New York Association Medical Staff Services
Albany, New York

"The Evolving Role of the Physician in the 21st Century"

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In the Beginning…..

What Characterized the Ideal Physician of the 20th Century?

- Fiercely independent and autonomous
- Willing to work exceptionally long hours and sacrifice one's personal life
- Proprietary business owner and manager
- Broad clinical training and experience
- Hierarchical and Micromanager (to control all clinical outcomes)
- Top of the 'food chain' in healthcare (social status and monetary rewards)

What caused the Demise of this Ideal 20th Century Model?

- Rise of the large employer and payer as a healthcare ‘stakeholder’ and ‘customer’
- Recognition of the ‘bell curve’ and non-value-added clinical variation in the cottage industry model (1999)
- Dissatisfaction of ‘consumers’ with the traditional ‘physician-centric’ and fragmented model of service
- Realization of the ‘perverse incentives’ of fee for service
- The 21st century revolution in healthcare

Like every other industry in the 21st century, Healthcare is becoming….

I. **Digitized: business intelligence tools with clinical/cost analytics powered by an enterprise data warehouse and supported by decision support tools**

II. **Standardized: elimination of non-value added clinical/operational variation and waste (1000%/65%)**

III. **Commoditized: the race to the bottom to provide high quality/low cost services in new ways**

IV. **Globalized: we are in competition with the world**

Strategic Imperative #1: Cultural Transformation is Necessary and Inevitable

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Can Physicians make the Cultural and Psychological Transition from….

- Autonomy to collaboration and interdependence?
- Working alone to working together?
- Managing a practice to managing part of a clinical enterprise together?
- Micro-management to delegation and empowerment of others?
- Clinical to holistic focus (clinical/operational/financial)?
- Focus on procedures/tests to clinical and business outcomes?
- From “Practice” to “Systems” thinking

Strategic Imperative #2: Engage and Align with all Strategic Partners

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Methodology

1. Physicians have an ‘ownership stake’ in part of the healthcare enterprise
2. Physicians agree to ‘hard wire’ regulatory quality into routine processes
3. Management works with physicians to monetize all major clinical and business quality metrics
4. Identify the ‘vital few’ into a ‘strategic quality plan’
5. Create co-management agreements with physicians around KPIs (key performance indicators)

Example of a President of the MS Contract (1999):

- Reduce legal costs of managing problematic physician by $100,000 ($6,000)
- Optimize Press Ganey Scores in ED from 15%tile to 75%tile ($6,000)
- Optimize Core Measures Compliance to 90%tile ($6,000)
- Reduce LWBS (left without being seen) in ED from 7% to < 1% ($6,000)
- Improve timeliness of medical records documentation to compliance of >99% ($6,000)

TOTAL: $30,000 for net return to hospital of > $500,000

ROI = 16.6/1

Example of a ED management contract (ED) (2006):

- 50% base pay **(10%tile MGMA compensation)**
- 10% quality program and performance (2% bonus for every 20% departmental compliance with agreed upon quality targets)
- 10% patient satisfaction (2% for each 10%tile above 30%tile Press-Ganey departmental scores)
- 10% physician satisfaction (2% for each 10%tile above 40%tile for hospital survey of physicians)
- 10% corporate compliance (e.g. medical records) (2% for every 10% compliance over 50%tile)
- 10% evaluation by President MS and CEO (top potential pay – (**90%tile MGMA compensation**)

Compensation varies from $25,000-$130,000

Recent $1.3 M Contract for OBGYN in West Texas (from 'piece work' to clinical executive):

1. Above average wRVUs (FMV1 = $400,000)
2. Supervision of four APNs (allowed by Texas State Law) (FMV2 = $200,000)
3. Leadership of Charity OBGYN Clinic (FMV3= $300,000)
4. Leadership of OBGYN Service Line with negotiated clinical and business outcomes (all have calculated ROI for both clinician and management) (FMV4= $400,000)

ROI for HCA = $3.9 M/$1.3 M = 3:1

Strategic Imperative #3: Redesign your Medical Staff

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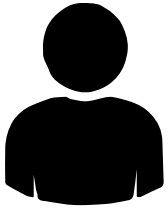
How are Top Performing Medical Staffs Adapting to these new demands?

1. Professionalizing physician leadership
2. Redesign medical staff committee structure (think project management)
3. Standardize credentialing/privileging, peer review and high-risk care
4. Separate membership from privileges
5. Transition clinical departments into service lines or clinical institutes
6. Utilize APPs and Clinical Scribes to leverage physician resources
7. Engage and align with all eligible practitioners to optimize system wide clinical goals
8. Unify and integrate the medical staff throughout a system

Three Compelling Reasons to Utilize Clinical Scribes

I. Opportunity Cost of $1 million/physician
II. Opportunity Cost of 35%-40% of every clean claim
III. Low case mix index (CMI)/Hierarchical Condition Categories (HCCs) and low risk/severity adjustment for all at risk and value- based contracts



Name:	John Doe	**Height:**	64 inches
Gender:	Male	**Weight:**	240 pounds
DOB:	07/01/1950	**BMI:**	42

Chief Complaint & HPI: No symptoms, presents for AWV with known T2DM on Insulin x 7 yrs. Polyneuropathy, COPD & Major Depression
Past Medical History: T2DM, Polyneuropathy, COPD, Major Depression, Traumatic toe amputation (1996)
ROS: Per HPI, all other symptoms negative

Exam:
Unremarkable except for obesity, decreased breath sounds and expiratory wheezes, great right toe amputation and positive monofilament

Assessment/Plan:
(1) Preventative visit and findings discussed
(2) DM, Type 2 – stable, continue current treatment plan
(3) COPD – stable, continue Advair
(4) Neuropathy – stable, optimize BS control
(5) Major depression – stable, continue Lexapro
(6) Morbid obesity – IBT to lose weight

John Doe's Risk Adjustment Opportunities

Financial impact of knowing what to document and code!

MODERATE SPECIFICITY Documentation & Coding				HIGH SPECIFICITY Documentation & Coding			
Condition	**I-10**	**HCC**	**RAF weight**	**Condition**	**I-10**	**HCC**	**RAF weight**
66 year old, male	--	Demo.	0.288	66 year old, male	--	Demo.	0.288
AWV	Z13.9	n/a	--	AWV	Z13.9	n/a	--
BMI=42.0	Z68.41	22	0.365	BMI=42.0	Z68.41	22	0.365
T2DM-Uncomplicated	E11.9	19	0.118	T2DM with Neuropathy	E11.42	18	0.368
Neuropathy	G62.9	n/a	--	Neuropathy (buddy code)	G62.9	n/a	--
Long Term Insulin Use	Not coded	n/a	--	Long Term Insulin Use	Z79.4	19	0.118
Major depression, unsp.	F32.9	n/a	--	Major Depression, Mild	F32.0	58	0.330
Asthma, Severe	J45.50	n/a		COPD, unspecified	J44.9	111	0.346
Great Toe Amputation	Not coded			Great Toe Amputation	Z89.419	189	0.779
No Disease interaction				**Disease Interaction is** T2DM-COPD	***Disease Interaction***		0.182
Patient RAF Score			**0.771**	Patient RAF Score			**2.776**
PMPM Payment			**$542**	PMPM Payment			**$1,943**
Annual Payment			**$6,493**	**Annual Payment**			**$23,333**

Strategic Imperative #4: Become HIM Adept and Literate

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In the 21st Century we are moving from….

- Data to analytics
- Autonomy to interdisciplinary teams and decision support tools
- Retrospective to concurrent and prospective analysis and management

Condition Summary

LINK

Endocrine Events

HgbA1c:	25 %	(8 weeks ago)	5.0 %	(4 months ago)	
BP:	140/86 mmHg	(6 days ago)	111/59 mmHg	(11 days ago)	
LDL:	92 mg/dL	(8 weeks ago)	H 138 mg/dL	(4 months ago)	
Tobacco Use/Currently Using:	No	(6 weeks ago)	No	(6 weeks ago)	
Foot Exam:	08/12/10	(3 weeks ago)	07/28/10	(5 weeks ago)	
Eye Exam:	11/17/09	(8 weeks ago)	07/07/10	(2 months ago)	

Diabetes Performance Measures (As of last night)

This Patient	Measure (As of last night)
○	1: Hgb A1c Done in last 6 months
●	2: Hgb A1c < 8.0%
●	3: BP < 130/80
○	4: LDL Cholesterol Done in last year
○	5: LDL Cholesterol < 100
○	6: Tobacco Non-user
●	7: Creatinine Done in last year
●	8: MicroAlbumin Done in last year
○	9: Foot Exam Done in last year
○	10: Eye Exam Done in last year
●	11: Diabetic Education Done in last year
◎	12: Flu Vaccine Done in last year
●	13: Pneumovax Done
◎	14: Aspirin Use

(09/02/10 06:26:00)

Chronic Disease Algorithm

Diabetes Mellitus
Hypertension in DM

Profitability by Physician –
DRG 193 – Simple Pneumonia

Physician	Cases	ALOS	CMI	Total Charge	Actual Payment	Variable Cost	Contrib Margin	Fixed Cost	Net Income
MULLA	10	4.80	1.1291	$27,050	$8,512	$3,076	$5,436	$3,487	$1,949
NIASH	7	4.00	0.7054	$17,779	$1,404	$2,618	($1,214)	$2,896	($4,110)
HAVZL	6	5.17	1.1291	$28,205	$10,785	$3,410	$7,375	$3,535	$3,840
BHAAS	5	2.40	0.7054	$11,428	$2,248	$2,136	$112	$2,624	($2,513)
MULKE	5	7.40	1.1291	$30,042	$5,431	$4,165	$1,266	$4,207	($2,941)
NEMST	5	7.40	1.1291	$25,596	$5,417	$3,865	$1,552	$3,796	($2,245)
AHSAZ	4	5.25	1.1291	$27,154	$9,862	$3,306	$6,556	$4,017	$2,539
AKIMU	4	2.00	0.7054	$8,830	$5,347	$1,695	$3,652	$2,043	$1,609
CHIUG	4	2.25	0.7054	$12,654	$3,807	$2,160	$1,647	$2,640	($993)
KABNO	4	8.50	1.1291	$39,054	$5,532	$4,620	$913	$4,891	($3,979)
Total:	178	4.58	1.0148	$21,935	$7,005	$2,888	$4,117	$3,128	$989

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Source: INSIGHTS Enterprise Edition, Cost and Clinical Reporting, www.hcillc.com

Strategic Imperative #5: Optimize Quality and Safety through Standardized Practices

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What do you think the impact is when Physicians Standardize their Top 20 DRGs in their Respective Clinical Specialties on….

- Quality?
- Safety?
- Service?
- Cost-effectiveness and cost of care?

What conditions should be placed when physicians standardize care?

Is there a difference in performance when physicians and management together?

Measurement	MHMD CI Physicians	Crimson-All Hospitals
LOS	4.52 (5%)	4.74
HAIs	0.68% (91%)	7.56%
General Complications	1.24% (66%)	2.82%
Mortality	1.95% (23%)	2.52%

Strategic Imperative #6: Optimize Customer Service and Loyalty through Standardized Practices

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It turns out that patient loyalty is the greatest driver of….

- Compliance with recommended treatment and follow up
- Reduced medical negligence claims (the critical 3%)
- Reduced turnover (LOS, mortality)
- Enhanced reputation and market share (think Apple/Harley-Davidson)
- Measurable quality outcomes

Strategic Imperative #7: Collaborate to Continuously Reduce Operating Costs

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A contemporary (and less painful) approach:

1. Align compensation models
2. Optimize human resource (labor) deployment and management
3. Simplify and optimize operational processes
4. Optimize supply chain management
5. Create a culture of customer service

2. Optimize Labor

The Labor Ratio: Your single most important operational metric

Labor Ratio = total labor costs/net operating revenue

Best practice = 44% (HCA)

Average = 56%

Poor = 65%

Why is this metric so important? **Every % savings goes straight to your bottom line!**

Homer Warner, MD:

“A physician should never do what a nurse practitioner can do.

A nurse practitioner should never do what a nurse can do.

A nurse should never do what a technologist can do.

A technologist should never do what a clerical specialist can do.”

4. Optimize Supply Chain:
There is widespread variation in supply chain costs!

Supply Chain Ratio =

Total Supply Costs/Net Operating Revenue

- Variation from 12% (best practice) to 18% (median) to 25% (worst)

- Each % saved goes straight to the bottom line!

Best Practice: Value Analysis Process

Physicians and executives decide on the following together:

- Vendors
- Suppliers
- Instruments
- Set ups
- Technology investments

What would be both the quality and financial impact of this?

Strategic Imperative #8: Build a Population Health Infrastructure

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Disproportionate Costs…The Foundation for Population Health

- Top 1% make up 23% of healthcare costs (critical care and dying)(>$90K/year)
- Top 5% make up 49% of healthcare costs (multiple chronic diseases)(>$45K/year)
- Top 10% make up 64% of healthcare costs (chronic diseases)(>$15K/year)
- Bottom 50% make up 3% of healthcare costs (healthy population)(>$8K/year)

Essential Operational Building Blocks of Population Health

1. Engaged and aligned stakeholders with at risk contracts
2. Build an integrated healthcare network together that makes clinical and operational sense
3. Palliative care, disease management, post-acute care/disease management
4. Retail medicine and e-health solutions
5. Health information exchange with enterprise data warehouse and clinical/business analytics

Strategic Imperative #9: Create a Population Health Delivery and Business Model

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Predictive Modeling: Predictive Summary

	Q3-2011					
MPC/ERG	Employee	Spouse	Dependent	Total	% of Total	Selected (All)
OTOLARYNGOLOGY	4	0	14	18	47.37 %	☐
DERMATOLOGY	0	0	7	7	18.42 %	☐
OPHTHALMOLOGY	3	0	3	6	15.79 %	☐
ORTHOPEDICS & RHEUMATOLOGY	1	0	5	6	15.79 %	☐
GASTROENTEROLOGY	2	0	3	5	13.16 %	☐
PULMONOLOGY	0	0	5	5	13.16 %	☐
PSYCHIATRY	1	0	3	4	10.53 %	☐
UROLOGY	0	0	3	3	7.89 %	☐
ENDOCRINOLOGY	0	0	2	2	5.26 %	☐
INFECTIOUS DISEASES	1	0	1	2	5.26 %	☐
CARDIOLOGY	0	0	1	1	2.63 %	☐
HEMATOLOGY	1	0	0	1	2.63 %	☐
LATE EFFECTS, ENVIRONMENTAL TRAUMA AND POISONINGS	0	0	1	1	2.63 %	☐
NEONATOLOGY	0	0	1	1	2.63 %	☐
NEUROLOGY	0	0	1	1	2.63 %	☐
NO KNOWN CONDITIONS	0	1	8	9	23.68 %	☐
TOTAL UNIQUE MEMBERS	5	1	32	38		
% of Total Members	13.16 %	2.63 %	84.21 %			
*Total Annual Low	$27,020	$25	$42,490	$69,535		
*Total Annual High	$37,900	$210	$55,280	$93,390		
% of Total High	40.58 %	0.22 %	59.19 %			

Source: Courtesy of Conifer Health Solutions, a revenue cycle management, population health management solutions company. www.coniferhealth.com.

Strategic Imperative #10: Transform your Clinical Delivery System and Business Model for the 21st Century

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Stage the Transition from FFS to Risk Based Contracting:

1. **Align with all key facilities and providers before everything**
2. Build the integrated network **together** (all solutions must make **clinical and operational** sense)
3. Focus on opportunities to lower cost structure **first** (labor, supply chain, palliative care, inpatient disease management) **(MUST HAVE ANALYTICS!)**
4. Grow new sources of revenue **second** (e-health solutions, contracts for domestic/international medical tourism, focused factories (VAPs), solution shops etc.)
5. Grow the ambulatory population health infrastructure **third** as you move into risk-based contracting (e.g. post-acute care, ambulatory disease management, retail medicine, home health, etc.)
6. Exit fee for service **last** and focus completely on health optimization and prevention of disease

What you can expect to see in the 21st century for healthcare….

- Consumer driven industry with physicians, hospitals, and care delivery systems commoditized
- Primary portal will be the I-phone supported by wireless technology, BI support tools, robots, tele-health, big data
- More focus on the ‘vital few’ and less focus on the ‘healthy majority’ (predictive analytics)
- Less futile end of life care
- More risk for all parties (including the consumer!)
- No outcome = no income!
- Patients instead of products; value instead of sales!

The 21st Century Model of the Ideal Physician:

- From ‘piece-worker’(procedures/tests) and proprietary business owner to clinical executive who oversees a clinical enterprise
- Creates standardized approaches to high risk, high cost, and high-volume clinical activities
- Assumes both control and accountability for both clinical and business outcomes (e.g. value) that others provide
- Oversees large clinical enterprises and directs other less experienced physician executives
- Is compensated based upon outcomes of ‘covered lives’

Meet Ronnie Smith, MD “A Humble Country Doctor” and his team from Vidalia, Georgia

Questions, Discussion, and "Next Steps"

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Thank You for your Participation!

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