Physician Engagement and Alignment Best Practices

Driving Performance and Elevating Quality Across the Care Continuum

Wisconsin Hospital Association
June 24, 2010
Economic Pressure Intensifying Imperative to Collaborate on Care

Accountability Expanding Across Care Continuum

Managing to New Medicare Margins

Over the longer-term, we believe that revenue per procedure will decline as funding sources will likely include reductions in Medicare reimbursement, causing margins to contract even further.

Moody's
July 20, 2009

Source: Thorpe K and Howard D, “The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity,” Health Affairs, 379, August 2006; Innovations Center Futures Database; Advisory Board analysis.
Widespread Variation in Care Growing More Conspicuous

Cost and Quality Discrepancies Persist

Direct Cost per Case, 2008¹

<table>
<thead>
<tr>
<th></th>
<th>AMI</th>
<th>CHF</th>
<th>PN</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>$4,779</td>
<td>$3,753</td>
<td>$2,827</td>
</tr>
<tr>
<td>2009</td>
<td>$3,698</td>
<td>$3,025</td>
<td>$2,448</td>
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</tbody>
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Medicare Readmission Rates²

<table>
<thead>
<tr>
<th></th>
<th>AMI</th>
<th>CHF</th>
<th>PN</th>
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</thead>
<tbody>
<tr>
<td>2003</td>
<td>14.4%</td>
<td>19.9%</td>
<td>19.4%</td>
</tr>
<tr>
<td>2005</td>
<td>14.3%</td>
<td>24.5%</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

¹ Advisory Board Innovation Center Proprietary Database.
² Commonwealth Fund.

Unambiguous OPPE Mandate

Standard MS.08.01.03: Ongoing Professional Practice Evaluation

Elements of Performance for MS.08.01.03

1. There is a clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice.
2. The type of data to be collected is determined by individual departments and approved by the organized medical staff.
3. Information resulting from [OPPE] is used to determine whether to continue, limit or revoke any existing privilege(s).
Physicians Required to Move the Dial Yet Still Operating in the Dark

Inherent Skepticism of Data

“Physicians disdain poor data, as they should. Physicians are data-driven, scientifically minded individuals, and organizations waste a lot of time, not to mention their own credibility, sharing poor data with physicians. That said, physicians are among the most competitive individuals on this planet. They will respond to good, detailed data that inspires their trust and can be accessed quickly because, at the end of the day, no physician wants to be an outlier.”

Chief Medical Officer
East Coast Hospital
Struggling to Illuminate the Problem for Physicians

Lack of Credible Profiling Data Undermining Ability to Influence Practice Patterns

Decision support analyst aggregates static paper-based data

Clinical Information System
Patient Billing System
Data Reporting Software
Care Management

CMO meets with outlier physician

Adjusts for case complexity
Eliminates outliers
Removes consulting physician data
Updates to include current cases

Week 1
Week 3
Week 6
Week 9
Week 12

Draining process must be started again

“My patients are sicker than the benchmarks”
“I had a few extreme cases”
“Other physicians also consulted on my patients”
“This data is too old”
“These aren’t even my patients”

Common Shortcuts

- Avoid sharing data with physicians
- Share only “surface level” data (e.g., ALOS, cost-per-case)
- Focus on small subset of physicians
- Mail profiles to physicians or review “in aggregate”
Engaging Physicians on Their Terms

Typical Physician Characteristics

**Time Constrained**
- Productivity pressures amplify value of time

**Trained as Scientists**
- Education includes critical analysis of medical research

**Intellectually Curious**
- Interested in understanding root causes of problems

**Naturally Competitive**
- Voluntarily entered competitive career track

**Driven to Help Others**
- Dedicated to saving and improving quality of life

**Background**
- Must accomplish goals in 20–30 minute meeting
- Easily identify weaknesses in data-based arguments, value statistical significance
- Insistent on answering “why” approach is incorrect, what intervention is appropriate
- Not used to having professional judgment challenged
- Motivated to improve outcomes, responsive to high quality data
# Key Lessons for Engaging Physicians in Performance Improvement

## Harnessing the Power of Technology
- Integrate cost and quality metrics
- Leverage a visually intuitive design
- Deploy a severity-adjustment methodology
- Provide quick access to patient-level detail

## Perfecting the One-on-One Meeting
- Prepare to respond to data denial and pushback
- Focus on building trust with individual physicians
- Stay on message regarding improvement goals
- Deliver precise feedback to drive practice change

## Addressing Attribution Concerns
- Minimize errors in data collection
- Build consensus on attribution policies
- Deploy a consistent attribution methodology
- Keep the attribution ambition in perspective

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*Key Success Factors*
Designing a Solution for Physicians

Key Components of an Effective Technology Platform

One-Stop Shop
- Beyond case management and decision support solutions
- Single source of physician performance data
- Integration of cost and quality measures

Data Integrity
- Proven methodology for severity-adjusting data
- Ability to exclude questionable cases from profile

Speed of Access
- Fast response times so physicians do not have to wait
- Ability to login and review performance profile in 15 minutes or less

Intuitive Interface
- Designed for physician users, not quality analysts
- Visually compelling design that provides at-a-glance overview of performance
- Easy navigation from dashboard to detail

Clinically Actionable Detail
- Immediate access to patient-level detail and case history
- Access to consulting physician information
- Availability of hospital-level, local and national benchmarks
Elevating Performance Through Collaboration and Transparency

Transforming “siloed” data... ...into insight around physician performance... ...to drive meaningful behavior change

Core Elements

- Charges / Patient Billing
- Core Measures Data
- Physician Roster

Additional Data Sources

- Cost Accounting
- Evidence-Based Medicine Order Sets
- Ambulatory Data
- Customized Data (e.g., OPPE, Patient Satisfaction, Specialty Databases)

Roles and Responsibilities

- Chief Medical Officer: Conduct detailed performance reviews with outlier physicians
- Chief Executive Officer: Maintain “short-list” of high-performing medical groups
- Chief Operating Officer: Able to evaluate performance of hospitalist service
- VP, Quality: Analyze physician performance against key quality metrics
- Medical Staff: Self-service access to their own performance data
- Re-credentialing: Satisfy OPPE requirement for re-credentialing of physicians
Perfecting the One-on-One Meeting

Focusing on Individual Physician Performance

Data-Sharing a Two-Step Process

Case in Brief

- 500-bed, not-for-profit teaching hospital in Long Branch, New Jersey
- An affiliate of the St. Barnabas Health System
- Leveraged technology to hone in on high-cost DRGs, eventually focusing on PCP-provided CHF care

Group Presentation

1. Targeted 44 PCPs managing at least five CHF cases
2. Shared blinded data with group, listing de-identified outcomes for all 44 physicians
3. At close of meeting, each attendee given note identifying own data on grid

Individual Follow-Up

1. Met privately with outlier physicians to discuss results, improvement opportunities
2. Maintained “open-door policy” toward answering questions, addressing concerns about data
Managing In-The-Moment Communication

Physicians’ Data Acceptance A Gradual Process

Resistant → Surprised → Bargaining → Engaged

**Reviewee**
- Shutting the Door
  “I’m not interested in seeing this data”
- Skeptical of Validity
  “This can’t be my data”
- Playing the Quality Card
  “My LOS is long, but it’s necessary for high quality,”
- Ready to Listen
  “I appreciate your making this data available to me. What can I do to improve?”

**Reviewer**
- Elucidate Data’s Value
  “We’re offering you transparency into data that payers already have.”
- Drill Down as Necessary
  “Let’s look at this case to understand where the numbers come from…”
- Stay on Message
  “You’re a good doctor, but we still need your help to tighten up in these other areas.”
- Get Specific, Solicit Input
  “These order sets, this case management contact might help…how would you expedite care?”
A Natural Result of Enhanced Trust

Meeting #1
45–60 minutes

Meeting #2
30 minutes

Continuing Review and Self-Service

- Explaining technology’s purpose
- Developing comfort with data validity
- Prompting performance improvement

- Comfortably accessing own data
- Proactively adapting clinical behavior

Even in a world of imperfect data, hospitals must start by sharing the data with physicians to create an imperative to make further progress against data issues.
Translating Individual Turnarounds into Group Gains

**CHF Case Outcomes, Dr. Jones**

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>11.67</td>
<td>4.5</td>
<td></td>
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<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>$10,017</td>
<td>$3,450</td>
<td></td>
</tr>
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</table>

**CHF Case Outcomes, PCP Group**

<table>
<thead>
<tr>
<th>ALOS (Days)</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.8</td>
<td>5.28</td>
<td>5.48</td>
<td></td>
</tr>
</tbody>
</table>

- Cumulative two-year savings of 242 days (across 577 cases) over 2007 performance
- ALOS increase in 2009 due to transition to MS-DRGs and increase in severity level of CHF patients

**CHF ICU Accounts**

<table>
<thead>
<tr>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>29</td>
<td>24</td>
</tr>
</tbody>
</table>

1 Pseudonym.
Word of Mouth at Work

AN ORGANIC GROWTH PROCESS

Getting Initial Conversations Right Builds Toward Broad Desire for Data
**Greater Transparency Driving Sustainable Cost and Quality Improvements**

**Case in Brief**

- 11-hospital health system in Houston, Texas
- Determined need to impact physician behavior, despite access to best-in-class tools including Cerner EMR, Midas+, TSI, UHC data, Solucient benchmarking data, and Business Objects for ad-hoc reporting
- Automated data collection and report creation capable of engaging physicians in performance dialogue
- Physician and case level data shared regularly with every oversight program physician

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**Early Efforts**

*Reducing Hospitalist Variability*

**Quality Management**

<table>
<thead>
<tr>
<th>Change in Readmission Rate</th>
<th>Change in Core Measures Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red (9.9%)</td>
<td>Blue (4.7%)</td>
</tr>
<tr>
<td>10.5%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

**Cost Management**

<table>
<thead>
<tr>
<th>Change in Total Cost per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red (6.3%)</td>
</tr>
<tr>
<td>Blue (1.8%)</td>
</tr>
</tbody>
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-$3.7 million savings

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**Follow-on Focus**

*Lowering Medicare Cost*

**Percent of Medicare Cases Making Profit**

- **First Six Months**
  - 46% Before
  - 62% After

**Medicare Contribution Margin**

- **After Two Years**
  - 5% Memorial Hermann
  - National Average (2%)

-$20 million savings

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**Memorial Hermann Today**

*Receiving National Recognition*

- Federal Trade Commission
  - Formal Clinical Integration (CI) Program with more than 1,150 participating physicians
  - First CI contract with Memorial Hermann Health Network providers in January 2009

- National Quality Forum
  - Presented National Quality Healthcare Award for “meaningful, sustainable quality improvement”
  - NQF President and CEO Janet Corrigan noted “extraordinary efforts to improve quality and patient safety and reduce disparities in its healthcare systems”
Who’s Responsible for Mr. Smith?

Even in Routine Cases, a Complex Assignment Process

Mr. Smith Goes to the Hospital

<table>
<thead>
<tr>
<th>Case Details</th>
<th>ED Arrival</th>
<th>CABG Procedure</th>
<th>ICU Stay</th>
<th>Post-ICU Recovery</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Smith arrives in ED with chest pain complaint; tests ordered</td>
<td>Surgery performed after tests reveal blockage</td>
<td>Post-op complication requires GI consult</td>
<td>Additional tests delay discharge by one day</td>
<td>New hospitalist takes over case two hours pre-discharge</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Provider</th>
<th>ED Physician</th>
<th>Cardiac Surgeon</th>
<th>Intensivist</th>
<th>Hospitalist Team</th>
<th>Discharging Hospitalist</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sample Outcomes Affected</th>
<th>Charges, Core Measures</th>
<th>Charges, Core Measures</th>
<th>Complications, Consultants, LOS</th>
<th>Charges, LOS</th>
<th>LOS, Readmissions</th>
</tr>
</thead>
</table>

Why wait to address attribution? You must share data with physicians before trying to fix the data to get them engaged in resolving attribution issues.
## We’re All in This Together

**Research Interviews with Hospitals About Physician Measurement**

- **n=15**

### Even Health Plans Inconsistent

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Case Assignment Methodology for Physician Performance Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCross BlueShield of Texas</td>
<td>Physician with most RVUs or E&amp;Ms billed for episode</td>
</tr>
<tr>
<td>Harvard Pilgrim HealthCare</td>
<td>Physician with most claims dollars, as long as represents at least 25 percent of episode fee charged</td>
</tr>
<tr>
<td>Aetna</td>
<td>Each physician with more than 20 percent of claims dollars in episode</td>
</tr>
</tbody>
</table>
| United Healthcare                     | • Non-proceduralists: Most care dollars  
|                                       | • Proceduralists: Physician who submitted claim for intervention                                                                  |

### Percentage Calling Case Attribution a Problem

- 95%
- 5%
In Pursuit of Progress, Not Perfection

Some Attribution Problems Lack a Flawless Solution

A Clear Right Answer
- Fixing existing errors in data collection processes, source systems
- Increasing capture of information around charges, utilization

A Question of Judgment
- Establishing rules for coding complex cases
- Deciding criteria for patient exclusion (e.g., DNR cases, palliative care)

An Uncertain Undertaking
- Pinning quality outcomes (e.g., complications, readmissions) on single physician

Ease of Solvability
Follow Structured Problem-Solving Process
• Create cross-disciplinary leadership team
• Unearth root causes of attribution inaccuracy
• Develop improved data collection procedures

Eliminate Errors in Data Collection
• Clean up rosters and repositories
• Create documentation and dictation standards
• Resolve overlaps in source IT systems

Establish Rules for Complex Cases
• Create assignment protocols in cases with multiple caregivers, other challenges
• Educate coders around new rules

Overcome Physician Resistance to Imperfect Data
• Involve clinicians in crafting coding rules
• Leverage solution features to your advantage
• Emphasize performance trends, collective responsibility

Near-Term Objectives
Ongoing Challenge
Bringing Everyone to the Table

Use Cross-Disciplinary Teams to Lead Attribution Response

Key Response Team Members:
- Quality / Utilization Staff
- Physician Leaders
- Coding Staff
- IT Representative
- Service Line Directors
Iterative Rule-Making Yields Steady Progress

Information Gathering
- Attribution concerns found in initial system rollout use
- Contacted other institutions: no consensus
- Developed own, complete list of problem areas

Rule Making
- Proposed department-based structure
- Set specific rules for each physician type
- Solicited feedback from department chairs

Refinement
- Department chairs offered revisions
- Chairs approved new rules
- Medical Staff Executive Committee endorsed new rules

Implementation
- Cross-checked consistency with other IT systems (billing, public reporting, etc.)
- Coordinated with coding department to introduce new rules

Integrating Rules Inputs
Ensuring Early Momentum

**MOVING QUICKLY ON THE KEY QUESTIONS**

*Task Chart Facilitates Expedient Process*

<table>
<thead>
<tr>
<th>Task</th>
<th>Start</th>
<th>Finish</th>
<th>Assigned To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop definitions for attending, admitting, consulting physicians</td>
<td>5/6/09</td>
<td>5/8/09</td>
<td>Stacy/Physicians</td>
</tr>
<tr>
<td>Determine whether surgical DRGs should be assigned to surgeon vs. medical staff</td>
<td>5/6/09</td>
<td>5/8/09</td>
<td>Pam/Physicians</td>
</tr>
<tr>
<td>Identify radiology complications and determine how to attribute</td>
<td>5/8/09</td>
<td>5/11/09</td>
<td>Pam/Physicians</td>
</tr>
<tr>
<td>Find out if Pharmacy can enter ordering doctor on drugs to flow to Affinity</td>
<td>5/5/09</td>
<td>5/5/09</td>
<td>Greg</td>
</tr>
<tr>
<td>Send ED physicians to alignment system (listed as Special Other Doctor)</td>
<td>5/6/09</td>
<td>5/6/09</td>
<td>Physicians/ Jamie</td>
</tr>
<tr>
<td>Decide whether DNR cases should be excluded from attending</td>
<td>5/13/09</td>
<td>5/13/09</td>
<td>Physicians</td>
</tr>
</tbody>
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Expanding on Physician Engagement and Alignment
**Distilling Lessons from a Progressive National Cohort**

**Cohort Circa 2010**
- Number of Hospitals: 270+
- Percent of Inpatient Admissions Nationally: >10%
- Number of Physicians in Cohort: 35,000+

**Expediting IV-PO Conversions**
- Detailed look at high LOS cases revealed variation in timing of IV to PO transition; changes yielded $446,000 in savings

**Tackling Medicare LOS**
- Saved 500 Medicare patient days while improving CMI by seven percent, resulting in $2.48 million in annualized ROI

**Monmouth Medical Center**
- Focusing on CHF Patients
  - Shared blinded LOS and cost data with 44 PCPs managing CHF cases; reduced average CHF cost per case by $373

**Reducing Outlier Variability**
- Identified outlier performance; reduced average cost per case for interventional cardiology by ten percent

**Improving Core Measures**
- Identified physicians with low compliance; improvements allowed hospital to capture 100 percent of $500,000 P4P incentive

**Yielding Greater Hospitalist Efficiency**
- Facilitated Hospitalist LOS reduction effort yielding savings of $235,250 across six months

**Jewish Hospital & St. Mary’s**
- Decreasing Surgery LOS
  - Reduced ALOS in cardiovascular surgery by 1.5 days yielding a savings of $347,000

**Reducing Avoidable Days**
- Reduced avoidable days by 2,000 across six months in targeted DRGs yielding an estimated cost savings of $800,000
What’s Next for Physician Alignment

Achieving Breakthrough Clinical Collaboration

- Improve clinical practice by comparing mortality, complications, readmissions, and core measure performance
- Benchmark performance on the full range of utilization metrics (LOS, cost per case, avoidable days, etc.)
- Provide physicians direct access to performance profiles

Prospering Under New Payment Models

- Track performance of participating physicians in payer contracts
- View performance across the continuum of care – inpatient, outpatient, and office-based
- Track compliance to payer-required clinical screens and wellness checks

Driving Future Revenue Growth

- Spotlight referral opportunities at PCP and specialist level
- Provide data-driven insight into physician loyalty and its impact on physician referral patterns
- Track progress against performance for referral activities

Strengthening Owned Practice Performance

- Profile cost and quality metrics of employed practices
- Track profitability of practices by examining revenue capture
- Track employed physician productivity across all specialties
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