Washington Association Medical Staff Services

"How to Succeed in the 21st Century Healthcare Transformation"

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Why is the Healthcare Industry going through a One Hundred Year Inflection?

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

Denial is Everywhere!

- "We are in a more conservative market in Washington"
- "We want to be a fast follower" (my contract runs out in two years)
- "We want to be seen as physician friendly"
- "We don't have the capital to invest in a new infrastructure"
- "The current federal administration will put the brakes on alternative payment models"

Ancient wisdom: "If you stay on the same path, you may end up where you are going." Lao Tzu (6th century BC)

Strategic Imperative #1: Cultural Transformation is Necessary and Inevitable

21st Century Bottom Line

- No outcome = no income! Low performers will be acquired by others.
- Are you willing to offer virtual services?
- Are you willing to eliminate non-value added clinical and managerial variation?
- Are you willing to drive down cost structure by 80%-90%?
- Are you willing to compete with the world for national narrow networks and global market share?

Bottom Line: At times of rapid change….

- Cultural transformation is necessary and difficult
- Executives/managers/physicians will need to let go of the 20th century delivery and business models (individual autonomy, volume/piece work etc.)
- Not everyone can adapt to change
- A new culture will attract new participants/leaders and leave others behind

"If the external environment changes faster than you do, you will be out of business." Jack Welch, Former CEO, GE

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

Summary Concepts:

1. You are heading towards a "closed medical staff" where all clinician members of the staff will have a contract with your system to provide world-class quality/safety/service at a fraction of the price.
2. Physicians will become business partners with your system and physicians/nurses will lead your executive team.
3. Everyone will go "at risk" based upon your payer contracts and strategic objectives.

Strategic Imperative #3: Redesign your Medical Staff

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

1. Professionalizing physician leadership
2. Redesign medical staff committee structure
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

Increasing use of Advanced Practice Practitioners

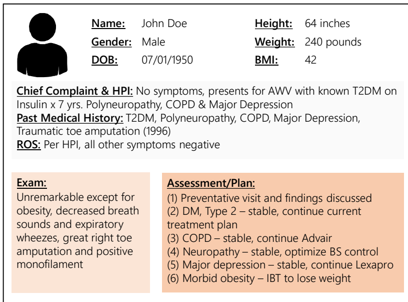
- High volume/low risk assessments and procedures (60%-90% depending upon specialty)
- Primary call coverage with MD/DO backup (what will be the financial impact of this?)
- Documentation oversight and support (histories/physicals, progress notes, discharge summaries, care coordination)
- Align with office/care management
- APP Advisory Committee as a sub-committee of MEC

Four Compelling Reasons why Physicians and Nurses should NOT perform (but rather oversee) clinical documentation

I. $1,000,000/physician and $400,000/nurse opportunity cost
II. 30%-40% opportunity cost for failure to document co-morbidities
III. Impaired Case Mix Index (CMI), Hierarchical Condition Categories (HCCs) which informs annual budget for both inpatient and outpatient
IV. Impaired risk and severity adjustment for all patients enrolled in value-based payer contracts

Ideal Clinical Scribe

- RN or LPN with specialized clinical knowledge in a desired area
- Certified coder!
- Present at point of care to coach team in optimizing specificity of documentation
- Real time documentation and revenue cycle management!



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

Why are Business and Clinical Analytics Essential?

- Reactive (Excel spreadsheets with data) to proactive (actionable information)
- Isolated (silos) to aligned (shared) information
- Confidential to transparent/un-blinded information
- Reflect/analyze to manage/predict/re-design in real time

Improve data capture (Tool: Ambulatory Summary)

Vitals and Measurements

- Adult Ambulatory Care Intake/History
- Ambulatory Vitals Height Weight
- Anticoagulation Patient Intake
- Pediatric Ambulatory Care Intake/History
- PHQ-9
- Diabetes Nurse Intake
- Health Assessment
- Asthma Assessment

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

E-Health: Most Common Uses (How many Americans Access this Care Now?)

- Urgent care (e.g. URI, UTI, rash, flu etc.)
- Chronic medical management
- On demand inpatient consults (e.g. rural areas)
- Emergency department case flow (MSE)
- Home healthcare services
- Post discharge/surgical care
- Behavioral health
- Contribute physicians to national pool

DO YOU HAVE AN APP YET? Healthcare System Apps (UCLA Cedars Sinai Health app by Mobile Smith):

1. **General Information:** map, directions, accepted insurance, phone numbers (tap to call)
2. **Services:** directory of services and providers (tap to call/e-mail)
3. **Virtual Tour:** 360-degree tour of rooms, maps and access information, times of operation
4. **ER Wait Times:** dynamic wait times for all facilities
5. **Interactive gallery, events, and social media:** streaming content and interactivity

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

Is there a difference in performance when physicians and staff work 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%
30 Day Readmissions	5.92% (43%)	10.38%
Mortality	1.95% (23%)	2.52%

Third party payers are moving forward

What AETNA did when it saw this data:

1. Requested to negotiate a new contract with MHMD
2. Offered a 8% **increase** in FFS payment with a guarantee of 3% next year minimum
3. With 10% movement of 'share' to the system, committed **$7.5 million to physician pool** and $8.0 million to system pool in bonuses
4. Committed to invest in a comprehensive marketing program to compete with United and BCBS

The New Reality

1. Average performance is not enough
2. Bottom decile performers will subsidize top decile performers
3. Top decile performers will earn disproportionate market share
4. Physicians and Management and Stakeholders must lead clinical + operational + financial performance together
5. Physician-Management-Stakeholder collaboration is *the* engine to get you there!

Profitability Analysis –
Top 10 Service Lines Based on Cases

Group Item	Cases	ALOS	CMI	Total Charge	Actual Payment	Variable Cost	Contrib Margin	Fixed Cost	Net Income
- Cardiology	762	3.93	1.1831	$33,047	$10,434	$4,629	$5,806	$4,132	$1,674
- Pulmonary	550	4.82	1.0604	$24,490	$7,325	$3,094	$4,231	$3,367	$865
- Gastroenterology	409	4.08	0.9821	$22,316	$8,606	$2,603	$6,003	$3,125	$2,878
- Orthopedics	333	5.03	1.5032	$41,769	$15,453	$6,525	$8,928	$5,472	$3,456
- Neurology	211	4.84	1.0767	$30,755	$10,422	$3,539	$6,883	$3,982	$2,901
- Oncology	78	6.26	1.5324	$40,191	$12,856	$5,440	$7,416	$5,326	$2,090
- Open Heart	71	7.62	4.4933	$99,785	$36,582	$16,118	$20,463	$13,090	$7,374
- Neurosurgery	62	5.95	2.5563	$107,339	$56,313	$19,907	$36,406	$14,459	$21,947
- Thoracic Surgery	39	16.08	8.2561	$171,837	$67,212	$24,448	$42,764	$23,492	$19,272
- Oncology Surgery	25	6.88	2.3670	$80,085	$31,316	$11,583	$19,733	$11,811	$7,922
Total:	2,540	4.80	1.4143	$36,912	$13,126	$5,220	$7,906	$4,879	$3,027

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

Profitability Analysis – Pulmonary Service Line – DRG Profile

MS-DRG	Cases	ALOS	CMI	Total Charge	Actual Payment	Variable Cost	Contrib Margin	Fixed Cost	Net Income
193 - Simple pneumonia & pleurisy w MCC	174	5.51	1.1291	$26,671	$7,579	$3,423	$4,156	$3,664	$492
192 - Chronic obstructive pulmonary disease w/o CC/MCC	160	4.42	0.9557	$21,604	$5,547	$2,680	$2,867	$2,916	($49)
202 - Bronchitis & asthma w CC/MCC	44	3.34	0.8093	$16,879	$5,154	$2,039	$3,115	$2,274	$841
177 - Respiratory infections & inflammations w MCC	32	8.63	1.7331	$44,912	$11,045	$5,891	$5,154	$6,196	($1,042)
203 - Bronchitis & asthma w/o CC/MCC	29	2.21	0.6199	$13,212	$6,396	$1,473	$4,922	$1,641	$3,281
189 - Pulmonary edema & respiratory failure	28	5.71	1.5310	$35,841	$11,874	$4,736	$7,137	$5,408	$1,729
176 - Pulmonary embolism w/o MCC	17	6.06	1.3229	$35,974	$15,370	$4,510	$10,860	$4,965	$5,896
204 - Respiratory signs & symptoms	14	3.00	0.6386	$20,350	$3,970	$2,190	$1,780	$2,538	($758)
205 - Other respiratory system diagnoses w MCC	12	4.83	0.9106	$19,355	$7,097	$2,607	$4,490	$2,866	$1,624
194 - Simple pneumonia & pleurisy w CC	12	2.00	0.7043	$11,445	$9,413	$1,434	$7,979	$1,556	$6,423
Total:	550	4.82	1.0604	$24,490	$7,325	$3,094	$4,231	$3,367	$865

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

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

Cost Accounting Analytics – Cost Variance Analysis to Best Practice

Physician	Total Cases	ALOS	CMI	Xrays/Case	Dir Var Cost/Case	% ED Cases	% Re-Admits	% Disch-Home	% Disch-Other
MULLA	10	4.80	1.1291	2.00	$3,969	50.0	30.0	70.0	30.0
NIASH	7	4.00	0.7054	0.86	$3,369	28.6	14.3	85.7	14.3
HAVZL	6	5.17	1.1291	1.00	$4,239	83.3	0.0	50.0	50.0
BHAAS	5	2.40	0.7054	1.60	$2,863	80.0	0.0	100.0	0.0
MULKE	5	7.40	1.1291	1.20	$4,922	100.0	0.0	60.0	40.0
NEMST	5	7.40	1.1291	1.80	$4,638	60.0	20.0	60.0	40.0
AHSAZ	4	5.25	1.1291	1.25	$4,500	75.0	25.0	50.0	50.0
AKIMU	4	2.00	0.7054	1.00	$2,272	100.0	0.0	100.0	0.0
CHIUG	4	2.25	0.7054	0.75	$2,919	100.0	0.0	100.0	0.0
KABNO	4	8.50	1.1291	2.75	$5,715	75.0	25.0	25.0	75.0
Total:	178	4.58	1.0148	1.30	$3,651	74.2	12.9	70.8	29.2

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

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What if 6 of the Top 10 physicians achieved a Direct Variable "cost per case" equal to the BEST PRACTICE of their peers?

Cost Reduction

- $2,251 – Cost Reduction per Case
- 50% - Cost Reduction %
- $76,534 – Total Cost Reduction

Increase in Quality

- 100% – Reduction in Re-Admissions
- 79% - Increase in Home Discharges

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

Why all the fuss about service? That's not our job!

"I'm here to save your ass; not to kiss it."

Liz Jazwiec, RN
Former ED Nurse Manager
Current Studer Group National Speaker

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%)
- Enhanced reputation and market share (think Apple/Harley-Davidson)
- Measurable quality outcomes

A simple truth: People who entrust their care to you are both PATIENTS and CUSTOMERS:

PATIENTS (10%-20%) = acute + dependent on clinician (more satisfying) + time sensitive + greater clarity in decision making (e.g. less choice) + technical expertise required + horizontal

CUSTOMERS (80%-90%) = less acute + more independent (less satisfying) + less time sensitive and more ongoing + less clarity in decision making (e.g. more choice) + service expertise required + vertical

"Best Practices"

1. Service orientation and training for everyone!
2. Empowered service recovery at ALL levels of the organization (this is not a management function)
3. Customized scripts (particularly for high risk situations: conflict, unexpected poor outcomes, unprofessional conduct etc.)
4. Service plan for all customers, patients, partners, stakeholders
5. Focus on the 'service' diagnosis and not merely the 'clinical' diagnosis (hint: it has a far greater impact!)

Strategic Imperative #7: Collaborate to Continuously Reduce Operating Costs

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."

Optimize Supply Chain:
There is wide-spread 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!

Interdisciplinary Value Analysis Committee

Best Practice: University of California, San Francisco-

Health Technology Assessment Program (HTAP):

- Executive Management and Physician Leadership
- Criteria for investment or utilization cost that triggers committee evaluation
- Evaluation of supply chain cost and clinical implications of decisions
- Recommendations carry throughout the organization

Strategic Imperative #8: Build a Population Health Infrastructure

Disproportionate Costs…The Foundation for Population Health

- Top 1% make up 23% of healthcare costs (life threatening conditions)(>$90K/year)
- Top 5% make up 49% of healthcare costs (multiple significant 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)

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

Population Health Contracting Methodology:

1. Identify a population of covered lives
2. Develop clinical and business analytics to assess clinical and financial risk
3. Risk stratify all covered lives into functional sub-populations
4. Develop a clinical and business plan to address each sub-population's targeted outcomes
5. Monitor, measure, and modify plans

3. Risk Stratify All Covered Lives into Functional Sub-Populations

Sub-Population	% of the Population	% of Cost	Annual Cost (2023)
Advanced Illness	3%	29%	$54,444
Multiple Chronic Illnesses	7%	23%	$14,232
At Risk	10%	19%	$7,728
Stable	30%	22%	$3,168
Healthy	50%	7%	$660

4. Develop a Clinical and Business Plan to Address each Sub-Population's Targeted Outcomes:

Advanced Illness: palliative care program and intensive disease management, home health

Multiple Chronic Diseases: intensive disease management, nurse navigator (UM/RM), medical home, monitor clinical/business analytics, home health

Chronic Disease and At Risk: medical home, registry, nurse navigator, home health, facilitated networks

Healthy: Tele-health with apps, retail outlets to manage minor acute episodes, personalized health maintenance

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

Stage the Transition from FFS to Risk Based Contracting:

1. **Align with all key facilities and providers <u>before everything</u>**
2. Build the integrated network **<u>together</u>** (all solutions must make **clinical and operational** sense)
3. Focus on opportunities to lower cost structure **<u>first</u>** (labor, supply chain, palliative care, inpatient disease management) **(MUST HAVE ANALYTICS!)**
4. Grow new sources of revenue **<u>second</u>** (e-health solutions, contracts for domestic/international medical tourism, focused factories, solution shops etc.)
5. Grow the ambulatory population health infrastructure **<u>third</u>** 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 **<u>last</u>** and focus completely on health optimization and prevention of disease

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**

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!

A sobering thought….

"If you don't like change, you are going to like irrelevance even less."

----General Eric Shinseki,

Former Chief of Staff, US Army and Secretary of Veteran Affairs, VA Hospital System

Questions, Discussion, and "Next Steps": What are your Biggest "Takeaways" from this program?

Thank You for your Participation!

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