Successfully Engaging Physicians in Value Based Initiatives:
Strategy and Best Practice from the Frontlines of Physician-Hospital Collaboration

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Who Are These Guys?

CLIENT LOCATIONS

50 STATES

YEAR FOUNDED

1983

OFFICE LOCATIONS

Atlanta
Kansas City
Knoxville
Nashville
Tampa

WE SERVE MORE THAN 1400 CLIENTS

Academic Medical Centers | Accountable Care Organizations
Ambulatory Surgery Centers | Blood Centers | Clinically Integrated Networks | County Owned Hospitals | Critical Access Hospitals | Diagnostic Centers | Dialysis Centers | Health Plans
Health Systems | Home Health Agencies | Hospices | Hospitals
Independent Practice Associations | Maternity Centers
Medical Groups | Mental Health Centers | Nursing Homes
Physician-Hospital Organizations | Physical Therapy Centers
Psychiatric Hospitals | Rural Health Centers | Safety Net Hospitals | Surgery Centers | Urgent Care Centers
AGENDA AND HOUSEKEEPING

1. Learning Objectives:
   - Trends Driving Continued Engagement
   - Strategy and Best Practice

2. Housekeeping:
   - Sign in Sheet
   - Handouts
Today’s Discussion

- Intros, Agenda and Housekeeping
- Physician Engagement in an Era of Payment Reform
- Strategies and Best Practice for Engaging Physician Leaders
- Engaging Physicians in Value-based Initiatives: Lessons From The Real World
PHYSICIAN ENGAGEMENT IN AN ERA OF PAYMENT REFORM
2016 Health Care Trends

- Consolidation
- Patient-centered
- Payment Reform Pilots
- 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
Old

- Cost not considered
- Independent doctors
- Independent hospital
- Med record secret
- Opaque
- Artificial harmony
- Analogue
- Hypothesis driven clinical trials

New

- Decreased cost
- Employed docs
- Integrated delivery system
- Open access record
- Transparent
- Cognitive conflict
- Digital
- Predictive analytics actionable correlations
Shifting From Volume to Value

The switch from volume to value-based payments is occurring…but in **market-specific ways and at different speeds.**

As **Figure 1** [above] illustrates, healthcare leaders must gauge the speed at which this transition will occur in their market. Leaders need both a **strategy** to ensure their organization’s survival during this **transition period** and a **strategy** to change the provider culture to match the requirements of value-based payments. It’s as if you find yourself with a foot in two canoes, and the river current is swift. Leaders need to find that branch to steady them as they move from one canoe to the other.
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
The CMS Definition of Value

Quality + Efficiency = “Value”
Many Programs Affect Revenue

**Quality Programs**

- Hospital Readmission Program
- DRG Modifier
- HAC Reduction
- Accountable Care Organizations
- Hospital Value-Based Purchasing
- Bundled Payments
- Care Management
- Physician Value Modifier
- Physician Quality Reporting System
- CAHPS Surveys
- EHR Incentive Program (Meaningful Use)
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. In 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
Medicare Transition To Value-Based Reimbursement

By 12/31 2016

- 85% of Medicare fee-for-service payments tied to scores on quality and efficiency measures.
- 30% of traditional Medicare payments through APMs

03/03/2016 - Mission Accomplished

By 12/31 2018

- 90% of Medicare fee-for-service payments tied to scores on quality and efficiency measures.
- 50% of traditional Medicare payments through APMs
VBR Framework

**Fee-For-Service (FFS) Payments**
- A: Traditional FFS
- B: Infrastructure Incentives
- C: Care Management Payments

**Adjusted FFS Payments**
- A: Pay For Reporting
- B: Pay For Performance
- C: Pay/Penalty For Performance

**APMs Incorporating FFS Payments**
- A: Total Cost of Care Shared Savings
- B: Total Cost of Care Shared Risk
- C: Retrospective Bundled Payment
- D: Prospective Bundled Payment

**Population-Based APMs**
- A: Condition-Specific Population-Based Payments
- B: Primary Care Population-Based Payments
- C: Comprehensive Population-Based Payments
MACRA

Medicare Access and CHIP Reauthorization Act of 2015

Repealed Sustainable Growth Rate for Calculating MPFS Rates

Replaced with Merit-Based Incentive Payment System (MIPS)
MIPS Regulation

1. CMS “Listening Tour”
2. Proposed Rule published April 26, 2016 ("Quality Payment Program")
3. Comments due to CMS by June 27, 2016
4. Final rule to be published prior to November 1, 2016
5. First performance year commences January 1, 2017
6. Payment adjustments commence January 1, 2019
MIPS Decision Tree

Are you a physician or eligible non-physician practitioner? 

- YES: Will you be newly enrolled in Medicare in 2017? 
  - YES: Will you have less than $10,000 in charges or see less than 100 Medicare patients in 2017? 
    - NO: Are you a participant in an Alternative Payment Model? 
      - YES: MIPS Participation Choice 
        - NO: 
  - NO: 

- NO: 
  - NO: 
  - YES: Is your APM on the list of Advanced APMs for 2017? 
    - YES: Determined to be a Qualified Participant (QP)*? 
      - YES: EXEMPT from MIPS 
      - NO: 
    - NO: 

* Or partial qualifying APM Participant (Partial QP) and elects not to be subject to MIPS
# Calculating the CPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Scoring</th>
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| Quality                 | ▪ Each measure 1-10 points compared to historical benchmark (if avail)  
                        ▪ 0 points for non-reported measures  
                        ▪ Bonus for reporting outcomes, patient experience, appropriate use, patient safety, and EHR reporting  
                        ▪ Measures averaged to generate category score                                                                                   |
| Advancing care information | ▪ Base score of 60 points achieved by reporting at least one case for each available measure  
                        ▪ Up to 10 additional performance points available per measure  
                        ▪ Total cap of 100 percentage points                                                                                             |
| CPIA                    | ▪ Each activity worth 10 points  
                        ▪ Double weight for “high” value activities  
                        ▪ Sum of activity points compared to a target                                                                                     |
| Resource Use            | ▪ Similar to quality                                                                                                                     |

1. Converts measures/activities to points  
2. MECs know in advance what is required to achieve specific CPS  
3. Partial credit available
Composite Performance Score

ACI Points × Component Weight = Advancing Care Information Score

CPIA Points × Component Weight = CPIA Score

Resource Use Points × Component Weight = Resource Use Score

Quality Points × Component Weight = Quality Score

COMPOSITE PERFORMANCE SCORE (CPS), 1 – 100
Composite Score Components

- Advancing Care Information (ACI)
  - 25% for 2019, 25% for 2020, 25% for 2021

- Clinical Practice Improvement Activities (CPIA)
  - 15% for both 2019 and 2020, 15% for 2021

- Resource Use ($)
  - 10% for 2019, 15% for 2020, 30% for 2021

- Quality
  - 50% for 2019, 45% for 2020, 30% for 2021

(and beyond)
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.
VBP Program Considerations

Workflow and operations may have to change…

- How will this impact patient care?
- How can technology be leveraged?
- Who can take ownership of specific programs?
- How do we track performance?
- What is the value proposition?
None of this will work without…. 

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

• First Principles: Where Value is Created In Healthcare
• Our Challenges are Evolving…

=> Our Leadership Needs are Also Evolving

• Past MD Leadership characterized by Situational Necessity
• Future MD Leadership Must be Characterized by Deliberate Choices, Planning and Design
ENGAGING PHYSICIANS AND LEADING THROUGH CHANGE
Managing Complex Change

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

- CHANGE
- Confusion
- Anxiety
- Gradual Change
- Frustration
- False Starts
Geoffrey P. Cole, M.D.

TRANSLATING ENGAGEMENT TO THE REAL WORLD – A CASE STUDY:
Formula for Organizational Change

\[ D + V \times L > R \]

- \(D\) = Dissatisfaction with how things are
- \(V\) = Vision of what is possible
- \(L\) = Leadership needed for success
- \(R\) = Resistance to change
Highly Reliability Organizations

• Reporting culture
• Non-punitive event analysis
• “Near misses” studied to improve system
• Dedicated to learning
• Standardized, proven processes
• Invest financially to improve quality
• Top leadership make quality top priority
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
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”
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
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”
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
- Leader’s 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
Resistance

Symptoms:
• 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
• Listen to and honor resistance
Evaluate 2 Dimensions of Conflict
(Michael Roberto, Why Great Leaders Don’t Take Yes for an Answer, 2005)

• Affective Conflict:
  – How much anger over decision?
  – How much personal friction in group?

• Cognitive Conflict:
  – How many disagreements over ideas?
  – How many differences about content of decision did group have to work through?
“Conflict is open and sometimes raucous but always communal, a public encounter in which it is possible for everyone to win by learning and growing…Conflict is the dynamic by which we test ideas in the open, in the communal effort to stretch each other and make better sense of the world.”
“Gentlemen, I take it that we are in complete agreement on the decision here. Then, I propose that we postpone further discussion to give ourselves time to develop disagreement and perhaps gain some understanding of what the decision is all about.”
Insufficient Candor

- Meetings like golf, not hockey
- Planning focus on producing reports
- CEO rarely gets feedback from ranks
- Concern for protocol across silos
- Workers wait for CEO before giving opinion
- Same people dominate decision making
- Sr. management rubber stamps
- CEO rarely hears from presenter re: criticism
Teams Need Conflict

(Liane Davey, HBR, December 25, 2013)

• Nice people need to have healthy conflict

• “It’s my obligation to bring a different perspective than what others are bringing”

• It is not necessary for someone else to be wrong for you to be right

• Use hypotheticals {Being contradicted does not feel good. Get opponent imagining not defending. I hear your concern, but if that concern went away how would you imagine the program working?}

• Ask about the impact {Direct open ended questions}

• Discuss the underlying issue {Understand the reasoning of people with whom you disagree}

• Ask for help {I know I am missing something here, but explain to me why doing that will solve the problem}
Klein’s Pre-mortem

- Imagine complete failure after a decision
- Brainstorm different paths leading to failure
- Identify probability and severity of paths
- Should we make a different decision
- Plan to prevent paths to failure
- Summarize learning & communicate
- Conduct post-mortem & compare with pre-mortem
When Ideas Collide, Don’t Duck
(Adam Bryant, New York Times, March 9, 2014)

• “When there was discord and we couldn’t agree on things, we tended not to address those issues head on. When there was disagreement, we’d all kind of put it aside and say, ‘Let’s get back to work and go.’ That didn’t serve us well.”

• “So in our current company, when people see conflict, they address it, talk about it, bring it out into the open. Conflict shouldn’t be taboo. In fact, resolving conflict is one of the key things companies do, since you have lots of people with lots of ideas about how the company should proceed.”
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

<See Handout>
Three Key Take-Aways

1. Find Your Canaries and Listen to Them “Chirp”
2. Have a Vision and Do Something
3. Act, Assess, Revise, Act Again
Questions?

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