How to Engage Physicians in Best Practices to Respond to Health Care Transformation

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What Leaders Do

• Establish a vision that can inspire others
  – Environmental assessment of opportunities, risks, challenges
• Translate the vision into strategies & tactics
• Assign responsibilities to the right people
• Hold the assigned people accountable
Managing Complex Change

CHANGE

Confusion

Anxiety

Gradual Change

Frustration

False Starts

Vision → Skills → Incentives or Consequences → Resources → Action Plan

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Vision → Skills → Incentives or Consequences → Resources → Action Plan
2015 Health Care Trends

- Consolidation
- Patient-centered
- Payment Reform
- Big Data PA
- Population Health

- Transparency
- Accountability
- Risk Transfer
- Technology
- High Cost Drugs
Old

• Sickness System
• Health: No Disease
• Acute Disease
• Fee for Service
• Hospital Beds Full
• Hospital Centric
• Doctor Centric
• Doctor Decides
• MD defines quality

New

• Wellness System
• Health: Wellness
• Chronic Disease
• Value Based
• Hospital Beds Empty
• Community Centric
• Patient Centric
• Shared Dec Making
• Measurable Metrics
<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost not considered</td>
<td>Decreased cost</td>
</tr>
<tr>
<td>Independent doctors</td>
<td>Employed docs</td>
</tr>
<tr>
<td>Independent hospital</td>
<td>Integrated system</td>
</tr>
<tr>
<td>Med record secret</td>
<td>Open access record</td>
</tr>
<tr>
<td>Opaque</td>
<td>Transparent</td>
</tr>
<tr>
<td>Artificial harmony</td>
<td>Cognitive conflict</td>
</tr>
<tr>
<td>Analogue</td>
<td>Digital</td>
</tr>
<tr>
<td>Hypothesis driven clinical trials</td>
<td>Predictive analytics actionable correlations</td>
</tr>
</tbody>
</table>
“I think my job ultimately is to close every one of our hospitals. Because we should take care of you at home. We should take care of you at school. Nobody wants to go to the hospital. We really need to work to keep people healthy. Now, people will still get hit by cars, and there’ll be complex surgeries that require hospitalizations. But I’m trying to put myself out of business.”
Payment Reform
The Curve

First Curve
Fee-for-Service
Quality Not Rewarded
Pay for Volume
Fragmented Care
Acute Hospital Focus
Stand Alone Providers Thrive

Second Curve
Value Payment
Continuity of Care Required
Systems of Care
Providers at Risk for Payment
IT Centric
Physician Alignment

Straddle
Revenue Drops
Minimal Reward for Quality
Volume Decreases
No Decisive Payment Change
Pay for Volume Continues
High Cost IT Infrastructure
Physicians in Disarray
Delivery System Reform

Fee for Service  Shared Savings  Bundled Payments  Partial Capitation  Global Payment

Reactive

Visitor
Symptomatic
Acute Needs
Services & Supplies
Unit Based
No Financial Risk

Focused

Patient
Episode
Most Common Conditions
Packaged Treatments
Efficiency Based
Partial Financial Risk

Predictive

Person
Overall Health
Community Health Characteristics
Manage Well Being
Outcome Based
Full Financial Risk
A Promise from HHS

“Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018.”

“Our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018.”

Source: HHS Secretary Sylvia Burwell (January 30, 2015)
The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured*

Zack Cooper, Yale University
Stuart Craig, University of Pennsylvania
Martin Gaynor, Carnegie Mellon
John Van Reenen, London School of Economics

December 2015

www.healthcarepricingproject.org

*This research received financial support from the Commonwealth Fund, the National Institute for Health Care Management, and the Economic and Social Science Research Council.
Medicare

Medicare spending per capita
Private insurance spending per capita
Introduction

• The US spends more than other nations on health care—$2.8 trillion dollars (17.2% of GDP)—without evidence of better outcomes

• Wide ranging analysis of variation in health care spending via Medicare suggests quantity of care given drives spending variation

• However, results may not generalize to private markets where prices are not set administratively

• However, almost no nation-wide hospital-specific price data and scant data on spending for privately insured
Key Findings – Price Plays Crucial Role in Spending by Privately Insured

1. Low correlation (0.140) between Medicare and private spending per person;

2. Price explains large portion of national variation in inpatient private spending;

3. Substantial variation in prices, both within and across markets;

4. Higher hospital market concentration is associated with higher hospital prices;
Overview of the HCCCI Data

• Claims level data from the Health Care Cost Institute

• Includes ESI claims from Aetna, UnitedHealth Group, and Humana for individuals with coverage from 2007 – 2011;
  • 88.7 million unique individuals;
  • Covers approximately 27.6% of Americans with ESI

• Data includes the price providers charged, the negotiated contribution of the payers, and the contribution of patients via co-payments and co-insurance;

• Able to link to a wide array of external data
Medicare Spending Per Beneficiary and Private Spending Per Beneficiary

![Graph showing Medicare and private spending per beneficiary. The x-axis represents Overall Medicare Spending per Beneficiary Rank, ranging from 0 to 300. The y-axis represents Overall Private Spending per Beneficiary Rank, also ranging from 0 to 300. The graph includes points for Grand Junction, CO, Rochester, MN, and La Crosse, WI.](image-url)
### Knee Replacement Facility Prices

<table>
<thead>
<tr>
<th>Location</th>
<th>Min/Max Ratio</th>
<th>Gini</th>
<th>CoV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denver, CO</td>
<td>3.09</td>
<td>0.190</td>
<td>0.362</td>
</tr>
<tr>
<td>Atlanta, GA</td>
<td>6.10</td>
<td>0.170</td>
<td>0.316</td>
</tr>
<tr>
<td>Manhattan, NY</td>
<td>2.10</td>
<td>0.125</td>
<td>0.260</td>
</tr>
<tr>
<td>Columbus, OH</td>
<td>2.77</td>
<td>0.121</td>
<td>0.262</td>
</tr>
<tr>
<td>Philadelphia, PA</td>
<td>2.94</td>
<td>0.162</td>
<td>0.292</td>
</tr>
<tr>
<td>Houston, TX</td>
<td>5.42</td>
<td>0.167</td>
<td>0.304</td>
</tr>
</tbody>
</table>

*Note: Each column is a hospital. Prices are regression-adjusted, measured from 2008 – 2011, and presented in 2011 dollars.*

© Cooper, Craig, Gaynor, and Van Reenen
Colonoscopy Facility Prices

Denver, CO
Atlanta, GA
Manhattan, NY

Columbus, OH
Philadelphia, PA
Houston, TX

Note: Each column is a hospital. Prices are regression-adjusted, measured from 2008 – 2011, and presented in 2011 dollars.
Conclusions

1. Private health spending per beneficiary per HRR varies by a factor of three across the nation.

1. The correlation between HRR-level spending per Medicare beneficiary and spending per privately insured beneficiary is low (14.0%).

1. There is extensive private spending variation within and across markets – up to 400% within markets and far higher than Medicare within/across markets;

1. Price is the primary driver of spending variation for the privately insured;

1. Monopoly hospitals have a 15.3% price premium.
Conclusions Con’t

• We need to look beyond Grand Junction, Colorado, Rochester, Minnesota, and La Crosse, Wisconsin;
• If we think focuses on regions is important, look at: Rochester, New York, Dubuque, Iowa, Lynchburg, VA, De Moines, Iowa;
• Potential savings from reducing prices is large;

  » Applying Medicare rates lowers private inpatient spending by 31%
  » Applying Medicare rates +10% lowers private inpatient spending by 24%
  » Applying Medicare rates +30% lowers private inpatient spending by 11%

– Rather than attending current provider, if everyone paying above median prices got Median prices in their HRR, it would lower inpatient spending by 20.3%.
Policy Implications

• Strategies to address health care spending variation across the US may differ for publicly and privately insured populations;

• Reducing spending for the privately insured will come via targeting high prices & service intensity;

  • Anti-trust enforcement
  • Price regulation
  • Raise patients’ price elasticity

• Significant scope for savings by steering patients towards low cost/high quality providers via value-based insurance design;

• Significant need to make prices more transparent to consumers.
Hospital, physician prices driving health costs, business groups say

• Boston Globe, February 9, 2016
• Associated Industries of MA
• MA Association of Health Plans
• National Federation of Independent Businesses
• Retailers Association of MA
State tells Boston Children’s Hospital to slow down

- Boston Globe February 13, 2016
- $1 billion Boston’s Children’s Hospital building expansion
- Hospital must provide independent analysis that shows the project is consistent with the Commonwealth’s efforts to meet health care cost-containment goals
ProPublica Surgeon Scorecards

• Medicare claims data 2009 to 2013
• Complication rates for 17,000 surgeons doing 8 procedures
• Mortality rates and readmissions data used as proxy for complication rates
• Complication rates were risk adjusted for coexisting conditions and hospital quality
ProPublica Surgeon Scorecards

• 11% of surgeons accounted for 25% of complications
• Hundreds of surgeons had complication rates at least twice the national average
• ProPublica recommends patients use the ratings to select a surgeon and a hospital
ProPublica Surgeon Scorecards

- Rand Corporation perspective attacked methodology and said pts should not use
- Dr. Lisa Rosenbaum in NEJM: no better than Yelp
- Dr. Peter Pronovost: adjusted complication rate was not true complication rate due to being based on flawed claims data
ProPublica Surgeon Scorecards

• Dr. Charles Mick, former president of North American Spine Society said scorecard long overdue and wonderful to have information in the public
• Dr. Robert Wachter: if I were a pt. I would give scorecard considerable weight in choosing doctor
• Paul Levy called for public release of American College of Surgeons National Surgical Quality Improvement Program results
ProPublica Surgeon Scorecards

• Dr. Shephard Hurwitz announced scorecard would be used by American Board of Orthopaedic Surgery to recertify surgeons.

• If a surgeon has a high complication rate, recertification may be delayed or interview for more details might be suggested.

• “It is controversial, but the fact is that we’re doing it in the spirit of transparency and holding people accountable for what’s already in the public domain”
<table>
<thead>
<tr>
<th>Hospital Readmission Program</th>
<th>DRG Modifier</th>
<th>HAC Reduction</th>
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<tbody>
<tr>
<td>Accountable Care Organizations</td>
<td>Hospital Value-Based Purchasing</td>
<td>Bundled Payments</td>
</tr>
<tr>
<td>Physician Value Modifier</td>
<td>Physician Quality Reporting System</td>
<td>Care Management</td>
</tr>
<tr>
<td>CAHPS Surveys</td>
<td>EHR Incentive Program (Meaningful Use)</td>
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Many Programs Affect Revenue

Quality Programs
Let’s Talk Dollars: What’s at Stake?

By 2017, up to 9% of Medicare PFS reimbursement could be lost due to Value-Modifier, PQRS, and Meaningful Use penalties. By 2016, 1.75% of DRG Payments will be withheld and potentially retained based on performance over several categories.
It’s Not Just CMS…

• Commercial payers are also beginning to require inclusion of quality measures and programs. Major payers are quickly jumping on board:
  – BCBS
  – Aetna
  – Cigna
  – United Healthcare
MACRA
Medicare Access and CHIP Reauthorization Act of 2015

- Removes SGR Methodology
- Development of MIPS
- Alternative Payment Models
- Plan for Quality Measure Development
- Expands Use of Medicare Data
## Payment Reform - Annual Updates

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2015</strong></td>
<td>0.5 percent update effective June 1&lt;br&gt;- versus 21 percent cut scheduled for April 1</td>
</tr>
<tr>
<td><strong>2016 – 2019</strong></td>
<td>0.5 percent annual updates</td>
</tr>
<tr>
<td><strong>2020 - 2025</strong></td>
<td>No updates</td>
</tr>
<tr>
<td><strong>2026+</strong></td>
<td>0.75 percent annual updates for providers in alternative payment models&lt;br&gt;0.25 percent annual updates for everyone else</td>
</tr>
</tbody>
</table>
The SGR Fix

Benefits:

- Certainty of payments for the next 10 years
- No annual fear of unrealistic payment cuts

Concerns:

- Does 0.5% keep up with medical inflation (plus the inherent costs of participation in quality programs)?
What’s the Problem With Current System?

Current Value-Based Payment Programs:
Good intentions, but…

- Complicated Requirements
- Confusing Timing
- Overlap in Requirements
- Wasted Resources
- Inconsistent Measurement and Payment Adjustments
MIPS – the Details

• Repeals PQRS and MU penalties and VM program effective December 31, 2018; replaces with MIPS.
  – Providers will receive a composite score from 1 to 100 based on quality measures, efficiency measures, meaningful use of electronic health records, and clinical practice improvement activities; score will be made publicly available.
  – Each year, CMS will establish a threshold score based on median/mean composite performance scores of all providers measured during previous performance period.
Composite Performance Score

- Quality Measures - 30%
  - For Example: Historic PQRS Measures

- Resource Use Measures - 30%
  - For Example: Cost Measures included in VM Program

- Meaningful Use - 25%
  - For Example: Potentially Stage 3 Requirements of MU Program

- Clinical Practice Improvement Activities - 15%
  - For Example: Population Health Initiatives
MIPS Scoring System

- Quality
- Efficiency
- Meaningful Use
- Clinical Process Improvement

National Median Composite Provider Score (Example)

- Medicare Provider
- National Median Composite Score
# Adjustment Factor

By no later than **December 2** each year, CMS will make available each eligible professional’s adjustment factor for upcoming year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty Cap</th>
<th>Bonus opportunity (subject to scaling factor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>-4%</td>
<td>Up to +12%</td>
</tr>
<tr>
<td>2020</td>
<td>-5%</td>
<td>Up to +15%</td>
</tr>
<tr>
<td>2021</td>
<td>-7%</td>
<td>Up to +21%</td>
</tr>
<tr>
<td>2022</td>
<td>-9%</td>
<td>Up to +27%</td>
</tr>
</tbody>
</table>

## Exceptional Performance Incentive Payment

If meet or beat stretch goal, also receive payment from annual $500 million incentive bonus pool (not to exceed 10 percent)
Quality Measures Component

- CMS to finalize annual list of quality measures by November 1 of preceding year
  - Clinical care
  - Safety
  - Care coordination
  - Patient and caregiver experience
  - Population health and prevention

- Preference for measures endorsed by professional organizations; others subject to peer review procedures
Quality Measure Development Plan

- CMS to publish draft plan by 01/01/16 and final plan by 05/01/16; annual reports on implementation
- $15 million annually from 2015 to 2019
- Priorities
  - Outcomes (including patient reported and functional status)
  - Patient experience
  - Care coordination
  - Appropriate resource use
Resource Use Measures Component

• Incorporate current VM total cost of care measures

• Measures development
  – CMS to develop new classification codes in 2016-17
    • Care episode groups
    • Patient condition groups
    • Patient relationship categories
  – Beginning January 1, 2018, claims must include new codes as appropriate
EHR Meaningful Use Component

• Credit based on meeting then-current meaningful use requirements
• Eliminate inconsistencies in quality measure reporting requirements
Clinical Practice Improvement Activities (CPIA) Component

• CMS to develop menu of specific CPIAs for which EPs will receive credit
  – Expanded practice access
  – Population health management
  – Care coordination
  – Beneficiary engagement
  – Patient safety and practice assessment
  – Participation in alternative payment model

• Consideration for small and rural practices
...More MIPS

- Providers scoring below threshold subject to payment cuts capped at 4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022.
- Providers scoring above threshold will receive bonus payments, up to three times the annual penalty cap.
- Providers scoring above “stretch” performance score will receive an additional bonus payment allocated from a $500 million annual pool.
- Providers participating in alternative payment mechanisms (APMs) may opt out of MIPS in favor of annual 5% bonus payment.
Raising the Stakes

- Over time, the MIPS penalties become substantially greater than those contemplated in existing CMS programs.
- This, coupled with the fact that private payers are likely to “piggy-back” on the MIPS program, make the push for quality and efficiency simply too strong for providers to ignore.

- Just as before, there will be winners and losers in this program.
- The legislation is very broadly defined, CMS will have to fill in the details...
Alternative Payment Models

- Professional who receives significant share of revenues thru qualifying APM
- 5% annual bonus between 2019 and 2024 (paid as lump sum)
- Additional 0.5% annual update beginning in 2026
- Excluded from MIPS assessment and most MU requirements

Definition of “Qualifying APM”
- Involves risk of financial loss + quality measure component
- CMS to develop specific criteria for multiple models
Two Tracks for Providers

Merit-Based Incentive Payment System

**Two Tracks for Providers**

**2015:H2 – 2019:** 0.5% annual update

2018: Last year of separate MU, PQRS, and VBM penalties

2019: Combine PQRS, MU, & VBM programs: -4% to +12% at risk

2020: -5% to +15% at risk

2021: -7% to +21% at risk

2022 and on: -9% to +27% at risk

**2026 and on:** 0.25% annual update

**Advanced Alternative Payment Models**

2015:H2 – 2019: 0.5% annual update

2019 - 2024: 5% participation bonus

2019 - 2020: 25% Medicare revenue requirement

2021 and on: Ramped up Medicare or all-payer revenue requirements

2020 – 2025: Frozen payment rates

2026 and on: 0.75% annual update

2020 – 2025: Frozen payment rates

2026 and on: 0.25% annual update
APM Framework White Paper
January 2016

• Health Care Payment Learning & Action Network (LAN)
• Established in March 2015
• Private payers, large employers, providers, patients, consumer groups, state governments, federal government
• https://hcp-lan.org/workproducts/apm-whitepaper.pdf
APM Framework White Paper
January 2016

• Changing financial reward to providers
• Patient input to APM design
• Patients should go to high value providers
• Patients should be active in shared decision making
• Shift toward shared risk and population based payment models
• Value based incentives intense enough for providers to invest in and implement delivery system reforms
• Value based incentives should increase
• Centers of excellence, ACO, PCMH can be supported by different payment models
APM Framework Category 1
January 2016

• FFS with No Link to Quality & Value
• DRG
• Not adjusted for
  – Infrastructure investments
  – Reporting of quality data
  – Provider performance on cost
  – Provider performance on quality
APM Framework Category 2
January 2016

• FFS Linked to Quality and Value
• 2A: Infrastructure payments
• 2B: Positive or negative incentives to report quality data
• 2C: Rewards for high clinical quality
• 2D: Reward high clinical quality & penalize low clinical quality providers
APM Framework Category 3
January 2016

- APMs Built on FFS Architecture
- Mechanism for management of procedures, episode of care or all health services
- 3A: Upside opportunity to share in savings
- 3B: Upside gainsharing and downside risk based on cost measures
APM Framework Category 4
January 2016

- Population Based Payment
- Holds providers accountable for meeting quality & person-centered care goals for a population of patients
- Cover preventive, health improvement, health maintenance, and specialized care
APM Framework Category 4
January 2016

• Population Based Payment
• 4A: Population based but limited to sets of condition specific services (asthma, DM, cancer); they remain person-focused in that they hold providers accountable for total cost and quality of care for that condition
• 4B: Capitated or population based for all of individual’s health care needs
Health Care Learning & Action Network (LAN)
January 2016

Population Based Payment Work Group
Clinical Episode Payment Work Group
 Docs Don’t Get SGR Fix Raise

• Medicare Physician Fee Schedule Final Rule Says 2016 pay will be 0.29% < 2015

• Protecting Access to Medicare Act & Achieving a Better Life Experience Act & RVU Budget Neutrality Rule mean conversion factor in 2016 will be $35.8279 (1.5 RVU = $53.74)

• RVU X Conversion Factor
  – 1.5 RVU X $35.9335 = $53.90 (2015)
  – 1.5 RVU X $37.7302 = $56.60 (2016)
None of this will work without....

- Physician buy-in and leadership is critical to success in a value-based payment world.

- Insulated from pressures of patient care
- Don’t understand how hard doctors work
- Paid for non-productive work
- Worry about how much things cost
- Focus on problems
- Don’t get out from behind their desks
Hospital Administrator View of Physicians  
Weber, Physician Executive, July, 2006

• Lack big-picture understanding
• Don’t make time to administrate; veto decisions made by others
• Unwilling to confront peer physicians
• Do not make decisions; no leadership
• Act as if other providers are less valuable than physicians; not good team players
Differences between Administrators and Clinicians

**Administrators**
- proactive planners
- work well with groups
- delayed gratification
- id. with organization
- establish rules
- multidisciplinary
- long time frame
- institutional prerogative
- influence
- hospital: community asset

**Clinicians**
- reactive
- work well 1:1
- quick gratification
- id. with profession
- resent rules
- specialists
- short time frame
- individual prerogative
- control
- hospital: work shop
Collective vs. Expert Cultures

- Nurses, administrators
- Others ahead of self
- Trusting
- Value loyalty
- Avoid conflict/risk
- Thin-skinned
- Consensus building
- Process oriented

- Engineering, MD, law
- Self-interest
- Accomplishment
- Power
- Team work not valued
- Quick decisions
- Thick skinned
- Outcomes oriented
Collective vs. Expert Cultures

- Malignant: Cynic/Victim
- Have common mission, values, vision
- Collaboration

- Malignant: Narcissism
- Specific vision where self-interest is obvious
- Do not need mission, values statements
- Collegiality
Expert Engineer Culture
Edgar H. Schein, DEC is Dead, Long Live DEC, 2003

• Individual commitment is not to employer
• People, organization, bureaucracy are constraints to be overcome
• Engineering culture disdains management and marketing
• No loyalty to customer: if trade-offs had to be made between building “fun” “elegant” technologically challenging computers and the needs of “dumb” customers guess who won?
Unhappy Doctors & Happy Doctors

• “Your doctor’s unhappiness is a catastrophic problem that the new law didn’t anticipate and is not prepared to address.” Dr. Marc Siegel, Associate Professor of Medicine, NYU Langone Medical Center

• “To us, supporting the ACA makes moral and medical sense” Dr. Jeffrey Drazen, Editor-in-Chief, and Dr. Gregory Curfman, Executive Editor, NEJM
Dr. Daniel F. Craviotto, Jr.

• Docs in the trenches do not have a voice
• “Damn the mandates…from bureaucrats who are not in the healing profession”
• EHRs waste time
• Board recertification is time consuming
• Physicians as a group should not accept any health insurance
Dr. Aaron Carroll

• Complaining about no voice in WSJ
• “Most people have to choose between doing God’s work and being in the 1%. Only doctors get to do both”
• Board recertification is mandated by doctors
• “It’s tone deaf in today’s economy for people at the top end of the spectrum to complain so publicly about how little they are paid”
• Less than 1% of physicians opt out of Medicare
Dan Munro

- His criticisms are not patient-centered
- Orthopedics annual compensation of $413,000
- 84 million non-elderly were uninsured or underinsured in 2012
- 100 million Americans in poverty or in the fretful zone just above it
- Half of all doctors believe they are fairly compensated
Defying the Medical Machine
NY Times, January 10, 2016

• Increasing efficiency vs. deference to MDs
• Sacred Heart Medical Center, Springfield
• Bids to outsource 36 hospitalists positions
• MDs at Sacred Heart see 15 patients a day
• EmCare MDs see 15 to 18 patients a day
Defying the Medical Machine
NY Times, January 10, 2016

• “Giving me a bonus for seeing two more patients – I’m not sure I should be doing that. It’s safe.” Dr. Rajeev Alexander

• 1/3 of hospitalists left Sacred Heart
Defying the Medical Machine
NY Times, January 10, 2016

• Form a union
• Independent hospitalist group
• Form an alliance with outsourcing firm that the doctors selected
Defying the Medical Machine
NY Times, January 10, 2016

• Spouse decides to play the field
• You’ve been great; you’ve always been there
• I just heard there could be better spouses out there
• The good news is, you’re still in the running too
Defying the Medical Machine
NY Times, January 10, 2016

• Formed union with American Federation of Teachers
• The administrator behind outsourcing left
• Outsourcing plan abandoned
Defying the Medical Machine
NY Times, January 10, 2016

• REAL rounds (Rounding embraced by all leaders)

• “Are you kidding me. Real rounds as opposed to what we do?” Dr. D. Schwartz

• “What’s the widget the hospital produces? It’s the hospital-patient relationship. You don’t improve it with extra little tasks.” Dr. Rajeev Alexander
Defying the Medical Machine
NY Times, January 10, 2016

• Hospitalists insist it is not about the money
• Administrators insist it is about the money
Defying the Medical Machine
NY Times, January 10, 2016

• Skin in the game

• “It really took all of my self control to not say, ‘What the hell do you mean skin in the game?’ We have our licenses, our livelihoods, our professions. Every single time we walk up to a patient, everything is on the line.”
Defying the Medical Machine
NY Times, January 10, 2016

• Skin in the game
• “My thought was, I’ll put some of my skin in the game if you put your name on the chart...If there’s a lawsuit, you’re on there. You come down and make a decision about my patient, then we’ll talk about skin in the game.” Dr. David Schwartz
Danielle Ofri, MD

- 33% of HA1C at goal
- 44% of cholesterol at goal
- 26% of blood pressure at goal
Danielle Ofri, MD

• “I don’t even bother checking the results anymore. I just quietly push the reports under the pile of unread journals, phone messages, insurance forms, and prior authorizations.”
Kaiser IDs Gaps in MD Readiness for a Reformed Delivery System (Crosson, Health Affairs, 2011)

• Systems thinking
• Leadership and management skills
• Continuity of Care
• Care coordination
• Procedural skills
• Office-based practice competencies
  – Inter-professional team skills
  – Clinical IT meaningful use skills
  – Population management skills
  – Reflective practice and CQI skills
AHA Physician Leadership Forum: Competency Development

- Leadership Training
- Systems theory and analysis
- Use of information technology
- Cross-disciplinary training/team building
Mindset of the Traditional Physician

- My success depends on my individual behavior
- Individual activities lead to personal financial success
- Individual activities lead to successful clinical outcomes
- Strong financial and clinical performance of my parent organization and physician colleagues have little impact on my personal success
- “Cowboys”
Mindset of the Integrated Employed Physician

• My success is enhanced by collaboration

• Individual activities lead to the financial success of parent organization

• Individual activities lead to successful clinical outcomes because of collaboration

• Strong financial and clinical performance of my parent organization

• And physician colleagues have major impact on my personal success

• “Pit Crews”
Traditional Physician Leadership

- Represent local physician interests at organization-wide venues
- Secure resources for local physicians
- Rally physicians against perceived enemy
  - Hospital administration
  - Insurance companies
  - Competing physicians
Physician Leadership in Integrated Aligned System

- Holding physicians accountable for performance
- Working as part of a leadership team of the organization
- Supporting decisions they may not personally agree with
- Modeling behavior that supports the overall organization goals
- Leaders job is not to protect, defend, and ensure local interests that may conflict with overall organization interests
- Leading in an integrated aligned system is a real job
Leading Physicians Through Change  (Mary Jane Kornacki & Jack Silversin)

- Effective physician leadership
- Shared vision
- Compact: Alignment of behavior with shared vision
Leading Physicians Through Change (Mary Jane Kornacki & Jack Silversin)

- Physician leadership needed in a transformed clinical delivery system
- Holding physicians accountable for clinical performance
- Holding physicians accountable for financial performance
- Working as part of leadership team
- Actively supporting decisions they do not agree with
Leading Physicians Through Change  (Mary Jane Kornacki & Jack Silversin)

• Collect and organize relevant data
  – Your organization’s mission
  – Reliable data on current market reality
  – Trend data suggesting what will be important for future success
  – Your organization’s capabilities and strengths
  – Your organization’s weaknesses
  – The mission and vision of the larger enterprise
Leading Physicians Through Change (Mary Jane Kornacki & Jack Silversin)

• Compact is the expectations members of an organization have regarding the intangible assets and benefits they’re entitled to and what their organization expects in return

• Compact is part of organizational life that is taken for granted

• Rewriting a compact is an example of adaptive change
Leading Physicians Through Change (Mary Jane Kornacki & Jack Silversin)

- Culture works that supports strategies and actions that result in a successful business
- Culture is differentiator between high- and low-performing hospitals treating AMI (Annals of Internal Medicine 154(6):384, 3/15/2011)
- Culture that contributed to past success does not change as fast as new strategies & tactics
- Culture shaped by shared assumptions & beliefs about the right way to do things (may not be conscious)
Leading Physicians Through Change  (Mary Jane Kornacki & Jack Silversin)

- Traditional compact
- Physicians Give
  - Patient care
  - Quality care as they define it
- Physicians Get
  - Autonomy
  - Protection
  - Entitlement
Leading Physicians Through Change (Mary Jane Kornacki & Jack Silversin)

- New compact
- Physicians Give
  - Patient centered care
  - Acknowledged interdependence
  - Delegated authority to leaders
  - Accountability
- Physicians Get
  - Market-responsive organization able to survive
  - Influence on governance
  - Input on decisions affecting the practice
  - Compensation linked to organization & individual performance on outcomes, cost, and quality
Symptoms of Resistance

- Superficial agreement with change with no commitment or follow-through
- Slow progress
- Apathy
- Excuses for lack of engagement or progress
Addressing Resistance

- Leaders cross bridge first by coming to terms with own concerns
- Help physicians let go of expectations that cannot be met
- Get out the news
- Listen to and honor resistance