

Developing and Maintaining Physician Engagement

National Medicare RAC Summit
Washington, DC
November 7-9, 2011

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Objectives

- How to motivate physicians for engagement
- Lessons learned from earlier experiences
- Current barriers to physician engagement
- Key issues needed for physician engagement
- Examples of successful physician engagement
- How to maintain physician engagement

Earlier Attempts at Physician Engagement

- HMOs
- PPOs
- PHOs
- IPAs
- Capitation models
- Purchased practices

PHO Failure

- Physicians pay \$1000
- Involved in managed care contracting
- Acquire more, better contracts
- More involved in the hospital organization

- Results: 20% decreased payments
No increased contracts
Cancelled contract—lost many patients

Reasons For Failure

- Legal and financial integration
- Not true physician engagement
- Physicians dissatisfied with arrangements
- Physician distrust of hospital
- Promises made, not kept

Reasons for Failure (cont)

Physicians invited for:

- Negotiations

- Contractual discussions

- To engage them

Little physician input after invitation

Poor communications

No true physician leadership

Reasons for Lack of Trust

- Lack of transparency
- Lack of communication
- Promises made, not kept
- Physicians rarely had significant input
- Competing goals

Physician poll on Trust of Hospitals

- Yes--- 23%
- No--- 20%
- Sometimes 57%

Barriers to Success

- Physician frustration with hospital organization
- Physician skepticism (prior experiences)
- Hospitals not comfortable with active physician involvement
- Physician hostility
- Competing goals

Keys to Success

- Physician leadership
- Trust
- Collaboration
- Governance
- Communication
- Strategy
- Transparency
- IT

Ways to Improve Engagement

- Be responsive to physician needs, requests
- Open door policy
- Credibility
- Trust
- Physician involvement in operations, strategy

Successful Physician Engagement

- Mayo Clinic
- Cleveland Clinic
- Geisinger Clinic
- Henry Ford

- True engagement and collaboration

Barriers to Physician Engagement

- Physicians prefer autonomy
- Lack of alignment hospital and physician business plans
- Organized medical staff not really organized
- Lack of trust in healthcare organizations

Forces Driving Hospital Physician Engagement

- Major transformation in healthcare
- Pay for service changing to pay for performance (outcomes)
- Payment tied to patient satisfaction
- Rising inflation

Forces Driving Hospital Physician Engagement

- Increasing medical costs
- Decreased reimbursement
- ACOs, CINs, Medical Home
- Bundled payments

Schynell

Drivers of Engagement

- Hospitals can not survive the above
- Physicians can not survive
- Both need each other to survive

HCAHPS

- 27 items (Critical aspects of hospital experience)
 - Communications with physicians, nurses
 - Responsiveness of hospital staff
 - Cleanliness, quietness of hospital
 - Pain control
 - Medication communications
 - Discharge information

Patient Satisfaction

- 61% variation due to Physician behavior
- 39% variation due to nursing behavior

- HCAPS survey 30% hospital reimbursement
- ? Incentive to impact physician satisfaction scores

- Physicians and hospitals must be aligned

Resnick 2009

Large State Wide Affiliations

- Hematology-oncology
- GU
- Ob-Gyn
- Ortho

Reasons to join:

Better contracts

Better reimbursement

Group purchasing

Large State Wide Affiliations

- Not true engagement
- Peer pressure to join
- Left out if don't join (?survival)
- Sharing a name
- Sharing costs, overhead
- Allow individual behavior
- Guidelines not mandated

Large Statewide Affiliations

- No sharing of values, excellence, accountability
- Held together by contracts
- No true leadership
- Often former competitors
- May not respect each other
- May not speak to each other

Large Statewide Affiliations Impact on Physician Engagement

- Significant barriers for hospital negotiations
- Difficult to align with large groups
- Hospitals may not be able to compete with contracts
- Groups may be deselected from hospital organizations

Large Statewide Affiliations

- Hospitals forced to hire PCPs and specialists to remain competitive
- Results in physician distrust
- Forces hospital physicians to refer to “new, untested” physicians
- Destroys preexisting relationships and referral patterns

Success Stories

- Consultants in Medical Hematology and Oncology (Philadelphia)
- 10 physician independent practice
- Consult with 3 different health systems
- Consult at 7 different hospitals
- Dissatisfied with managed care contracts

Success Stories (cont)

- Action plan:
 - Collected data
 - Measured performance, outcomes
 - Standardized care (practice guidelines)
 - Evidenced based medicine
 - Constantly refining process

Success Stories (cont)

- Results:
 - Decreased hospitalizations
 - Decreased ED visits
 - Decreased LOS
 - Increased revenue
 - Increased referrals
 - Decreased FTEs

Awarded first oncology Patient Centered Home (National Committee for QA)

Truly an ENGAGED GROUP

McCleod Regional Medical Center

- 453 beds
- 400 physicians
- Received 2010 AHA McKesson Quest for Quality Prize

What McCleod Did

- Hospital asked physicians to lead new programs
- Physicians recognized publicly for their efforts
- Improvements in 90 days
- Met the six IOM Quality Aims:
 - Patient satisfaction
 - Patient centered care
 - Effectiveness
 - Efficiency
 - Timeliness
 - Equity

Value Based Purchasing

- Accountable Care Act
- Payments based on outcomes
 - MI, CHF, Pneumonia, surgeries

Payments impacted by:

30 day readmissions(all cause)

30 day mortality(all cause)

HACs

HAIs

Efficiency measures

Bundled payments

30 Day Readmissions

- Original intent—no payment for preventable readmission in 30 days
- Became—30 day readmission all cause
- Penalty—denied payment 2nd admission
- Potential 1% decrease all DRG payments following year

- Physicians very involved in readmissions

30 Day Mortality

- Should be mortality for condition patient was hospitalized
- Now—30 day all cause mortality
- Will impact payment under outcomes
- Physicians very involved in mortality data

Present on Admission and Hospital Acquired Conditions

Hospital Acquired Conditions (Oct. 2008)

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility

ABOVE ARE “NEVER EVENTS”

4. Pressure ulcers stage III and IV
5. Falls and trauma (Fx, dislocations, intracranial injuries, crushing injuries, burns, electric shock)

HAC (cont.)

6. Manifestations of poor glycemic control (ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity) (Forget to order insulin, monitor BS)
7. Catheter associated UTI
8. Vascular catheter-associated infection
9. Surgical site infection following:
CABG-- mediastinitis

HAC (cont)

Bariatric surgery

- Laparoscopic gastric bypass

- Gastroenterostomy

- Laparoscopic gastric restrictive surgery

Orthopedic procedures

- spine, neck, shoulder, elbow

10. DVT/PE

- total knee, hip replacement

SCIP INDICATORS

Impact on HAC

- SCIP 1 ABX one hour
- SCIP 2 Evidenced based ABX
- SCIP 3 D/C ABX 24 hrs or less
- SCIP 4 Controlled 6AM BS post-op cardiac surgery
- SCIP 9 Indwelling catheter out by post op day 1 or 2
(New effective October 2009)
- VTE 1 Prophylaxis ordered
- VTE 2 Appropriate prophylaxis ordered

ISSUES with HAC

- Not all preventable
- Some occur in spite of best care (appropriate DVT/PE prophylaxis, ABX)
- Pressure ulcers can occur with best RX
- Lines can get infected after admission
- Impossible to prevent all falls

Potential Future Hospital Acquired Conditions

- Ventilator Associated Pneumonia
- Staph Aureus Septicemia
- Methicillin Resistant Staph Aureus (MRSA)
- Clostridium Difficile Associated Disease

Unintended Consequences of HAC

1. urine/culture pts admitted with foley
2. Blood cultures on pts with PICC lines, implanted ports
3. Ultrasound daily to catch early DVT
daily D-Dimer
4. Prolonged ABX to “prevent” post op infect.
5. Daily blood sugars
6. ?? Restrain all patients

Unintended Consequences HAC (cont)

- Costly testing
- Tests difficult to evaluate
- Patient inconvenience
- Inappropriate RX because of cultures

Significant Implications of POA

- Liability: If condition not POA, presumed “hospital acquired” ??avoidable/preventable
- Financial: May impact payment
- Public reporting: Negative data, hospital acquired infections/complications on CMS/State websites

Expectations of Physicians

- Improved, legible, documentation
- Early documentation to support POA
(documentation by any provider involved in care and Rx i.e.--any physician, or qualified healthcare practitioner)
- Clarify POA anywhere in medical record

Expectations of Physicians (cont)

- Respond ASAP to queries
- Make physician aware of impact of POA
- Caution re: R/O, probable, suspected Dx
(Impact on core measure compliance)
- If condition not POA occurs, careful documentation explaining not avoidable

What's In It For Physicians

- Must understand the payment implications
- Must understand the public reporting implications
- Must understand the legal implications
- Peer review issue , track/trend, reappointment process

Physician Involvement with HACs

- Must document conditions as POA or HAC
- May get query to clarify
- What is incentive for physician to respond to query?
- What is incentive for physician to prevent DVTs/PEs?
- Need physician engagement

Healthcare Associated Infections

- MRSA
- C. Diff
- Physician issues:
 - Appropriate hand washing, gown, mask, etc.
 - Inappropriate use of ABX

Physicians very involved in control of both conditions

Efficiency Measures

- Cost of care for beneficiary for episode of care
- 3 days before admission-30 days after D/C
- All Part A and B payments included
- CHF admission, cataract surgery 1 week later
- Physicians very involved in this measure

Hospital Need for Physician Engagement

- 30 day mortality
- 30 day readmissions
- HACs
- HAIs
- Efficiency measures
- Bundled payments

Inappropriate Utilization

- Antibiotics
- Lab tests
- X-rays (CT,MRI)
- Transfusions
- Diagnostic cardiac cath

Inappropriate Utilization (cont)

- Cardiac stenting minimal disease
- Pacemakers/AICDs
- Vertebroplasty
- Arthroscopy

Overutilizers

- Lack of medical necessity
- Inappropriate billing
- Potential fraudulent issues
- OIG, CMS investigating cardiac procedures, vertebroplasty

- Do hospitals want to engage this type of physician??

Developing Engagement

- Advisory Board meetings
- Physician Advisory Council
- Quarterly update meetings
- Transparency
- Physician involvement in strategy

Developing Engagement (cont)

- Clinically integrated network
- Physician governance
- Physician credentialing
- Physicians determine guidelines

Developing Engagement(cont)

- Physicians determine outcome incentives
- Physicians do peer review
- Physicians can deselect peers based on outcome data, participation

Maintaining Physician Engagement

- Trust
- Communications
- Involvement in strategy, vision, goals
- Address problems quickly
- Effective management of morale and motivation
- Outcome based reimbursement
- Physician governance, leadership

Questions??

Thank You

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