Developing and Maintaining Physician Engagement

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Mark Michelman, MD, MBA
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 cannot survive the above
- Physicians cannot 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
Success Story

• 2000 1300 patients average HbA1c 9.4

• 2004 2150 patients average HBA1c 7.6

• Physicians: developed the process
  coordinated care
  measured care
  improved care

True engagement and collaboration

Crusader Community Health
Rockford, Illinois
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 caths
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
Mark Michelman, MD, MBA

727-461-8016

mark.michelman@baycare.org