Washington Association Medical Staff Services

"Physician Engagement and Alignment-What Works and What Doesn't"

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Methodology: All Steps Require Collaboration

1. Align with all key physicians/practitioners first!
2. Hard wire regulatory quality into your system (requires physician approval and support)
3. Establish strategic quality goals/objectives (quality plan) consistent with your organization's strategic plan
4. Monetize those goals/objectives and create a pareto diagram to identify the 'vital few'
5. Create aligned co-management agreements with ALL employed/self-employed physicians/practitioners and stakeholders with a calculable ROI

1. Align with all Physicians and Strategic Partners First

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What is Alignment?

Self-Interests:

When physicians', managements', payers, and 'governing boards' self interests overlap with organizational interests in a synergistic and mutually beneficial way.

Litmus Test: What % of physicians' total compensation is alignment with organizational goals/objectives?

What is Engagement?

Pride of Ownership:

Who controls the strategy of the organization and the budget?

Litmus Test: If physicians believe that it is management, there is no engagement

Malalignment is Everywhere!

- Employment and 'pay for call' ≠ alignment!
- What are your organization's key strategic goals/objectives for 2024-2025?
- How do you currently compensate your employed and contracted physicians?

What is the Impact of RVU Compensation on….

- Quality?
- Safety?
- Service?
- LOS?
- Documentation (revenue cycle)?
- Readmissions?
- Cost per case?
- Operating costs?
- Margin?

A better approach to utilize productivity: utilize wRVUs as eligibility benchmarks, not as direct incentives

- To receive 50%tile MGMA compensation, must at least achieve 25%tile MGMA wRVUs
- To receive 75%tile MGMA compensation, must at least achieve 50%tile MGMA wRVUs
- To receive 90%tile MGMA compensation, must at least achieve 75%tile MGMA wRVUs

Fundamental Principles of Engagement and Alignment

I. **Cultural alignment (the relationship) precedes….**

II. **Economic alignment (the contract) precedes…**

III. **Clinical alignment (at risk contracts)**

What are the 'relationship' issues?

- Organizational 'fit' and personal/professional values (e.g. autonomy, independence)
- Willingness to embrace evidence-based medicine (EBM) and standardize routine processes and procedures
- Willingness to adopt high standards of professional conduct and communication
- Willingness to accept 'risk contracting' to create value added services
- Willing to treat everyone with civility and respect!

Physician Relationship Management (PRM) Program-The Foundation for any Successful Alignment Strategy

Based upon the customer relationship management (CRM) principle: a disproportionately small number of customers make up a disproportionately high share of profits.

Hence, segmented marketing.

PRM: How it Works….

- Each member of the management team serves as a PRM leader
- Each manager responsible for a small number of relationships (e.g. 6)
- Physicians are assigned based upon quantitative (e.g. revenue/volume) and qualitative data (e.g. formal and informal leadership)
- PRM leaders meet with physicians quarterly in their offices

What are the non-negotiable quid pro quos of such a partnership?

- Standardize regulatory quality, safety, service and cost effectiveness
- Work with management to drive down operating costs
- Work with management to achieve strategic goals/objectives (e.g. service culture, population health etc.)

Key Components of 'At Risk' Contracts with Physicians (Intermountain Health):

I. Be willing to participate in 'at risk' contracts based upon strategic goals/objectives developed and approved by physicians and management
II. Comply with clinical and business 'best practices' as determined by peer group/management (and be willing to be peer audited for exceptions)
III. Agree to un-blinded transparency of all clinical and financial data/analytics
IV. Be willing to comply with value analysis process
V. Disclose all potential conflicts of interest and accept determination of deliberative physician bodies

Physicians Can and Cannot Act like Regular Employees

- Contractual obligations do not transcend professional fiduciary responsibilities to patients
- Employment ≠ Alignment
- Partnership (respect) works better than hierarchy
- Performance management objectives/goals should be negotiated collectively and individually!

Errors to Avoid with Physician Employment

- Lack of a strategic and business plan!
- No downside risk in compensation
- Lack of partnership and ownership
- Not account for ancillary revenues
- Over allocate overhead and labor/supply chain costs to medical group
- Lack of good physician and managerial leadership
- Lack of physician participation in governance, management, and budgeting
- Lack of aligned performance objectives

Best Practices for Physician Employment:

- Duplicate the 'private practice' model throughout the enterprise (think of every employment as a separate business unit!)
- Give employed physicians opportunities for financial and professional growth
- Share all important decision-making processes
- Support STRONG physician leadership (physician to physician accountability)
- Give them the keys to the car! (P and L)

To Recapitulate….

1. Cultural alignment (the relationship) precedes….
2. Economic alignment (the contract) precedes…
3. Clinical alignment (at risk contracts)

2. Hardwire Regulatory Quality into your System

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What is Regulatory Quality?

I. HEDIS measures
II. Value Based Purchasing measures
III. STS measures
IV. HCAPHS, CAPHS
V. "Never Events"
VI. Metrics imposed by insurers and health plans
VII. MIPs
VIII. CMI/HCC

Hardwire Regulatory Quality!

- Clinical and functional pathways
- Standardize communications (e.g. SBAR) in high-risk situations
- Decision support software and default functions
- Clinical and business analytics to monitor for variance (audit!)
- Many organizations are hitting 100% all the time!

3. Create a Strategic Quality Plan

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What did we learn from "Money Ball?"

"In order to buy wins, you have to buy runs. In order to buy runs, you have to buy players that get on base."

A small number of quality/safety/service/cost metrics carry disproportionate weight.

Focus on the "vital few"!

4. Monetize Strategic Quality into a Pareto Diagram to Determine Strategic Priorities (the "vital few")

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Obvious ROIs for your organization: What would be the impact on cash flow (and clinical outcomes) if Physicians could lead the:

- Reduction of LOS by 1 day?
- Increase the CMI by 0.2?
- Reduction of adjusted cost/case by 5%?
- Optimization of top box HCAHPS scores?
- Reduction of clinical morbidity/mortality by 5%-10%?
- Eliminate that disruptive individual costing the organization so much time and money?
- Reduce the labor and supply chain ratios?

BUT what is each metric worth?

Please Assume that you are a healthcare system with $1,000,000,000 in operating revenues and:

- Medicare Part A revenue of $500,000,000
- Medicare Part B revenue of $100,000,000
- Average length of stay of 5 days with 10% of total costs generated in the final day and average expenses of $1,000/day (total of 80,000 patients)
- CMI of 1.7 with Medicare base rate of $7,000 and DRG weight of 1.7 with 40,000 Medicare patients
- Labor ratio of 60%
- Supply chain ratio of 20%
- Net operating margin of 4%

Please Monetize for your 'Organization' the Estimated Dollar Value for the following:

- Reduction of ALOS by 1 day
- Increase the CMI by 0.2
- Optimization of value-based purchasing from 'average' to 'top decile'
- Increase your MIPS from 'average' to 'top decile' (2024)
- Decrease your labor ratio from 60% to 55%
- Decrease your supply chain ratio from 20% to 17%
- Reduce your cost per case by 10% (total 80,000 patients)

Calculations

Decrease LOS by 1 day = $500 costs (10% of $5,000) X 80,000 patients = $40,000,000 cost savings

Increase CMI by 0.2 = $7,000 Medicare payment X 40,000 Medicare patients = $280,000,000; 1.11764706 (1.9/1.7) X $280,000,000 = $312,941,176 or $32,941,176.50 incremental revenue

Increase VBP by 1% = $500,000,000 Medicare part A revenue X 1.01 = $5,000,000 incremental revenue

Calculations (continued)

- Increase MIPS from average to tope decile = $100,000,000 Medicare part B revenue X 1.09 = $9,000,000 incremental revenue
- Decrease your labor ratio 5% = $40,000,000 (net operating margin) + $50,000,000 (5% of $1B) = $90,000,000 (new net operating margin) with = $50,000,000 (incremental revenue)
- Decrease your supply chain ratio 3% = $30,000,000 incremental revenue
- Reduce your cost per case by 10% = $500 (10% of $5,000) X 80,000 patients= $40,000,000 cost savings

Pareto Chart to Prioritize (first five make up > 95% of total):

Decrease your labor ratio 5% = $50,000,000
Reduce your cost per case by 10% = $40,000,000
Decrease LOS by 1 day = $40,000,000
Increase CMI by 0.2 =$32,941,176.50
Decrease your supply chain ratio 3% = $30,000,000
Increase MIPS by 4% = $9,000,000
Increase VBP by 1% = $5,000,000

TOTAL NEW REVENUE: $177,294,116 (How many new patients did the organization see in order to achieve this?)

5. Create aligned Co-Management Agreements with Calculable ROIs

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Co-Management Agreements

Partnering physician and managerial leaders to oversee inpatient/outpatient services, ancillary, multi-site specialty care (exclusives), service lines, clinical institutes, and enterprises for performance in:

- Quality
- Cost savings
- Service
- Safety
- Efficiency
- Marketing/branding

Give Physicians a Choice to go 'At Risk':

90%tile MGMA

75%tile MGMA

50%tile MGMA: Minimum wRVU, quality, safety, service, cost-effectiveness expectations with a potential downside

25%tile MGMA

10%tile MGMA

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 an 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)

ROI = $1.6 million new revenue/$100,000 cost = 16:1

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

1. Above average wRVUs (75%tile MGMA) (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 3:1 ($3.9M incremental margin to system)!

Perspective from the Ages….

"Excellence is never an accident. It is always the result of high intention, sincere effort, and intelligent execution; it represents the wise choice of many alternatives - choice, not chance, determines your destiny."

--Aristotle (384-322 BC)

Questions and Discussions

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Thank You for your Participation!

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