

Healthcare Leadership & Management Report

A PRACTICAL STRATEGIC RESOURCE FOR HEALTH SYSTEM EXECUTIVES AND PHYSICIAN LEADERS

Editor's Note: In this article, author Alice G. Gosfield refers to a related article that was published in our sister publication Disease Management & Quality Improvement Report. This article, titled, "It's About Time: What CEOs and Boards can do for Doctors, Nurses and Other Healthcare Professionals," Was written by James L. Reinertsen, MD. We have posted the article in PDF format at:

www.americangovernance.com/abouttime.pdf

Ms. Gosfield is the Chairman of the Board of the National Committee for Quality Assurance (NCQA) but the opinions expressed here are entirely her own and should not be attributed to NCQA in any way.

In This Issue

Making Quality Happen: Confronting the External Challenges to Time and Healing Relationships.....	1
News Front.....	10

Making Quality Happen: Confronting the External Challenges to Time and Healing Relationships

By Alice G. Gosfield, Esq.

The quality challenge, whether in the guise of patient safety, medical errors or the quality chasm, is squarely in the gunights of purchasers, public policy activists and legislative initiatives as never before. We know we have problems of overuse, underuse and misuse of health care services. We know that physicians do not routinely apply the science we have at hand. Still, creating a culture within hospitals and systems that truly drives quality improvement as a bedrock value has eluded the industry for at least the 30 years I have been involved with these issues. Although the high profile of reactions to the Institute of Medicine report on medical errors would lead one to believe that these problems are new, it is merely the recharacterization of them that seems novel.

Why are we having the same conversation about quality over and over again? Some may answer that the problem is the absence of technology to manage quality effectively. Others may argue that until the advent of managed care created sufficient nodes of behavior to measure, it was difficult to know how extensive quality failures have been. Still others say there is no business case for quality: who will pay for what is necessary to create a quality culture? In hospitals, there are no doubt many challenges that confront managers charged

with meeting a wide range of conflicting demands from shrinking payment, restive work forces, increased patient clinical acuity, and disaggregated, disorganized management silos within oxymoronically labeled "integrated delivery systems."

All of these are true. But I would counter that the single biggest barrier to seeing enormous changes in quality has been the inability of any of the efforts to date to even engage, let alone capture, the hearts and minds of the physicians – the most critical significant others to hospitals. Many other laudable initiatives will certainly improve certain sectors of the industry. But none will ever fully succeed to change the real cultural predicates of how hospitals function unless and until they engage the physicians. How can this be, you may ask, when what we now understand is that the key to real quality is addressing the systems that deliver care and not individual behavior?

The Centrality of Physicians to Systems and Patients

Contrary to what some may assert, it is by no means mindless pandering to physician egos to observe that the role of the physicians in hospitals cannot be overstated. The hospital has many other professional stakeholders; and major



Confronting External Challenges to Time (continued...)



clinical contributions are increasingly made by other clinicians, but patients are admitted to a hospital on a physician order. For all of the brand identification efforts and creative consumer marketing initiatives of today's health care system, patients go to the hospital to which their physician refers them, unless they are carted elsewhere by an emergency ambulance or appear off hours at the most convenient place they can find, when they perceive an emergency for which they have no physician or their physician is unavailable.

Under the law, the physician has the broadest scope of authority in relationship to the patient of any other clinician in the institution. It is a longstanding truism that the most expensive form of healthcare technology is the ballpoint pen that the physician uses to generate hospital orders. The physician performs some of the most personal and vital procedures the patient will experience. Taken together, whether explicitly acknowledged or not, these facts produce a setting in which the physician is the formal and informal leader of the care team. Physicians are the portal through which the patient accesses the rest of the healthcare delivery system. In many ways the physician interprets the system in all of its complexity to that patient.

These implications to the hospital and system are confounding by themselves. But for quality purposes, understanding this business imperative does not go far enough. This article is the second part of the consideration begun by Dr James Reinertsen (see editor's note on page 1) in which he noted that the doctor-patient relationship is the critical touchstone for all efforts at quality within the hospital and throughout the system. Efforts to eliminate any toxins to the doctor-patient relationship within the hospital that the hospital can control

can only improve that fundamental relationship. This is not simply good business, it also represents a very significant quality improvement challenge. Studies show that where patients are bonded with their physicians in truly healing relationships, their actual healthcare outcomes are improved. The goal of creating the setting for a strong healing relationship between physician and patient is therefore a real

“Studies show that where patients are bonded with their physicians in truly healing relationships, their actual healthcare outcomes are improved. The goal of creating the setting for a strong healing relationship between physician and patient is therefore a real quality mandate.”

quality mandate.

To look to that principle to drive hospital behavior will surely produce a different hospital environment. Reinertsen focused on internal steps to strong healing relationships in terms of work flow, highest and best use of clinicians and eliminating time-stealing hospital processes. Time is a critical, scarce resource for physicians. To recapture it is a necessary goal if the quality efforts we desire of physicians have any chance to flourish. Any such initiatives within hospitals and organizations will create a more quality-fertile delivery system.

There are also challenges to be met looking outward from the hospital, too. To understand how internal organizational initiatives can proceed most productively and in greatest concert with other demands, we must also recognize the external forces that thwart stronger doctor-patient relationships, understand how physicians respond to them and then do something about them, too. The rest of this article will present a range of external regulatory toxins to strong doctor-patient relationships and then will discuss four principles, a theory and some conclusions for hospitals to use in addressing practical responses to advance the

state of the art, so that internal and external challenges can be met in a coordinated way which gives time back to physicians instead of stealing more of it.

The Force of Law

Three sources of law already have created demands about quality that implicate both the hospital-physician relationship and even more subtly the doctor-patient relationship: (1) federal law in the form of direct quality control provisions, payment rules, fraud and abuse controls, peer-review protection, antitrust and information sharing; (2) state law in the form

of licensure, incident reporting, malpractice insurance requirements, peer review protection acts, managed care reform legislation, still other shadow antitrust and information sharing laws, and state performance measurement and reporting; then (3) as a third and little appreciated legal demand, managed care contracts contain their own mandates regarding payment and quality incentives, utilization controls which often run at cross purposes with the physician's malpractice exposure, licensure, anti-referral proscriptions and a host of other issues which are often overlooked when the contract is negotiated, whether by the hospital on a global basis or by the physicians when they bargain by themselves. These three sources of law play out against the ever present risk of malpractice liability and the quality problems it creates in the form of defensive medicine—unnecessary and potentially harmful services rendered simply to avoid potential liability for failing to perform them.

Each of the regulatory efforts emanated from some policy impulse, which usually purported to rest on a desire to improve or at least protect quality. Ironically, much of what has been enacted in the name of quality actively thwarts it



Confronting External Challenges to Time (continued...)



because of the hodge-podge, patchwork nature of the rules. Moreover, the draining effect of these legal influences is powerful because they primarily focus on punishment for outlying behavior. Through civil money penalties, potential criminal liability, denied claims, and exclusion from networks, these controls operate intentionally through a chilling effect. Their point is fear of the sanction for failure to comply. They offer absolutely nothing helpful in terms of motivating positive behavior. Still further, their intended chilling effect forces good actors to take the same steps to comply that are really aimed at the miscreants at the margins of appropriate behavior. All must expend the same energies, lest they fall into the snares of the enforcers.

Imagine a changed healthcare world, a context in which accountability for dollars and performance are made real, but in doing so the regulators endorse and even adopt the doctor-patient relationship touchstone as the foundation for all regulatory and legal initiatives, eliminating those regulatory mandates that steal time from the doctor-patient relationship. It would be serious understatement to observe that such a system would be different! Until that happens, though, hospitals seeking to make real headway in the quality struggle will have to address the world as we actually know it. You may be surprised to learn that this can be done, I believe in a way which makes a business case for quality even as the forces enumerated below have accumulated over the years in the world outside the hospital's walls.

Although there are many regulatory forces at work on hospitals themselves, such as conditions of participation in Medicare and PRO (now QIO) review of hospital services and payment, the focus in this article is on barriers which affect the doctor-patient relationship in both obvious and less apparent ways. Let us begin by looking at the policy and

regulatory mandates imposed on physicians which steal time to no useful end.

Irrelevant Payment Systems

The most significant time stealer in the doctor-patient encounter is the requirement to document services for payment through detailed recording of specific data to no clinical purpose at all. The recorded information merely provides evidence for postpayment audits



designed to assure the government that the services were documented sufficiently to support the bill submitted. The American Medical Association has data that show that physicians spend one hour on administrative demands for every four hours of patient care. Clinical oncologists are now reportedly spending four times as much time documenting care and engaging in administrative work than they did 25 years ago. I have yet to encounter a physician anywhere in this country, even among those who understand and embrace the need for accountability for healthcare dollars, who thinks this system makes sense.

Much of the problem actually began at the behest of physicians, when the government published guidelines in 1992 to provide for payment based on some kind of quantification of the cognitive efforts spent by physicians with patients, rather than paying mostly for procedures and technology. By 1995 those initial rules were expanded, more fully explained and enumerated in a specific set

of documentation principles. The 1995 rules did not achieve their purpose and were refined further in 1997 with an even more detailed set of requirements. Those were met with such a firestorm that the government said: "Well, use the set of rules—95s or 97s—which you are more comfortable with. Either set is fine."

In 1998, they tried once more to design some approach to the documentation problem and the furor over those efforts was so great they simply had to withdraw their proposal. Discussions continue even today with regard to what to do about documenting care to meet payment needs, but no solution has emerged.

All of these rules, which were inherent in the payment system, have now been bolstered by guidance from the Office of the Inspector General for compliance plans that manage the systems by which claims are submitted. Physicians who fail face penalties of up to \$10,000 per claim plus triple the charges on the claim. The weight of these administrative burdens is increasing while the dollars the physicians are being paid continue to decrease. The basic math alone is no longer working for the physicians and they feel they are able to spend less and less time with patients.

All of this Medicare payment system is working alongside managed care (MCO) contracting rules, which sometimes are quite different as in capitation, percent of premium, contact capitation and global risk arrangements, and sometimes simply adopt the Medicare system subject to idiosyncratic, contract-specific rules which are kept secret by the MCO. One of the founding principles of capitation had been that gatekeeping and payment to keep patients healthy would align the incentives within the system, eliminating unnecessary services. In fact, MCOs did not trust capitation to do its job, and in 1995 a study showed that MCOs were using prior authoriza-



Confronting External Challenges to Time (continued...)



tion, concurrent and postpayment review, utilization and medical management systems, profiling of physicians, variable incentive models and everything else they could lay their hands on to check up on whether the doctors were doing what they were supposed to. Unlike the Medicare rules, which at least are public, the MCO rules are determined in each individual contract, they are very often not revealed to those who are controlled by them and they operate through the potential penalty of contract termination to motivate physician behavior. Capitation itself is now under attack since it also has almost no clinical relevance and creates suspicion that it leads to underservice.

As if that were not bad enough, even if the physicians themselves could come up with a system that would be an improvement, the anti-trust laws do not let otherwise competing physicians come together in common cause to negotiate for better rates. As a result, state laws in places such as New Jersey and Texas are springing up around the country to permit physicians to bargain together for rates, when the MCO with which they must deal has very large market share. But these laws are cumbersome and time consuming to implement, so that physicians who seek to use them to advance their bargaining posture directly have to spend inordinate energies doing that, too. Can a hospital help? Yes, as we will see in our following four principles and a theory.

Civil Money Penalties and Exclusions

In addition to physician false claims liability, large hospital companies, academic medical centers, pharmaceutical companies, kidney dialysis companies and clinical laboratories have all paid hundreds of millions of dollars in settlement of false claims allegations. Yet, these are not the only forms of fraud the

enforcers have targeted. The healthcare fraud and abuse laws in this country now reach far and wide even into the internal workings of physician groups, governing their internal compensation arrangements. These laws directly affect how hospitals relate to physicians, how physicians relate to each other, and ultimately get in the way of otherwise logical arrangements undertaken to motivate quality-driven behavior.



Civil money penalties of \$2,000 now attach for administrative issues such as failing to put ICD-9 codes on a claim form, failing to reveal to a Medicare patient the expected charge in an elective surgery costing more than \$500, breaching the agreement to accept assignment from the patient and therefore Medicare's payment on the claim as payment in full, or charging more than the Medicare established limiting charge. All of these penalties assume that physicians will adopt administrative processes to prevent violations.

So far, these annoyances pertain primarily to claims submission practices. There are other civil money penalties

which address quite different problems and the dollar stakes are higher. Hospitals and physicians can be assessed civil money penalties for offering to a physician (and the physician accepting) an inducement to reduce or limit services to the patient, or \$15,000 for providing false information that could lead to a premature discharge, or for submitting claims for a pattern of services which are not medically necessary. Hospitals and physicians can be excluded from the federal healthcare payment programs for providing or causing to be provided services substantially in excess of the needs of a patient or of a quality that fails to meet professionally recognized standards of care.

The Peer Review Organization/Quality Improvement Organization program can assess overpayments, and recommend exclusion from the program for a hospital and/or physician that provides services that do not meet professionally recognized standards of care, are not reasonable or medically necessary, or were provided on an inpatient basis when they could be more effectively provided in an outpatient setting. The potential penalties turn on matters for which there are no enunciated standards, and they directly implicate quality in terms of preventing or punishing underuse, misuse and overuse. Still further, even those that are directed at the hospital itself can be triggered by or depend on physician behavior in ordering and directing service delivery.

Stark and Anti-kickback

These laws are primarily about appropriate utilization of services and distorted utilization patterns to obtain economic benefit. The Stark statute affects only physicians (and their families) and only Medicare and Medicaid patients referred for specified healthcare services. Since the designated services include all inpatient and outpatient hospital services, all economic relationships



Confronting External Challenges to Time (continued...)



between physicians who refer Medicare or Medicaid patients to hospitals must conform with Stark law mandates. Failure to comply leads not only to overpayments but also to a civil money penalty of \$15,000 for each tainted referral by the physician and another \$15,000 for each claim submitted by the hospital pursuant to the tainted referral. Because of the impact of the statute, ordinary transactions that would be permissible in any other setting between a producer of business (the referring physician) and the business-entity itself (the hospital) are prohibited. The statute sets forth 17 separate exceptions to the prohibition, so hospitals and physicians must navigate very carefully through these shoals which address employment, personal services contracts, recruitment subsidies, and physician incentive plans, among other things.

The Stark statute is quite separate from the anti-kickback statute which affects all federal healthcare payment programs and all players within those programs. Hospitals and their managers, and physicians are all liable both for criminal penalties of up to \$25,000 fine, up to five years in jail or both, as well as civil money penalties of \$50,000 for each violation. This law would punish anyone who pays or receives, or merely solicits or offers, any remuneration, whether in cash or in kind, for the referral of a patient, to induce a referral or for ordering, providing, leasing, furnishing, recommending or arranging for the provision of any service, item or good payable by a federal healthcare payment program.

The upshot is that these laws prohibit hospitals compensating physicians even to do the right thing for their patients when those physicians merely refer to the hospital. The concept of “gainsharing” fell to the implications of these statutes because the Inspector General took the position that any payment by the hospital for reduced services, even from a baseline of improper or overutilized services, would violate the statute. After its grand pronouncements,

though, the OIG did approve a very carefully crafted cardiac surgery gainsharing program which contained strong and explicit service safeguards. But the utility of the concept of gainsharing in hospital-physician relationships is much diminished.

So what do these laws have to do with our concern for time and the doctor-patient relationship? Taken together, not only do they implicate even minor transactions between hospitals and physicians—even where those transactions are intended to benefit quality, improve doctor-patient relationships or otherwise address the need to motivate quality behavior—but they also instigate long analyses of corporate structuring and business transactions that drain time and energy (not to mention money) that physicians could far more productively spend with their patients.

Physician Reactions

There is no doubt that the accumulation of all of these demands on physicians has subjected them to a crushing administrative burden that increases their costs and diverts their energies from their patients. The control systems imposed by their MCO contract partners require them to spend time themselves or pay someone else to unearth clinical data requested by the MCO, the laboratory, the hospital or the pharmacy, obtain prior authorizations for care from nurses at far flung locations questioning their medical judgment, and manage specific formulary systems that vary by plan. They know that the multiple plans they participate with have incentives to motivate their behavior, but often these vary so subtly or are so complex that they simply have no idea what they are being motivated to do.

In addition to the regulatory, antitrust, and contractual demands placed on physicians, they are confronting wildly escalating malpractice premiums and continued liability for malpractice when the MCOs, which contractually require them

to reduce services, seem not to have to bear any responsibility for the harm their patients suffer. Their patients both bombard them with information from the Internet, which is of questionable value, and demand drugs that they have seen advertised as what they need. The decreased reimbursement they get from Medicare and MCOs forces them to see more patients with less intimacy in the interactions. The plans report data about them which they believe measures things they cannot control. The knowledge base they must bring to bear to serve their patients well is exploding at unprecedented rates. The MCOs with which they must contend unilaterally change their payment rates as they increase their power in the market while the physician costs to run their offices increase. They are furious, saddened, and as a result paralyzed in many ways by the vast conspiracy they feel is at work against them. But as we have seen, their paranoia is not groundless—just because you are paranoid doesn't mean no one is after you.

As they have lost time from their office practices, within the hospital the medical staff often feels marginalized and excluded from the real corridors of power as hospital managers struggle themselves to manage the demands on the institution. The traditional medical staff organization sees decreasing physician enthusiasm and participation, which only further erodes the hospital-physician relationship and impedes productive undertakings. No wonder physicians are both resistant to the hospital's initiatives to solve its problems and deaf to the blandishments of hospital administrators to help the hospital fulfill its mission. How in the world can quality happen against this backdrop? Can this marriage be saved?

Four Principles and a Theory

Viewed in this light, it is evident that to make things better physicians need a different healthcare world. Four prin-



Confronting External Challenges to Time (continued...)



ciples—standardization, simplification, clinical relevance, and accountability—would dramatically improve quality while meeting physician needs. (1) Physicians need more and not less standardization to reduce wasted administrative time and decrease their administrative burden. (2) We need to simplify their lives contractually and administratively. (3) We need to make their payment systems and the administrative burdens that are legitimately imposed upon them clinically relevant. If we standardize, simplify and make clinically relevant the demands we impose on them (4) physicians will likely be more willing to be held publicly accountable for their performance when they are measured in terms of the things they can control—their application of the best science available and the quality of their relationships with their patients. Are these utopian principles which cannot be applied in this world? Not at all.

One simple theory, judiciously applied can knit together these disparate themes into a unifying platform that solves an enormous number of problems: To use evidence-based clinical practice guidelines as the bedrock for organizing, paying for, documenting and delivering care can standardize, simplify and make clinically relevant the care context, acting as an antidote to the external toxins to the doctor-patient relationship. How might this theory work in practice?

Clinical Practice Guidelines At Work

Many physicians and hospitals believe they are using clinical practice guidelines in optimal ways. Yet they usually relegate the development and application of them to the quality assurance department or utilization management. In the most sophisticated settings, CPGs are used to drive standing orders and prompt physician treatment, but very

rarely are CPGs used to document, price and literally reorder the way care is provided throughout the hospital.

The Institute of Medicine has articulated eight attributes of good clinical practice guidelines which justify their broad application. Imagine what would

“Four principles—standardization, simplification, clinical relevance, and accountability—would dramatically improve quality while meeting physician needs.”

happen to the time physicians had to spend with their patients as opposed to administrative tasks if the hospital and the physicians together selected a single CPG to treat congestive heart failure (CHF), for example, a guideline to be used in the office as well as in the hospital as the patient’s condition warranted. A good guideline, such as that published by the Institute for Clinical Systems Improvement, lends itself to translation into procedure codes and diagnostic codes which can be templated so as to facilitate standardized treatment and standardized documentation of care. This change can only save time from the individually recorded, idiosyncratic notations used by most clinicians today.

Not only that, but analyzing literally the resources necessary to produce each element of the care process set forth in the guideline, and then focusing on the actual cost to the hospital and physician of each element, can, in turn, lead to a true clinically relevant payment system designed around that algorithm. Case rates, fee-for-service budgets in accordance with the guideline, variations and combinations can be constructed to reflect the science and the costs that are elucidated.

If the payer can accept the guidelines recommendations as the way care will be provided, then the constant inspection, prior authorization and reevaluation of whether the physicians are do-

ing what the guideline says can be done away with. Ongoing documentation merely to justify medical necessity of care and the scope of the service provided becomes redundant because the guideline itself makes that case. Physicians and hospitals could contractually agree to provide that algorithm to CHF patients. Limited post-payment audits simply to verify that they have followed the essential steps contracted for would eliminate major elements of time-wasting behavior.

Not only would more science be brought to bear more easily, physicians could not help but have more time to spend with their patients in more connected relationships.

Such an approach must incorporate flexibility in its application so as not to create rigid new punishment bases. But this is not difficult even as we adhere to principles of standardizing as much as possible. Flexibility entails two basic concepts: (1) Accommodate anticipated clinical variation. Here the issue is variation within the CPG. As the Institute of Medicine has observed, a good guideline contains within it expected clinical variability such as frequent co-morbid conditions (e.g., patients with CHF often have hypertension or diabetes). These should be anticipated as much as possible and set forth in the system to apply the CPG. (2) Allow for unanticipated variation. Here the issues can be an unusual clinical course (e.g., an unexpected allergic reaction to a drug or a surgical complication) or a socioeconomic issue (e.g., the patient would be discharged to home care but lives in an inaccessible environment where family members and visiting nurses are unavailable). For these types of developments, deviation from the CPG must be allowed. To do so makes the system workable in the real world and credible to the physicians who know that patients cannot always be managed strictly in accordance



Confronting External Challenges to Time (continued...)



with a CPG (which is why they have historically resisted these types of approaches as “cookbook medicine”).

Ah yes, you may say, this may work with enlightened MCOs, but the Medicare laws are written in stone and the physicians must follow the current rules of documentation. In fact, the rigidity of Medicare is real but it may not be absolute. The Medicare statute already provides that money is available to develop experiments and demonstration projects to determine whether other methods and approaches could enhance efficiency and utilization, including a change to methods based on negotiated rates, which could increase the efficiency and economy of healthcare services without adversely affecting their quality. Even if hospitals and physicians together did not seek to generate innovative payment schemes, Medicare fee-for-service reimbursement can still be time- and quality-enhancing by this approach.

The Antidotal Effects

The external toxins described here are potent but blunted by this standardized, simplified, clinically relevant technique. By applying the same CPGs to treat patients regardless of payer, office and hospital administrative systems to track benefit coverages can be simplified. In following a well-established national CPG, by definition there is no risk of underuse, premature discharge or underservice, thereby forestalling the need for additional administrative systems to prevent civil money penalties or exclusions on quality grounds. Nor must the physicians be fearful that they have over-responded to managed care incentives, nor over-used services in the practice of defensive medicine. Moreover, since the heart of a malpractice case turns on whether the physician met the standard of care, to explicitly use CPGs and document this approach in the medical record, can mitigate the possibility of a malpractice law-

suit if there is a therapeutic misadventure of some kind.

Because the documentation of care in this setting is oriented around the clinical delivery of the care and the guideline itself states the scope of the service rendered and its medical necessity, even for Medicare, the physician need not



record in his own handwriting every word of the documentation supporting his service. There is a wide variety of ways in which this approach to documentation can be implemented depending on the setting and the technologies at hand (e.g., pen and paper, personal digital assistant, laptop-based electronic medical record, voice recognition transcription software). The point is not the specifics of the implementation but the principles of its application.

Astonishingly there is even a specific regulation under the Stark statute that permits a hospital to train its physicians in such an approach, which can directly economically benefit those physicians in their own practices and will

not run afoul of the wide-reaching prescriptions of the law. Where the hospital provides compliance training that addresses billing, coding, reasonable and necessary services, documentation requirements and education on unlawful referral arrangements, the hospital is meeting its own needs and those of its physicians. (42 CFR 411.357(o)) Talk about finding a way to help physicians help themselves and the hospital in the process without the necessity to look to complex gainsharing programs!

Whether these types of efforts are part of a hospital-physician collaborative undertaking or the physicians initiate the changes themselves, the systems and processes by which physicians review their own compliance with the CPGs and analyze the data they find in the interests of being more efficient, providing better quality and refining their behavior, can have another very major antidotal affect under the antitrust laws. While it is true that generally speaking otherwise competing physicians may not bargain collectively over fees, there is a little-appreciated piece of guidance offered by the Department of Justice and the Federal Trade Commission regarding their positive views of “clinical integration” efforts as distinct from “financial integration”.

In the aftermath of failed Clinton health reform many physicians toyed with the idea of merging their practices for better bargaining power and economies of scale. The instances in which the advertised potential of these mergers was realized were few and far between. Short of true mergers, the antitrust enforcers have provided safety zones for certain kinds of financial integration. The types of financial risk which qualified for protection have not always been available in the specific marketplace and raise their own challenges. Broad-based capitation and global fee arrangements have not swept the industry and fee-for-service medicine is returning in quarters where many thought it was long dead.



Confronting External Challenges to Time (continued...)



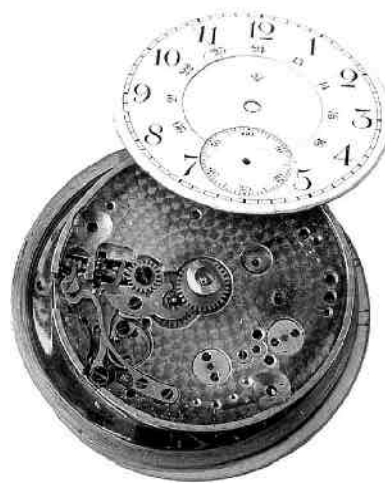
But where physicians come together even in loose affiliations where they apply CPGs for the purposes described here, as an ancillary effect the enforcers have said that these physicians would be able to negotiate collectively for fees since they would not consider such a program per se violation of the law. The enforcers have now officially approved a proposed physician program in Denver that would conduct such internal management, evaluation, profiling and data management programs. The efforts necessary to win the government's approval are substantial, but where this type of unified approach to health care is undertaken for the quality-propelling and timesaving reasons discussed here, the economic benefit of joint negotiation may emerge too. This is truly a business case for quality.

Finally, the value of this technique in dealing with external challenges is only the beginning. This approach also provides a consistent and obvious foundation upon which to address the internal challenges that Reinertsen presented. By explicitly recognizing the many ways in which this CPG based approach can standardize, simplify, and make clinically relevant the internal hospital processes by using the same CPG regardless of where the patient is treated, the power of the technique is fortified.

Getting There From Here

To implement this CPG technique in the comprehensive way described here is enormously appealing to physicians both because of its logic and its time-saving potential. It speaks to physicians the way they think, and as Reinertsen says, it makes the right thing to do the easy thing to do. But if the hospital managers go to the medical staff and simply propose this kind of program, I can guarantee they will be met with suspicion. Beleaguered as they are, physicians are highly suspicious of unilateral hospital efforts even where they are well intentioned and might produce for physicians

the time and control they crave. Physicians will only be receptive if the program is truly collaborative from the earliest stages. The process by which this kind of initiative unfolds is critical to its success. How to proceed calls into question the underpinnings of the hospital-medical staff relationship, which itself merits renewed consideration for a host of reasons.



Following are some simple principles that can help hospitals move forward with their physicians:

1. Involve physicians from the earliest moments that the project is considered. This means the first step likely is for an interested administrator to approach critical physician leaders to jointly determine how to proceed with the staff and where.

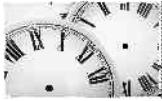
2. Choose physician leaders who can communicate and champion effectively and are motivated to take some risk and initiative because they understand the significance to their constituency. This is not necessarily the titular head of a department.

3. Make the physician involvement visible so the other physicians know who is involved and how. Back room conversations and informal discussions will not support the effort most effectively.

4. Develop trust in the process. This one principle garners more questions to me from physicians and hospital managers than anything else when they contemplate such a program. "Our relationship is not working. We don't trust them. How do you rebuild trust in a broken setting?" Both sides ask the same question. This is a problem that can only be resolved over time, but it also entails two very simple axioms: (1) Do what you say, say what you do, consistently over time. (2) Share all the data and problems along the way. Based on their training, physicians distrust interpreted data. They often believe that hospital administrators are managing the data to which they give access. Good news and bad news alike must be addressed collaboratively. This is far more easily said than done but is an important hallmark of a sufficiently reordered approach as to permit the physicians to believe the exercise is worth it to them.

5. Be realistic and not grandiose. Many efforts in hospitals to fix broad-based problems assume the need for widespread application of new approaches. This rarely works and almost never works where the physicians are the critical actors. It is far better to begin with one or two clinical conditions until proof of concept has been won. Physicians are trained to believe data, so the more information can be provided to them about what has worked, the better the chance to get second adopters to act.

6. Think broadly. As the CPGs are applied, look for more ways in which to drive hospital processes and clinical care based on the CPGs. For example, think about how to determine which clinicians should have responsibility for the elements in the CPG with the goal of highest and best use of each—doctors, nurses, therapists. Now consider what that means about workflow, job descriptions, medical and nursing staff planning and even medical staff bylaws issues. The implications are quite far reaching and



Confronting External Challenges to Time (continued...)



clarify the basic functions around which the hospital is engaged.

A New Way of Thinking

The notion of using CPGs to standardize, simplify, and make clinically relevant much of the physician's work environment both inside and outside the hospital is a different way of confronting the forces which buffet physicians and hospitals alike and increasingly impede their abilities to work together. The theory appeals to physicians in fact because it is not revolutionary, but the insights behind it speak to their challenges in ways they have not heard before. Where hospital administrators are willing to articulate their explicit recognition of the physicians' challenges and express a believable willingness to work collaboratively to meet them head on, real change becomes possible.

Many who have heard these thoughts when I have presented them have asked where the evidence exists that what is propounded here will work. I have no such evidence to report, yet. What I can report though, is that the enthusiasm of the physicians to come to grips in this way with the challenges they feel every day is astonishing to me. To recapture time to practice medicine and

engage with their patients in truly meaningful relationships is the single greatest desire of physicians today. Many also understand the need to assure the policymakers, legislators and payers, that they are delivering good quality care and that they are willing to be held accountable for the payment they receive. They struggle to find what to do. In the face of the disparate forces that confront them, they have felt impotent and depressed. This approach gives them hope and engenders a willingness to try. That alone is remarkable in today's world.

Hospitals hold a special place for physicians. Even the concept of a hospital medical staff recognizes this unique relationship by providing a context through which otherwise independent physicians come together in common cause only in their use of the hospital's facilities. The vehicle of the medical staff provides the mechanism through which are defined many of the most critical elements of that environment in terms of the clinical credibility of the place they will bring their patients for care. Physicians want to do the right thing and hospitals can only benefit by helping them do so. By helping the physicians regain time for their patients and reorient their approach in standardized, simplified, clinically relevant ways will lead to collabo-

rations that can only improve upon what is typical today. There is no longer any question for hospitals or physicians that something different must be done. In the proposal here there is almost nothing to lose and an enormous amount to gain. In the long run the result may be that physicians and hospitals can do well by doing good.

Additional Resources

Gosfield, "Making Quality Happen: In Search of Legal Weightlessness" (a consideration of four legal problem for physicians—payment and compensation, Stark and anti-referral laws, HIPAA privacy regulations, and antitrust, and how to confront them) (Health Law Handbook, 2002 Ed., WestGroup, pp. 609-678)

Gosfield, "Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations," (a white paper on the role of the organized medical staff in hospitals and MCOs and how to change the ways that hospitals and physicians collaborate, including a specific continuum of issues around which it is variable imperative, important, useful or not a priority, that physicians are intimately involved in hospital activities) (American Medical Association, Chicago, IL (1998) 25 pp. <http://www.ama-assn.org/ama/pub/category/8340.html>)

In Re MedSouth: The FTCs consideration of the clinical integration model proposed by a loosely affiliated IPA in Denver) (In Re: MedSouth Inc., Feb. 19, 2002, (<http://www.ftc.gov/bc/adops/medsouth.htm>))

Gosfield, "Physician Practices" (written for attorneys, an analysis of why and how physicians approach business and regulatory issues differently from their business others) (Vol. V. The Business Environment, Chapter 35) Health Law Practice Guide Clark Boardman Callaghan, pp. 35-1-35-24

ALICE G. GOSFIELD practices law in Philadelphia through Alice G. Gosfield and Associates, P.C. (www.gosfield.com) Ms. Gosfield has restricted her practice to health law and healthcare regulation since 1973 and places a special emphasis on matters related to physician representation, managed care, noninstitutional reimbursement, medical staff issues, fraud and abuse, and utilization and quality issues. A graduate of Barnard College and New York University Law School, she served as President of the National Health Lawyers Association (now the American Health Lawyers Association) from 1992-1993. She has served on four committees of the National Academy of Sciences Institute of Medicine studying issues in utilization management and clinical guidelines, and has consulted to the federal Agency for Health Care Policy and Research, the General Accounting Office, the Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation. Since 1998 she has been the Chairman of the Board of Directors of the National Committee for Quality Assurance (NCQA), the managed care accrediting organization, reelected to serve five terms through 2002. She has been a member of the board since 1992.