Beyond the Walls of the Hospital:
Governance Oversight of Quality and Safety for a Health System

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A Future Scenario

- Your hospital has a high readmission rate, and gets a big financial penalty in 2013
- In response, your administrators and physicians design, test, and implement an effective “high risk readmission” program
- The medical staff and Board adopt a policy requiring all doctors to use it
- Dr. Wright, a high volume primary care doctor, refuses
A Future Scenario, contd.

- Dr. Wright’s reasons for refusing:
  - “The hospital has no right to tell me how to practice in my office.”
  - “Nurses are going to steal my patients.”
  - “I have never liked the specialist who sold out to the hospital and is now the medical director of the readmission program.”
  - “I haven’t followed stupid hospital rules for the past 16 years, and nothing bad ever happened.”

A Future Scenario, contd.

- After a series of high-profile readmissions of Dr. Wright’s patients, and his continued refusal to use the program despite warnings, the medical staff recommends to the board that Dr. Wright’s admission privileges be suspended.
- Dr. Wright sends a letter to the board warning them of his intent to sue the hospital “for everything it’s worth” if he is suspended.
The Board Meeting
What Are You, As the Board, Going to Do?

- What action will you take on the medical staff’s recommendation?
  - Would your options be any different if Dr. Wright were employed by the health system?
  - Would your options be any different if Dr. Wright were a member of your “ACO?”
- Looking back, what opportunities did you have as a board, to prevent this blow-up?


Percentages of Active U.S. Primary Care Physicians (PCPs) and Specialist Physicians Employed by Hospitals, 2000–2012.


Two Doctors Talk on a Plane

“Are you going to accept the hospital’s offer?”

“I’m thinking about it, but I really value my autonomy. Tell me, how has it worked for you? Do you have to do everything they tell you? Do you have, like…a boss?”

“No way! I’m doing what I’ve always done, my own way. There are no bosses in my life. Basically, I got financial security without giving up any autonomy! You should do this!”
Some Facts About Employing Doctors

- Hospitals lose $150-250K per year for 1st 3 years, and $75-150K thereafter.
- In many instances, you’ve been getting the volumes from these doctors all along, **without** paying for them.
- Relationships don’t improve just because you now sign their paycheck.
  - Would you want every independent doctor now on staff to come onto your payroll?

Non-Financial Risks of Employing Your Own Doctors

- Employment creates a “two-class” medical staff, with implications for…
  - Credentialing and privileging
  - Board representation
  - …etc.
- There’s a lot of work involved! Employment **by itself** doesn’t lead automatically to
  - Standardized practice
  - Coordinated care and referrals
  - Improved quality, safety, and value
So Why Would a Hospital Rush to Employ Doctors?

- Scenario 1: Old business model and pricing power
  - AG Martha Coakley: “In Massachusetts, high prices and price variation are largely correlated with market share.”
  - Carilion, Roanoke, and the $4,727 colonoscopy
  - Favors employment of specialists
- Scenario 2: New business models
  - Bundled payment, responsibility for populations, accountable care, Triple Aim...
  - Favors primary care employment
- Other
  - Power struggles within health care
    - Who will wind up on top? Plans, hospitals, or doctor groups?
    - And if all other arguments fail… “If we don’t, the other hospital will.”

If you’re going to employ doctors, do it in a way that achieves **true clinical integration**:

> “Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.”

Achieving Clinical Integration with Highly Engaged Physicians

By

Alice G. Gosfield, J.D.
and
James L. Reinertsen, M.D.

Strategic Tensions in Clinical Integration

Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About

Capsules THE KHN BLOG

Survey: Few ACOs Ready For Financial Risk

By Jenny Gold

Few hospitals interested in becoming accountable care organizations are ready to take on financial risk, according to a survey released Friday from The Commonwealth Fund.
A Cynic’s View of the Historical Business Model for Aetna, United, WellPoint…

Contract with the existing messy health care delivery system, sell a card that allows access to that messy system, collect the money, and delay paying those who actually deliver services as long as possible… without actually changing anything significant about the rate of growth of costs, or the quality of care…

(…but causing mind-boggling administrative burdens for everyone)

Does the insurance card you carry have anything to do with the quality of your care?

http://www.youtube.com/user/UnitedHealthcare?v=8O1i0InZ8bM&feature=pyv&ad=15332119071&kw=united%20health
Why did Partners do this?

Why did Park Nicollet want to join with a health insurer, again?

2 giants - HealthPartners, Park Nicollet - plan to merge

Two of the Twin Cities' most prominent health care systems, HealthPartners and Park Nicollet, have signed an agreement to join operations, marking the biggest merger in the local health care market in two decades.

If approved by state and federal regulators, the merger would create the state's second-largest hospital system by revenue, behind the Mayo Clinic in Rochester, and combine two organizations with storied traditions in Twin Cities medical care.
Anthem Blue Cross after proposing 39% rate hikes: “We can’t do anything about the rapidly increasing costs of delivering care.”

*Without care delivery, this emperor has no clothes.*

The Real Strategic Opportunity in Accountable Care

If providers in a community were to work together systematically to achieve the Triple Aim (in particular, to prevent complications and reduce overused services), the traditional health insurance model would be seriously threatened.

*“Do it for yourselves, or have it done unto you”*
Where is Your Practice, or Your Healthcare System, on These Two Curves?

Volume Drives Success

Value Drives Success

Clinical Model
- Episodic Care → Coordinated Care → Patient Directed Care

Business Model
- Fee for Service → Bundled Payment/Capitation → Disruptive Innovation?

Infrastructure
- Segmented → Integrated → Cloud

Adapted from The Second Curve, Ian Morrison 1996

Are you capable of moving to a value-driven business model?

Environmental Feature
- Value-based purchasing
  - Core Measures
  - SCIP
  - Primary Care Chronic Disease Pay for Performance

Capabilities Required
- Process improvement
- Reliability Science
- Coding, Documentation and Measurement across a broad spectrum of practices (EHR)
- Chronic Disease Registries
- Wagner Chronic Disease Model
Are you capable of moving to a value-driven business model?

<table>
<thead>
<tr>
<th>Environmental Feature</th>
<th>Capabilities Required</th>
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<tbody>
<tr>
<td>Penalties for Healthcare-Acquired Conditions and Safety Events</td>
<td>All of the above plus...</td>
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<tr>
<td>- Infections</td>
<td>- Comprehensive Approach to Safety</td>
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<td>- Decubiti and Falls</td>
<td>- Blunt End Leadership and Management</td>
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<tr>
<td>- Medication Errors</td>
<td>- Sharp End Accountability</td>
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<tr>
<td>- Surgical Complications</td>
<td>- Safety Culture</td>
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<td>- Readmissions</td>
<td>- High Risk Clinics and Nurse Management Programs</td>
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<td>- AHRQ and CMS &quot;never events&quot;</td>
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<td>Bundled Payment: Episode-based budgets or payments for</td>
<td>All of the above plus...</td>
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<tr>
<td>- Elective Procedures e.g. hip and knee arthroplasty, bariatric surgery, 30 days prior to 6 months after...</td>
<td>- Clinical integration with the necessary professionals and services</td>
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<tr>
<td>- Acute Illnesses e.g. AMI, pneumonia, CHF...3 days prior to 30 days after...</td>
<td>- Knowledge of where your current costs and &quot;potentially avoidable complications&quot; are occurring</td>
</tr>
<tr>
<td>- Chronic Illnesses e.g. a year’s care for diabetes...</td>
<td>- Ability to reduce unnecessary costs and PACs</td>
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<td>- All part A and B, SNF, ...</td>
<td>- Patient-centered re-design of services</td>
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<td>- Control of service capacity</td>
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<td>- Coordination of referrals and &quot;outside contractors&quot;</td>
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<td>- Ability to accept and distribute bundled payments</td>
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<td>- Alignment of individual provider performance feedback and incentives with bundled payment business model</td>
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An example: specialty compensation system that drives value, not volume

- All specialists paid salary set at 70th %tile of compensation survey
- All specialists paid the same, regardless of RVU’s generated
- Field report:
  - “Our specialists are fairly aggressive about consulting, and will tell a referring physician to get a different test, or send the patient to a different specialty, or simply wait and watch, if they think it’s a better idea. They have no volume incentive, so they can focus on what’s right for the patient, not their paycheck.”

Are you capable of moving to a value-driven business model?

Environmental Feature
- ACOs and other “population health” models
  - Attributed costs for a population of patients
  - Capitation

Capabilities Required
- All of the above plus...
- Clear understanding of actuarial “incidence risk”
- Reserves
- Enrollment and communication systems for communities
- “Public health” and disease prevention systems
A Self-Assessment on “Clinical Integration”

(Free Tool Available at http://uft-a.com/CISAT.pdf)

Table Exercise Using the Clinical Integration Self-Assessment Tool

- At your table, describe your health care system’s stage of clinical integration for these three attributes:
  - Standardization, guidelines and protocols
  - Referrals and care coordination
  - Teamwork
- How many of you are “committed and capable?” What could others learn from you?
- What are you struggling with?
**Clinical Integration Assessment Tool**

**OPERATIONS: Standardization: Guidelines and Protocols**

<table>
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<tr>
<th>Not Really in the Game</th>
<th>Getting Started</th>
<th>Fully Capable</th>
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<tr>
<td>We don't evaluate physicians for their economic performance, nor do we require standardization for privileging in the hospital or participation in our ACO.</td>
<td>A few clinics and some employed practices have adopted guidelines and some standing order sets, but they are not an expectation of all physicians in the system.</td>
<td>Standardization is an expectation of all physicians, is taken into account in credentialing and privileging and those who cannot conform or actively resist have their privileges and/or ACO contracts terminated.</td>
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**Clinical Integration Assessment Tool**

**OPERATIONS: Standardization: Referrals and Care Coordination**

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<td>The physicians are free-range chickens and refer wherever they want. We can’t really control that. We have no knowledge of how well this is working, from either a quality or cost standpoint. Why should we? This is the health plans’ problem.</td>
<td>We have a list of preferred physicians to whom our “integrated” physicians are supposed to refer, but it’s not mandatory. (The “preferred” doctors take call here and that’s why they’re “preferred.” We have no actual data on their quality or cost.)</td>
<td>As an integrated organization we require that our employed physicians and those with services agreements with us (e.g., co-management) refer to our specified list of providers, which is developed based on specific performance criteria for quality and cost. We actively share performance data with these referral providers, and they have a stake in our bundled payments and other value-based performance contracts.</td>
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**FEELING: Culture and Values: Teamwork**

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<td>We have no stated expectations for professional team behavior. There are a number of jerks in the system but they're technically OK and productive, so we tolerate them, as long as there are no actual physical assaults.</td>
<td>Teamwork is a stated value, and clearly described as an expectation in employment and ACO participation agreements, but it really isn't translated into action or systems e.g. recruiting criteria, regular performance feedback, or compensation.</td>
<td>Teamwork is a stated value. We specifically recruit for teamwork and respectful professional behavior. Jerks are not tolerated, regardless of how technically proficient or productive they are.</td>
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**The Four F's**

- **Form**
  - The doctors work in our building
  - We employ/partner with the doctors
  - Community ownership

- **Finance**
  - Individual FFS
  - Evidence-based case rates, bundled payments...
  - Population-based budgets

- **Function**
  - High quality care for individual acute and chronic patients
  - High value care for specific sets of acute and chronic disease patients
  - The Triple Aim: High value care for populations

- **Feeling**
  - Individual responsibility and autonomy
  - Team accountability
  - Patient and family empowerment
  - Care team, patient, and community responsibility for health
“Leaders must emerge who regard themselves as defenders not of organizations but of the underlying purposes that have temporarily created those organizations in their current forms. Leaders will have to be willing to unmake the very organizations they hold in trust. That’s a big job. It requires a kind of courage that is rare among human beings, including organizational leaders.”

Don Berwick MD
“Seeking Systemness,”
Healthcare Forum Journal, March/April 1992

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Taking Action on Today’s Learning

- **Personal Planning (3 minutes)**
  - List 3 actions you plan to take with your board to improve oversight of quality and safety

- **Table Conversation (12 minutes)**
  - Share your planned actions at your table