care

N=27 at entry

Disease Management Program – Clinical Indicators

CHF-Ace at Therapeutic Level

CHF- Beta Blockers

CHF- on Spironolactone
**Disease Management Program – Clinical Indicators**

**Diabetes Mellitus Hyperlipidemia Treatment**

<table>
<thead>
<tr>
<th></th>
<th>Pre Admission</th>
<th>6 mos.</th>
<th>9 mos.</th>
<th>1yr. - 2yr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HgbA1c%</td>
<td>25</td>
<td>60</td>
<td>70</td>
<td>80</td>
</tr>
</tbody>
</table>

**Average HgbA1C results**

- Pre Admission: 25%
- 6 mos.: 60%
- 9 mos.: 70%
- 1yr. - 2yr.: 80%

**Steps to get from here to there**

1. Accepting and preparing the new organization
2. Creating a totally new culture with your partners
3. Developing the Integrated Delivery Platform
4. When it works, here is what you can do
5. Steps to get from here to there
6. From independent agents to employee-partners

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