In Common Cause for Quality

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“The things that unite us...are more important than the things that divide us.”

Overview

• The sources of pressure for collaboration between hospitals and physicians around quality
• What is a business case for each?
• Debunking the legal mythologies
• How physicians can help hospitals
• How hospitals can help physicians
Sources of Pressure

- The rise of the quality zeitgeist
  - IOM, purchasers, NQF, IHI, Congress
  - The industry of infrastructure support
- Transparency, data, performance measurement
- Patient safety and efficiency
- Pay for performance
- The 100,000 Lives Campaign and tort
A Business Case for Quality

- Does the investing entity realize a financial return in a reasonable time frame, whether actual profit, reduced losses or avoided costs?

- Does the entity believe there is a positive indirect effect on organizational function and sustainability that will accrue within a reasonable time?

  - Leatherman et al.
A Better Concept

Is the intervention consistent with strategic goals, understandable, not too capital intensive relatively speaking, with positive impacts across stakeholders, and able to produce sustainable, acceptable margins, near term and long-term?

–Gosfield and Reinertsen
Why the Physician’s Business Case for Quality Is Critical to the Hospital

- Physician centrality
  - Plenary legal authority
  - Portal to the system

- Their critical and fundamental role in the hospital (AMA Monograph)

- Expertise (Reinertsen’s Axioms)
  - Explain, predict and change patient futures: the healing relationship
The Tensions

- Hospital success turns on physician engagement
- Physicians have their own business problems – reimbursement decreases, malpractice expense increases
- Together they create their own quagmires: economic credentialing, conflict of interest policies, investment in competing enterprises, derailed CPOE initiatives
- “The law won’t let us” be more positive
More Tensions

- Invasion of the body parts snatchers
- Recruiting economic competitors
- “I don’t see those kinds of people”
- “He’s got heads for the beds and knives for hire”
- “It’s not my job to worry about this”
- “We are about market share and bottom line”
How the Medical Staff Plays Today

- Self-governed, autonomized and excluded from real power
- Individualized credentialing
- Barely true review for privileges: only for serial maimers
- Avoidance of NPDB reports: “there but for the grace of God go I”
- Difficult to get a quorum at medical staff meetings
Can this marriage be saved?
The Legal Myths: Stark

- “Everything that benefits physicians financially is prohibited by Stark”
  - No intent necessary; referrals are everything; all hospital services are implicated

- “Fair market value is a number”
  - The new definitions for hourly payments
The Legal Myths: Anti-kickback, Antitrust

- No intent is necessary
  - Requires bad intent
- The safety zones are so narrow
  - There is safety in management services, personal services, bona fide employment, IT safe harbors
- Anything not in a safe harbor is illegal
  - Safe harbors are not the only legitimate relationships
- Antitrust prevents collaboration
  - Not so, stay tuned for clinical integration
New Quality Initiatives That Will Require Physician Engagement

- CPOE
- “Lean” manufacturing
- Flow
  - ICU beds; OR scheduling; getting patients out of ED to floors; getting patients from one department to another
- Redeployment of personnel
  - Hackensack, red lights, rapid response teams
- 100,000 Lives Campaign Six Planks
- Pay for performance and reporting
What Makes Physicians Different?

- Responsibility for individuals
- Accountability for life and death
- Legal captain of the ship
- Collegiality and “groupiness”
- Evidence based, scientific decision-making
- Outcomes and quality improvement feedback (the dynamism of medicine)
- Due process as the scientific method
**Principles of Engagement for All**

- Involve physicians at the earliest stages of initiatives that will affect them
- Identify the real leaders: not always the one with the crown and scepter
- Build trust: Do what you say, say what you do consistently over time
- Communicate openly, frequently, candidly
- Be willing to be held accountable for participation
Principles for Physician Leadership

- Pay attention to process, not structure
- Do something real and meaningful: take a risk
- Don’t let one loud negative voice stop you
- Work across boundaries: you need administrators, and they need you
- Collaborate with other stakeholders (e.g., nurses) in common cause
Physicians Helping Hospitals

- Time is money
- Pay for some things: FMV under Stark
- Doing the work on the quality initiatives
- Medical staff service may be on the list
- Gainsharing: who is helping whom?
- On-call coverage
- Avoiding LaHue-type messes
Hospitals Helping Physicians (Friends With Benefits)

- Give them time
  - Standing order sets
  - Templatized documentation
  - Empowering nurses on the units
  - Standardize processes
- Offer staffing services
  - NPs, PAs, CNSs
Help Them Clinically Integrate

- Not exactly a “safety zone”
- Production of data is part of the point
- It is not the only reason to clinically integrate
- The five principles of UFT-A (www.uft-a.com)
  - Standardize, simplify, make clinically relevant, engage the patients, fix accountability at the locus of control
- Clinicians learning from each other and improving is also part of the point
Otherwise competing physicians can bargain collectively for FFS (and other forms) IF
- They use protocols and/or CPGs to standardize delivery of care
- They engage in internal review and profiling of participating physicians
- They invest in infrastructure with money and time
- They take action against poor performers
- They provide data to payors
- The fee bargain is ancillary to the reason to come together
The Hospital’s Potential Role

- Identify CPGs
- Facilitate access to hospital infrastructure for monitoring
- Help with profiling
- Help construct rates
- Multi-provider network formation
More

- Compliance training exception under Stark
- Information technology support
- Physician recruitment for quality
PROMETHEUS PAYMENT

Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-Reduction, Excellence, Understandability and Sustainability

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Purposes

- Get beyond P4P, which is not sustainable as a payment reform model
- Deal with the toxicities of FFS and capitation
- Reduce administrative burden on physicians
- Pay to deliver the right combination of services according to science
Basic Concepts

- Amount of payment is derived from assessment of projected resources to deliver care in a good CPG
- Negotiated base payment takes into account severity and complexity of patient’s condition
- Bulk of it is paid prospectively
Evidence-based case rate (ECR) encompasses all providers treating a patient for that condition and is allocated among them in accordance with that portion of the CPG they negotiate to deliver.

Comprehensive scorecard measures process, outcomes, patient experience of care, relative efficiency (not in an IDS).
Potential Benefits

- Clinically relevant
- Sustainable as a business model
- Offers certainty in payment amount
- Expects negotiation between providers and plans
- Should reduce admin burden (no E & M bullets, no prior auths, no concurrent review, no postpayment claims audits, maybe no formularies)
- Designed to permit “easy” implementation by plans
• The hospital can help physicians prepare to do this
• They can bid together if they want without anyone holding the other guy’s money unless they want
Conclusion

- Quality is a strategic mission and a measure of success for the enterprise and its executives
- It is the essence of what hospitals and physicians have in common
- It provides leverage for significant new ways of collaborating to meet the business needs of both parties
“The only progress we make in health care is the progress we make in medicine. In the daily chaos that is the U.S. health care system, there are but three elements that matter: patients, caregivers and medical technologies. Everything else is noise.”

−J. D. Kleinke
Resources


Gosfield and Reinertsen, “CPGs: Think Core Concept,” Health Affairs, (May/June 2005) http://content.healthaffairs.org/cgi/content/extract/24/3/885-a
More Resources


FTC MedSouth Staff Opinion on Clinical Integration, http://www.ftc.gov/bc/adops/medsouth.htm


