

In This Issue:

Is Physician Collaboration, Recruitment and Employment a Centerpiece of Your Hospital's Strategy?

Quality Time: Physicians Should Lead Outcomes Improvement

Why It Is Time to Shuck Your Old Care Management Model

Is Physician Collaboration, Recruitment and Employment a Centerpiece of Your Hospital's Strategy?

C. E. Mickey Bilbrey, Sr. Managing Director, Phase 2 Consulting

Today, many hospital and health system CEOs are reconsidering their strategies related to physician collaboration, recruitment and employment. In today's competitive environment the collaboration between the hospital and medical staff is more crucial than ever to each others' futures.

By taking a few minutes to answer the following questions, you can judge how well positioned your institution is on this issue.

1. Is a for-profit or physician-owned specialty hospital (heart, orthopedic, etc.) operational or in development in your service area?
2. Have physicians on your medical staff or a competitor hospital, independently or in conjunction with others, developed free-standing ambulatory surgery, diagnostic or imaging centers in your service area?
3. Have members of your medical staff commented that their incomes are being threatened by decreasing reimbursement, increasing medical liability costs, government regulation or other market issues? Do members of your medical staff allege competing hospitals have better technology, better services and pay more attention to physicians?
4. Has physician employment resurfaced as a topic of discussion in your senior management meetings or in the physician lounge?

The Phase 2 Advisor is a free quarterly e-mail advisory. Written by the Directors and staff of Phase 2 Consulting, The Advisor is a quick, easy-to-read synopsis of pertinent industry information, current trends, and lessons learned from our engagements. We monitor industry journals and compile knowledge gained from our consulting assignments to create a concise review of the trends, problems and potential solutions that we hope this will benefit your operations. We welcome your suggestions for ways to make The Advisor a more useful tool, as well as content recommendations. E-mail us at lapeterson@phase2consulting.com, or call 1.800.995.0097.

5. Does your hospital experience access issues, scheduling delays and/or throughput problems in your outpatient clinical services (i.e., imaging, endoscopy, ambulatory surgery, etc.)? Are physicians' hospital practice patterns (i.e., LOS, materials utilization, etc.) affecting your service line margins?
6. Are you struggling with achieving meaningful cooperation from your medical staff in your quality, safety and performance improvement initiatives?
7. Are your medical and surgical specialty physician groups, e.g., cardiology, neurosurgery, general surgery, gastroenterology, experiencing recruiting difficulties, and are new physicians in your service area struggling with getting new patients and establishing referral sources?
8. Is "call pay" for certain specialty services, e.g., trauma coverage, a growing issue and point of contention with your medical staff?
9. Do members of your medical staff complain about a lack of access to and communication with you and/or senior leadership of your hospital?
10. Do you suspect members of your medical staff believe hospital leadership is insensitive to the issues facing physician practices?

If you answered YES to more than two of the above questions, a re-examination of your hospital's strategic position regarding physician collaboration is in order. Give us a call at 800-995-0097 to talk to one of our experienced senior directors about your situation and how Phase 2 Consulting can assist you and your organization in crafting the correct solution for your physician strategy.

Quality Time: Physicians Should Lead Outcomes Improvement

Preston Gee, Managing Editor, Phase 2 Consulting, reproduced with permission of HealthLeaders Online News

Quality is all the buzz right now — for good reason. Mounting sentiment is that American healthcare may not be worth the price tag, especially given its rapidly rising costs and a corresponding decline in interest from a major funding group — employers — in sustaining the increased expense. This development, along with several other factors, is leading to an increasingly resolute inquiry — if not inquisition — on quality.

Among many prominent groups leading the quality charge are the Leapfrog Group, the National Business Group on Health, CMS and a host of commercial and public quality rating agencies and organizations. What all these groups have in common is the desire to publicize the data and catalyze providers. The prevailing sentiment is that bringing quality data to light will improve quality and increase accountability. Give these groups their due. The early returns tend to corroborate their hypothesis. What perplexes some hospitals and health systems in the midst of this hue and cry for improved quality and increased reporting is how best to proceed, and how to effectively involve and engage the medical staff in the effort. Based on the experience of some of the leading institutions in terms of quality focus and outcomes, four critical factors will have a marked impact on improving clinical quality:

1. Involving a physician leader or champion to orchestrate the undertaking
2. Making sure the initiative and process is data driven
3. Beginning with one or two prototypical projects or areas to achieve early success
4. Once favorable results are visible, expanding to other areas of the organization

The Doctor is In (of Necessity)

So, just how do successful systems involve their medical staff in the quality improvement effort? This question has been the subject of much debate by quality leaders such as Brent James, M.D. and Steve Berkowitz, M.D. Berkowitz suggests three approaches to engage the physicians. First, the effort must be viewed as a physician-driven initiative. If it comes across as top-down mandate by the administration, it will be regarded with some suspicion and perhaps even disdain. Second, Berkowitz recommends that a physician coordinate the endeavors. Ideally, this person would be the chief medical officer, a physician executive or one of the medical staff leaders who has a keen interest in, and the time for, leading such a valuable effort. Physicians will not respond — especially at the outset — to a non-physician leader. Even a physician executive comes with some baggage, says Berkowitz, but that can be overcome far more readily than can the baggage associated with a non-M.D. administrator. Much of the success of the effort hinges on the personality and collegial capital the physician leader owns, so affability and professional affinity may be as important as expertise or clinical improvement outcome experience. The latter can be learned or assimilated, but professional adaptability is largely innate — they either have it or they don't. If an organization does not have a physician leader who is willing and able to step into the breach, then the leadership might want to consider — at least at the outset — bringing in experts who have done this for other hospitals or health systems. Many of the leading organizations that have pursued sophisticated and robust quality initiatives have done just that, and found a champion in the ranks once the process got under way.

Show Me the Data

As Edwards Deming demonstrated with his Total Quality Improvement tsunami in the '70s and '80s, a data-driven quality effort not only works, but it also takes the emotion and subjectivity out of the process. This truth is especially relevant and applicable when it comes to working with physicians in discussing, presenting, monitoring and comparing outcomes data. Anything less than accurate and consistent data will be viewed with skepticism and eventual disdain and disengagement. Even when the data is reliable and relevant, many physicians will go into the five stages of dealing with data, according to Berkowitz, who compares the reaction to the well-known work of Elizabeth Kubler-Ross. Spanning the spectrum of reaction from denial to eventual acceptance, physicians are not an easy lot to convert to data-driven evaluation, but it is the only immediately palatable and eventually successful method of monitoring and modifying physician practice behavior.

To achieve a data-centered effort, the organization must have the resources to obtain and disseminate the data in a way that preserves confidentiality and ensures trust and acceptance. If the data effort is viewed as punitive or patronizing, healthcare executives face nothing short of a mutiny on their hands, as some unfortunate executives have already learned. However, if the initiative is viewed as constructive and collaborative, many doctors will rally around the notion of improvement with individual participation. As one family practice physician recently noted in a strategic planning session, "I want to know how to improve my practice, and to assist the hospital in its quality and efficiency efforts. Show me the data, and I'll do what I can to make the appropriate adjustments."

The fundamental problem with the quality initiative is that many hospitals and health systems aren't quite sure how to proceed. They are therefore caught in a tight squeeze of wanting to improve, but not knowing exactly how to do it. Far too often, this creates a situation of heightened activity with minimal progress — a lot of churning the waters with little forward movement. Part of the dilemma is knowing how to begin the process and whom to involve.

As for where to begin the outcome improvement initiative, so much data is available and there are so many options to choose from that the process is often hopelessly derailed by trying to do too many things and improve in too many areas at once. Another major deterrent involves getting the physicians to take ownership and to get actively engaged and thoroughly involved in the quality improvement initiative. This was the sad lesson of the TQI movement in which there was a great deal of clinical activity and focus, but it largely took place without physician involvement. Consequently, the results were understandably minimized by the reality that the key players were not in the game.

Upcoming Events Featuring Phase 2 Consulting

- Preston Gee will speak at the Western Colorado Health Network meeting on August 12 and 13
- Look for Jon Clark's article on budgeting in the July issue of HFM and several other articles from Phase 2 in upcoming issues
- Preston Gee will present "Optimizing New Product Opportunities" at the SHSMD national conference in Chicago on September 16
- Mickey Bilbrey will present "State of Healthcare 2005" to the Knoxville Area Health Underwriters on September 22
- Preston Gee will give a presentation to the Metro Healthcare Executive Group of St. Louis on October 20

Small is Beautiful — and Preferential

The other key component that successful hospitals and health systems recommend is to start out with one or two projects. Quality improvement is definitely an area where trying to take on too much may prove more detrimental than beneficial. An overly aggressive effort at the onset of the program can produce more frustration than fruition, and can lead to an early demise. Given that the effort may require some gradual acceptance from members of the medical staff, it is far better to bring people along gradually than to shove them forcefully. The value of an incremental execution is that the physicians will buy in at their own pace and be more supportive in the long run.

The data disclosure component will bring the process forward on its own, so it is not necessary to use mandates and other coercive measures. The value of this process is that it self-ambulates if done correctly.

Case Study: The Patients of a Saint

One of the best examples of the potential gains to be derived from following this model can be seen with the St. David's HealthCare Partnership in Austin, Texas (In the interests of full disclosure, I worked for St. David's until two months ago). St. David's is one of the leading health systems in Texas with six hospitals and several ambulatory surgery centers and other health-related entities. St. David's began its journey down the quality improvement road three years ago under the leadership of CEO Jon Foster and Berkowitz.

St. David's has experienced considerable success with its quality initiatives, but one of the more compelling examples can be found with its emphasis on deep vein thrombosis education and treatment. DVT is one of the leading causes of hospital-induced infections and a major contributor to pulmonary embolism, which the Journal of American Medicine has called "the most preventable cause of mortality in hospitals."

Taking a cue from two well-known and extensively researched articles from the New England Journal of Medicine, Berkowitz and his fellow medical staff officer colleagues, Ross Hemphill, M.D., and John Marietta, M.D., began an educational effort aimed at highlighting the value of prophylactic treatment of patients with DVT conditions. The effort included meeting with members of the medical staff, distributing educational materials on the benefits, proper treatment and suggested protocols for prophylactically treating patients with DVT symptoms, and consistent monitoring and reviewing of the results of the initiative.

Within two years of the educational effort, St. David's had reduced its incidence of DVT patients by nearly two-thirds. These impressive results were not only well regarded by members of the medical staff community, but were understandably appreciated by the employer community and the public in general.

Replicate the Results-Expand to Other Areas

The lessons from the St. David's experience can be summed up in a phrase that Berkowitz likes to quote: That which is measured tends to improve, that which is measured and made public tends to improve dramatically. Once this truism has been tried and proven, the hospital or health system can expand its efforts to other critical categories or areas that will benefit from the focused effort. The value in taking an incremental approach is in testing the model, proving its efficacy, and bringing the clinicians along so they buy into the concept. Organizations that have tried to do too much too quickly have often overreached and underperformed. It is far better to start gradually and succeed than begin pervasively and fail.

As shown by the St. David's experience — and that of other hospitals and systems — the most effective quality effort hinges on these four main facets listed at the outset: Engage the physicians and enlist a physician champion/coordinator; center the effort around data; start the effort with one or two projects or disease categories that can produce ready results; and eventually expand the effort into other areas.

Experiences in organizations like St. David's prove that quality can be improved dramatically and readily. In the final analysis, this is what hospitals and health systems should be focusing on. Not only can hospitals improve organizational performance, but they also can benefit from increased physician engagement and interaction. Perhaps most importantly, such an effort is likely to engender the achievement of this field's most important goals, which are to constantly strive to improve quality of care and increase patient satisfaction.

Why It Is Time to Shuck Your Old Care Management Model

Mary Wilkes, Sr. Managing Director, Phase 2 Consulting

Care management is one of the few functions in a healthcare delivery system that can have a significant impact on admissions, utilization, revenue, cost, clinical quality and customer satisfaction. Because of this wide impact, effective patient management throughout the continuum of healthcare services (from acute admission to post-acute services and in the ambulatory setting) is critical for long-term financial success.

Since the 1980s, when the Prospective Payment System (PPS) was implemented, healthcare systems have struggled to implement the most cost-effective and manageable programs for patients. Although care management programs have improved, the programs appear to be focusing only on utilization review or the payor aspect. With declines in acute care revenue, capacity constraints, and scarce capital dollars, healthcare systems have to take a more assertive approach to care management.

The four core functions of most current care management models are:

1. Utilization Review/Denials Management,
2. Discharge Planning,
3. Outcomes Management, and
4. Performance Improvement
 - Quality/Patient Safety
 - Risk Reduction/Loss Prevention.

Each of the core functions of care management is important, but something is missing in current care management strategies - providing the best clinical quality, financial results, and patient, physician and staff satisfaction. To achieve care management objectives in the last decade, many organizations have focused on only utilization review and/or denial management, which have been largely commercial payor driven. One approach to the future model is to consolidate the care management functions (acute, post-acute, and ambulatory) under one umbrella. This allows managers to focus on the primary customers (patient, physician, and staff), not the payor, to assure optimal results.

Transition Management is the Key

Phase 2 employs a model, called CareNexus™, that focuses on the largest missing component of care management — managing the patient transitioning from one level of care to the next. Many refer to this process as discharge planning, but transition management takes this process one step further by accurately detailing frequent assessments of patients' conditions and daily actions to assure they are receiving the right care, in the right setting, on the right shift.

The average patient is moved five or more times across the continuum of health services. This transitioning is fragmented, slow, stressful, and confusing for families, patients, and healthcare providers, since no one person guides them through each transition. This ineffective process is costly for healthcare systems and patients, and often results in the patient not receiving the required care at the appropriate levels.

Below is a partial checklist for hospitals to gauge their need and potential benefit of a comprehensive transition management system.

1. Is the hospital experiencing unprofitable acute care stays?
2. Does the hospital have higher than necessary acute care staffing costs?
3. Are profit margins negative or dropping below 2% or 3%?
4. Is capacity averaging above 85%?
5. Is the Medicare/Medicaid acute LOS above the national average of 4.5 days?
6. Is there excessive utilization, long Emergency Department wait times, lack of post-acute services?
7. Are current referral patterns ineffective in moving patients through the continuum?
8. Is there a developed transition plan that begins at entry-point and continues through each stage of care through the continuum?
9. Is there a transition plan with measurable outcomes at each change in health status?
10. Does the hospital have structured processes for daily management?
11. Has the hospital developed clearly defined roles and job descriptions for all providers?
12. Does the hospital have an early warning system to help with the transition to the next appropriate level of care?
13. Has the hospital delineated and clearly defined organizational responsibility?
14. Is the provider educated and knowledgeable about the appropriate placement for the various levels of the continuum of care?
15. Does the hospital have a patient tracking system across the continuum of services?
16. Are patient satisfaction scores low or dropping?

The lack of clearly defined transitioning processes creates delays in appropriate treatment, duplication of services leading to increased expenses, and declines in revenue across the continuum. These outcomes are measured by longer length of stays, reduction in patient satisfaction and missed new business opportunities.

What's the Potential Impact?

In our experience with financial and operational improvement projects, we have identified several revenue and cost enhancement opportunities that have gone unnoticed for healthcare organizations. In some of our most recent system analyses the opportunities average \$3-5M in return if implemented.

Utilizing the CareNexus model at one facility over a nine-month period, we achieved:

- a 5.9% reduction in average length of stay
- a 4.5% increase in admissions
- a 1% increase in operating margin

At another facility over a three-month period, we achieved:

- a 44% reduction in denial days
- a .23-day decrease in Medicare/Medicaid LOS

If you would like to learn more about care management and CareNexus, please contact Mary Wilkes at 314-659-2104.

Phase 2 Consulting Management Team

Brent Hardaway, *Operating Officer*

Mickey Bilbrey, *Senior Managing Director*

Rick Carter, *Senior Managing Director*

Howard Salmon, *Senior Managing Director*

Peter Singer, *Senior Managing Director*

Mary Wilkes, *Senior Managing Director*

Marlowe Dazley, *Managing Director*

Preston Gee, *Managing Director*