The Impact of Population Health on Credentialing and Privileging

Session Code: MN08
Date: Monday, October 23
Time: 12:45 p.m. - 2:15 p.m.
Total CE Credits: 1.5
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What’s the problem and what is the root cause?

- We spend almost twice as much as every other industrialized nation ($10,000 per capita) with relatively weak quality metrics to show for it (37th in overall health, 39th infant mortality, 36th life expectancy etc.)

- We tolerate an unacceptable variation in quality, safety, service (24,000/45,000 deaths per IOM/OECD annually), and cost (up to 1000%)

- Our national debt is $21.2 trillion with a virtual debt of $65-95 trillion [24% SS, 16% interest on debt, 14% Medicare, 9% Medicaid]

  - GAO: To balance the budget by 2046 cut federal spending by 20% or raise taxes 2.5 times *Source: NEJM 2010: 362:98-99
Quality shortfalls: Getting it right 50% of the time

Adults receive about half of recommended care

54.9% = Overall care
54.9% = Preventive care
56.1% = Chronic care

Life expectancy at birth and health spending per capita, 2011 (OECD)(Preston Curve)

Another “Root Cause” of United States Healthcare “Waste”
Disproportionate Costs and Sub-Populations: The Foundation of Population Health

- Top 1% make up 23% of healthcare costs (critical care and dying) (> $90K/year)
- Top 5% make up 49% of healthcare costs (multiple chronic diseases) (> $45K/year)
- Top 10% make up 64% of healthcare costs (chronic diseases) (> $15K/year)
- Bottom 50% make up 3% of healthcare costs (healthy population) (> $8K/year)

Clayton Christensen: The Disruptive Innovation Model

- The cost of innovation (‘high quality and high cost’) outpaces the public’s ability and willingness to pay
- Less demanding customers find lower cost and simpler options with easier access that are ‘good enough’
- “Good Enough” services diffuse throughout the system and become the new norm, displacing the original service
- Why does disruptive innovation take place?

What Causes Disruptive Innovation?

- The Ritz Carlton
20th Century “Solution Shops”

- Independent autonomous physician model with hospital as ‘workshop’
- Lack of integration and alignment between specialties with fragmentation and inefficiencies
- Lack of integrated information network
- Expensive, cumbersome, with high probability of error (e.g., multiple hand-offs) and delayed diagnosis/treatment
- Reimbursement based upon units of service or cost (volume)

21st Century “Solution Shops”

- Integrated and organized healthcare network
- Completely aligned physicians working in collaborative multispecialty teams
- Evidence based approaches and processes (Watson decision analysis support)
- Lower cost with high reliability and more rapid and efficient development of diagnostic plan (e.g., solution)
- Reimbursement based upon a cost effective and successful ‘solution’/plan (value)
- Examples: Mayo Clinic (coherent solution shop) and Cleveland Clinic (clinical institutes)

Sample credentialing and privileging criteria for Diagnostics Team Leader

Diagnostics Team Leader:

- Complete an accredited residency in internal medicine, pediatric, family medicine or other eligible specialty
- Board certified in primary specialty
- Employed by healthcare system as a member and leader of the diagnostics team
- Willing to comply with all medical staff and organizational requirements and clinical/business analytics as determined by physicians and management
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the diagnostics team
- Qualified to utilize IBM’s Watson and other decision support tools software
20th Century “Value Added Processes (VAPs)"
- Each physician provides a unique customized approach to manage a given diagnosis (solution)
- ‘Preference cards’ with wide variation in cost, quality, and outcomes (value)
- Institutional tolerance for significant variation based upon need for volume/revenue

21st Century “Value Added Processes (VAPs) and Focused Factories”
- These are “Focused Factories”
- One collaborative and standardized evidence based approach for every significant diagnostic and therapeutic entity
- Value analysis committee (multidisciplinary) to minimize and simplify vendors, suppliers, and technology
- Emergence of new information, evidence, innovation, technology stimulates real time collaborative modification of the VAP
  - Example: Shouldice Hospital, Heart Center (Cleveland Clinic)

Sample credentialing and privileging criteria for Focused Factory Member
Focused Factory Team Member (PICC and Central/Arterial Lines):
- Complete an accredited residency in general surgery, vascular surgery, interventional radiology, or other eligible specialty
- Board certified in primary specialty
- Employed by healthcare system as a member and leader of the focused factory team
- Willing to comply with all medical staff and organizational requirements and clinical/business analytics as determined by physicians and management
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the focused factory team
- Performed at least 50 relevant procedures within the past year of which the first 25 were under direct supervision
Chronic Diseases: BIG NUMBERS!
- 133 M-157M Americans with at least one chronic disease! (almost half) (25% of these with limited ADLs)
- 74.5 M with hypertension
- > 1 M MI's annually (#1 cause of death)(80% preventable)
- >33% Americans obese (#2 in world) and contribute to cancer (#2 cause of death)
- 24 M have diabetes (5X expected due to high sugar diets)
- >20% Americans smoke (greatest cause of premature death) (40% of CA preventable)

Chronic Diseases require "Facilitated Networks"
- Participants with a common clinical condition who share information, guidance, and support (e.g. AA, weight watchers etc.)
- Rely heavily on behavioral modification (e.g. smoking, eating, exercise, medications etc.)
- Business model based upon facilitation and operation of the network with membership fees (e.g. capitation)
- The traditional hospital/physician based practice counter productive

Key Population Health Clinical Operational Components:
1. Palliative Care for severe and life threatening conditions (1%)
2. Disease management programs to optimize quality/reduce costs (5%)
3. Post-acute care programs to support health
4. Retail medicine for healthy individuals with minor acute problems
5. E-health solutions for the healthy (50%)
Palliative Care is Far More than Hospice Care:

World Health Organization:
“An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.”

Examples: severe prematurity/developmental issues….CF, CHF, COPD, severe asthma, cancer, Alzheimer’s….and end of life.

Goal Discovery and Establishment is at the Core:

- Personal and life goals (HLE or QALYs v. LE or DALYs or YLDs)
- Values that are of greatest importance to an individual (e.g. autonomy, freedom, mobility etc.)
- Family’s personal and material resources (e.g. care giving, willingness (or not) to forego day to day obligations, financial, advanced directives
- Negotiation and reconciliation of goals/objectives that work for everyone
- Most objectives can be achieved (80%) within two days of interdisciplinary consultation and facilitation

Managerial Components of Chronic Disease Management (inpatient and outpatient)

1. Collaborative and aligned practice models with strong care management
2. Criteria for identification based upon claims data and clinical analytics
3. Evidence based practice guidelines
4. Patient self-management education and empowerment
5. Process and outcomes measurement (clinical/business analytics)
6. Continual reporting, feedback, and involvement of all key stakeholders (e.g. patient/family, providers, payers, employers) in care modulations
Evidence Based Practice Interventions and Measures for Colon Surgery (Intermountain)

<table>
<thead>
<tr>
<th>Evidence Based Intervention</th>
<th>Associated Measure</th>
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<tbody>
<tr>
<td>Patient Education</td>
<td>% Enrollment</td>
</tr>
<tr>
<td>Early Mobilization after Surgery</td>
<td>% Activity/PT</td>
</tr>
<tr>
<td>Appropriate IV fluid administration</td>
<td>% Compliance with optimum fluid (inputs and outputs)</td>
</tr>
<tr>
<td>Narcotic sparing analgesia</td>
<td>Optimum non-narcotic pain management/scores</td>
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<tr>
<td>Early enteral nutrition</td>
<td>Diet administration, monitoring of flatus/bowel sounds/emesis</td>
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<td>Operating and financial measures</td>
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Project Zero (St. Luke’s Health)

- Created to reduce surgical site infections for 2,000 spine and 2,000 joint surgeries
- Traditional infection rate 1.3% (national average 1.9%)
- Primary causes: excessive traffic through OR (case carts), particulate matter in ventilation system, excessive OR time with some surgeons, lack of data transparency among surgeons
- Increased cost of SSI: $31,182 v. $15,131 (106%)

Sample credentialing and privileging criteria for Palliative Care Team Leader

Palliative Care Team Leader:
- Complete an accredited residency in general surgery, internal medicine, hospital medicine, or other eligible specialty
- Board certified in primary specialty and certified by the American Academy of Hospice and Palliative Medicine
- Employed by healthcare system as a member and leader of the palliative care team
- Willing to comply with all medical staff and organizational requirements and clinical/business analytics as determined by physicians and management
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the focused factory team
- Led at least 50 palliative care consults over the past one year
Process and Outcomes Measures (Intermountain)

<table>
<thead>
<tr>
<th>Enrolled</th>
<th>Non-Enrolled</th>
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<tbody>
<tr>
<td>First tolerated meal: 1.40 days</td>
<td>First tolerated meal: 3.28 days</td>
</tr>
<tr>
<td>BM: 2.35 days</td>
<td>BM: 3.74 days</td>
</tr>
<tr>
<td>Emesis: 9.7%</td>
<td>Emesis: 12.5%</td>
</tr>
<tr>
<td>Average variable cost: $6,133</td>
<td>Average variable cost: $10,503</td>
</tr>
<tr>
<td>Average total cost: $11,808</td>
<td>Average total cost: $20,585</td>
</tr>
<tr>
<td>Net operating income: $3,510</td>
<td>Net operating income: $1,806</td>
</tr>
</tbody>
</table>

Bottom Line for all Colon Surgeries (Intermountain 1,675 patients):
- $1,200,200 annual savings
- LOS decreased from 8.44 to 6.75 days with equivalent or improved clinical outcomes
- Improved patient, family, and provider engagement and satisfaction scores
- Stimulated collaborative efforts in many other clinical areas
- Computer World Business Intelligence Award (2010)-Driving Process Change with BI

Project Zero (St. Luke’s Health)

Process changes: reduced traffic in OR, kept all OR carts in room, installed a high grade HVAC system with a HEPA filter to capture particulate matter, shortened OR time through analytics/feedback/assertive physician management

Results: Reduced SSI to 0.6% (280 fewer infections X $16,051= $4,494,280 cost savings annually)
Sample credentialing and privileging criteria for Post-Acute Team Leader

Post-Acute Team Leader:
- Complete an accredited residency in general surgery, internal medicine, hospital medicine, or other eligible specialty
- Board certified in primary specialty
- Employed by healthcare system as a member and leader of the post-acute care team
- Willing to comply with all medical staff and organizational/system requirements and clinical/business analytics/payer contracts as determined by physicians and management
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the focused factory team
- Led at least 50 post-acute care consults over the past one year

What’s the Problem? Drivers of Unnecessary Readmissions and ED Visits:
- Lack of a standardized discharge process with significant variation
- Lack of patient/family engagement (appropriate incentives)
- Unable to understand discharge instructions or medications (est. 77 M)
- Unable to afford discharge plan/medications
- Ineffective communication of discharge plan/medications
- Unaware of cost-effective alternatives to 911/ED

What’s the Problem? Drivers of Unnecessary Readmissions and ED Visits:
- 51% of discharges do not have timely follow up within 30 days (1000% more likely to be readmitted)
- Top four conditions: CHF/CAP (50%), COPD/Asthma (16%), Diabetes (13%)
- 75%-85% of admissions < 30 days are preventable
- 3% Medicare penalties for avoidable readmissions in a growing number of conditions
Post-Acute Care ‘Best Practice’: Structured Transition Care Rounds (Yale New Haven Hospital System)

- The same process in every unit every day
- Same staff (MD/DO, RN, CM, RM, pharmacist) led by care manager/coordinator
- Structured interview with every patient (several minutes) regarding transition
- Occurs in afternoon (every day)
- Proactive utilization review and transitions planning

How did ‘Patients’ become ‘Consumers?’

- Cost/risk shifting from defined benefits to defined contribution ($338B (2014) to $413.5B (2019) out of pocket expenses)
- High deductible policies and health savings accounts (HSAs)
- Squeezed out of the traditional market (25% of disposable family income)
- Frustrated and ‘value starved’ from complexity, cost, and physician/hospital centered system

What do “Consumers” want and need?

- Value transparency (quality/cost) (The Surgery Center of Oklahoma)
- 24/7 access from anywhere
- Responsiveness to ‘market driven’ (as opposed to ‘sales driven’) demand
- Reasonable margins based upon real (and not fabricated or cost shifted) costs with optimization of cost structure
- Standardized evidence based practices and elimination of non-value added variation (quality/safety)
- Outstanding and responsive service!
Transparent Consumer Markets

- Castlight, ZocDoc
- [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
- [www.physiciancompare.hhs.gov](http://www.physiciancompare.hhs.gov)
- Transparent pricing (referenced based pricing), quality metrics
- Significant financial incentives by employers and payers (narrow/tiered networks)
- iPhone will be the primary healthcare entry point

Retail Clinics

- Predicted to grow to 50,000 outlets by 2020
- Staffed by APRNs under medical directorships
- 36 high volume/low risk diagnoses and treatments (URI, OM, bronchitis, rash without fever etc.) with strict compliance to protocols and medical consultation
- No charge for consultation and referral
- Increasing use of lower cost diagnostics (e.g. Theranos)

Sample credentialing and privileging criteria for Retail Medicine Medical Director

Retail Medicine Medical Director:

- Complete an accredited residency in internal medicine, pediatrics, family medicine, or other eligible specialty
- Board certified in primary specialty
- Employed by healthcare system as a member and leader of the retail medicine team
- Willing to comply with all medical staff and organizational requirements and clinical/business analytics as determined by physicians and management
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the focused factory team
- Overseen and participated in at least 100 retail medicine encounters over the past 1 year
E-Health: Disruptive Innovation for Low Cost
24/7 Access

- Retail Kiosks (employers, retail and clinic settings)
- Mobile apps and devices (computers, I-pad, smart phones, smart watches, etc.)
- 24/7 access to physicians or APRNs for common, low risk, easy to diagnose/manage problems
- Rapid expansion with large employers, health systems, health plans

E-Health: Most Common Uses

- Urgent care (e.g. URI, UTI, rash, flu etc.)
- Chronic medical management
- On demand inpatient consults (e.g. rural areas)
- Emergency department case flow (MSE)
- Home healthcare services
- Post discharge/surgical care
- Behavioral health
- Contribute physicians to national pool

Sample credentialing and privileging criteria for E-Health Practitioner

E-Health Practitioner:

- Complete an accredited residency in internal medicine, pediatrics, family medicine, or other eligible specialty
- Board certified in primary specialty
- Employed by healthcare system as a member of the team-health department
- Willing to comply with all medical staff and organizational requirements and clinical/business analytics as determined by physicians and management
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the focused factory team
- Participated in at least 100 retail medicine encounters over the past 1 year
Everyone will be Disrupted!

- Hospitals to ambulatory VAPs and retail outlets (e.g. MinuteClinic) and e-Health
- Physicians (specialists to generalists) to mid-level practitioners and web-based services
- US based services to international medical tourism
- Commercial indemnity carriers to captive/self insurance programs with private exchanges
- Low end to high end disruption
- Centralized to decentralized (home based tele-monitoring wireless care)
- Patient/consumer centered and driven with 24/7 on demand access

Segmented Services for Different Populations:

1. Healthy individuals with transactional healthcare issues: online services
2. Healthy individuals with minor acute issues: 24/7 retail clinics staffed by APNs (50,000 by 2020)
3. Individuals with chronic medical conditions: PCMHs to facilitated networks and home based tele-health monitoring services
4. Individuals with complex undiagnosed problems: Integrated solution shops
5. Individuals with significant conditions: Evidence based VAPs
6. Terminally ill individuals: Outpatient palliative care

Stage the Transition from FFS to Risk Based Contracting:

1. Align with all key facilities and providers before everything
2. Build the integrated network together (all solutions must make clinical and operational sense)
3. Focus on opportunities to lower cost structure first (labor, supply chain, palliative care, inpatient disease management) MUST HAVE ANALYTICS)
4. Grow new sources of revenue second (e-health solutions, contracts for domestic/international medical tourism, focused factories (VAPs), solution shops etc.)
5. Grow the ambulatory population health infrastructure third as you move into risk based contracting (e.g. post-acute care, ambulatory disease management, retail medicine, home health, etc.)
6. Exit fee for service last and focus completely on health optimization and prevention of disease
Takeaways:

- Population health will create new clinical specialties and roles to create criteria to support
- Many population health roles will cut across departments, service lines, and institutes
- Most population health roles will be ambulatory and system based
- Quality will be increasingly defined by value based payer/CMS/health plan metrics

A Final Thought:

“You cannot cut your way to success. Build a new clinically integrated enterprise based upon cost-effective health ($5T) rather than disease ($3.2T), quality adjusted life years rather than life years, patients/consumers rather than providers/enterprise, and you will be far more likely to succeed.”

Your Humble Speaker

Thank You for Joining Us!
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