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ideas. answers. action.

Key Concepts for Successful Clinical integration

Becker's Hospital Review Annual Meeting 2012

Chicago, Illinois

May 17, 2012

Healthcare Reform and its Impact on Providers

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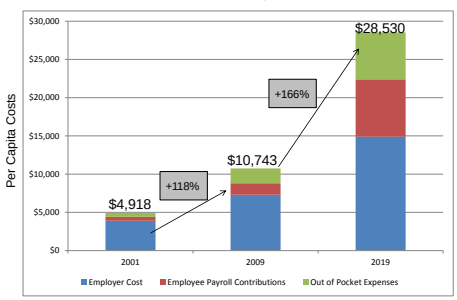
The Elephant in the Room: Increased Employer Cost

Why Innovate? → Affordability

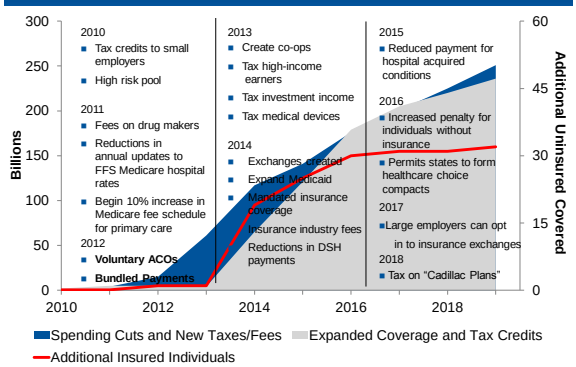


Source: Paul Grundy, M.D., ICQV 2011 Clinical Integration Forum. AON Hewitt Trends in HR and Employee Benefits, November 2010 Report.

Core Themes of Healthcare Reform

	Proposed Method
Expand Coverage	▪ Expand Medicaid ▪ Subsidies for moderate income individuals ▪ No exclusions for pre-existing conditions ▪ Create new market competition for health insurance ▪ Individual and employer mandates
Paying for It	▪ Increase payroll taxes on high earners ▪ Tax on "Cadillac" plans ▪ Disproportionate Share Hospital ("DSH") payments reduced ▪ Drug companies, medical device, and health insurers assessed fees
Payment Reform	▪ Reduced payment for hospitals with high readmission rates ▪ Value-based purchasing ("VBP") program - hospitals and physicians ▪ Further payment reductions for healthcare - acquired conditions ▪ Increased payments for primary care services - more for shortage areas
Delivery System Reform	▪ Medicare Bundling "Acute Care Episode" pilots ▪ Accountable Care Organizations ("ACO") ▪ CMS Center for Medicare and Medicaid Innovation ("CMI") ▪ Medicaid payment demonstration projects

Patient Protection and Affordable Care Act Timing

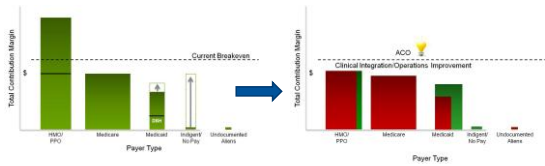


"Actually, these aren't bad times to be delusional."

THE NEW YORKER, AUGUST 16 & 23, 2010

Insurance Providers Moving to Match Medicare

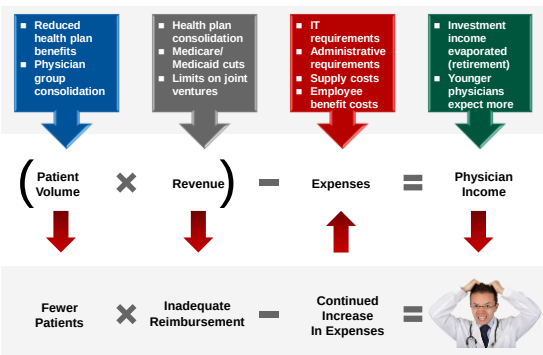
An outcome of pressure to reduce premiums, commercial health plans will be forced to reduce their HMO and PPO reimbursement rates to levels approximating Medicare. As a national average, the combined impact is estimated to be a 25 percent reduction to hospital contribution margins and a situation in which the resulting margin is significantly below the current breakeven level as shown on the chart below:



How to achieve new breakeven level?

- **Accountable Care Type of Organization**
- **Clinical Integration/Operations Improvement**

Marketplace Challenges Impacting Physicians

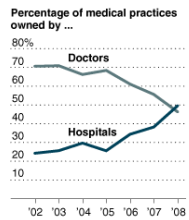


Hospitals and Systems are Employing More Physicians

- Hospital employment of physicians has increased rapidly in the last five years:
  - As recently as 2005, over two-thirds of medical practices were physician owned
  - By 2008, less than fifty percent were physician-owned
- Factors driving physicians to seek employment include:
  - The growing emphasis on patient safety and quality
  - **Changes in government payments to doctors**
  - The expense of an electronic medical record
  - Desire for economic stability without the risk of buying into a practice
  - Lifestyle (e.g., less call)

Fewer Private Practices

More doctors are joining hospitals and health systems rather than go into private practice.



Source: Medical Group Management Association

Source: "More Doctors Giving Up Private Practice," New York Times, March 25, 2010

Hospitals are Seeking Physician Alignment Solutions

Concerns	Solutions
Economics	
■ Subsidy of affiliated physicians ($80K to $100K per physician) ■ Readiness for bundled payments and accountable care organizations ■ Primary care base to feed specialists ■ Pay for physicians' time	■ Improve management of hospital-affiliated practices ■ Restructure physician organizational model (e.g., clinical integration, accountable care delivery systems) ■ Revenue cycle redesign/improvements/leverage
Physician Leadership	
■ Engagement on quality initiatives ■ Engagement on cost initiatives ■ Collaboration on practice operations improvements ■ Leaders to guide/expand physician-hospital relationships	■ Defined leadership path for emerging leaders (e.g., education and experience) ■ Meaningful involvement of physicians in decision-making (e.g., governance, co-management) ■ Redesign of physician leader incentive compensation (e.g., cost, quality)
Physician Retention	
■ Succession planning for aging medical staff ■ Loyalty of private practice physicians	■ Expanded affiliation model (e.g., employment, foundation) ■ CI strategy ■ Nurture culture of mutual respect

Health Plans See Changes Coming and So Do Providers

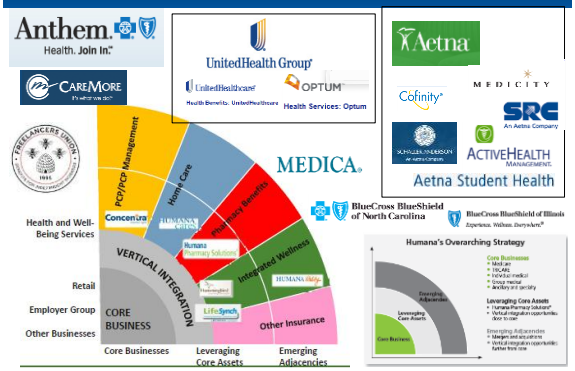
- **Implications for Providers**
  - Soft demand for elective procedures
  - Bad debt pressure on providers
  - More price shopping for services
  - Continued increasing use of the emergency medical services
  - Continued consolidation of providers; hospitals, physician organizations, and outpatient providers
  - Payer/Provider collaborations, partnerships, and horizontal and vertical integration

NEWS FLASH

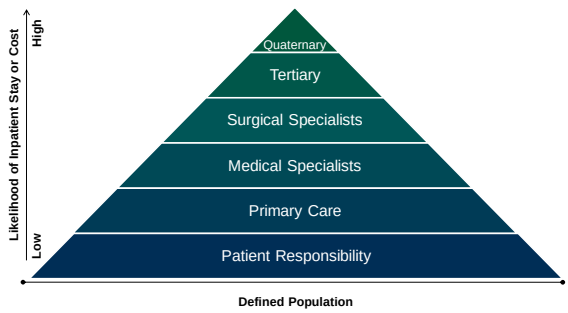
Health Plans Acquire
Physician Management Groups

- June 28, 2011: Highmark Inc. to acquire West Penn Allegheny Health System
- June 8, 2011: WellPoint Inc. to buy CareMore Health Group
  - CareMore provides managed care to 54,000 elderly
- November 22, 2010: Humana Inc. to buy Concentra Inc.
  - Concentra provides urgent care, physical therapy, and wellness services from more than 300 medical centers in 42 states. Concentra operates in more than 240 medical facilities.

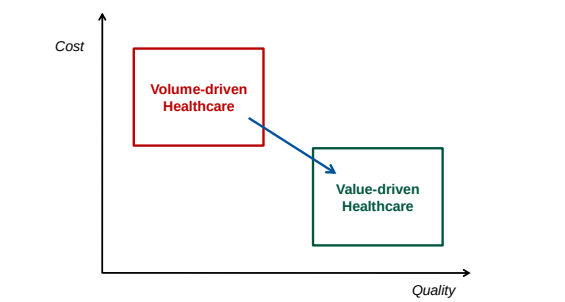
So Let's Look at the Health Plans Changes



New Paradigm: Increase the Defined Population We Care For

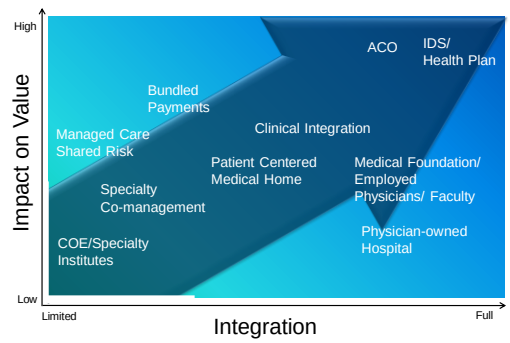


Impact of Healthcare Reform and New Care/Payment Models

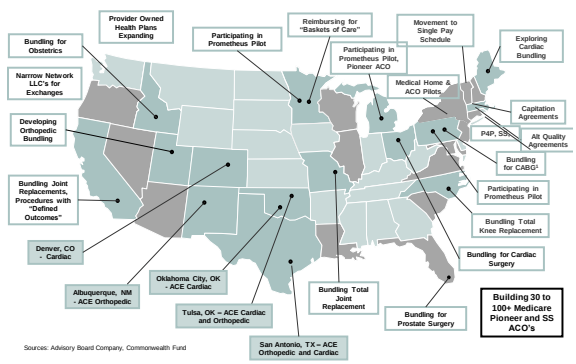


Source: Center for Healthcare Quality and Payment Reform

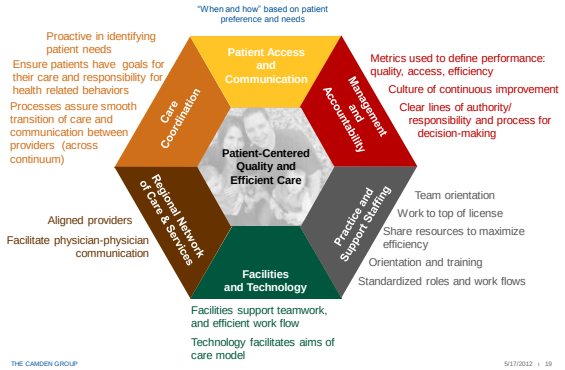
Physician-Hospital Integration: Driving the Value Proposition



Nearly One-half "probably more" of Nation Now Testing Bundled Payment and P4P, Shared Savings, ACO, Payer and Provider Collaboratives

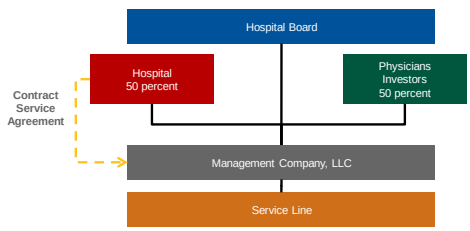


Patient-Centered Medical Home Initiatives



Co-management Aligns Interest Without Full Integration

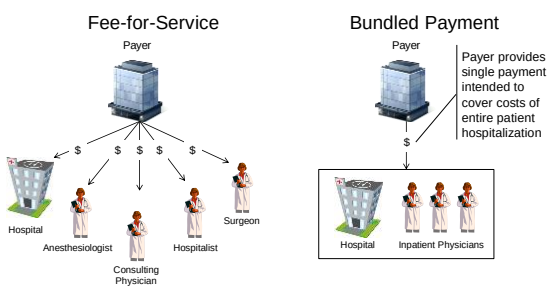
- Next Step for COEs? Co-Management Model Design



- Management company governance is typically equally split between the Hospital and physician investors.
- Equity split does not need to be 50/50, but typically is. The goal is to create an attractive arrangement for both the physicians and the hospital. The equity arrangement determines the distribution on returns.

Building the Foundation for Shared Risk: Bundled Payment

Inpatient Episode Payment Models



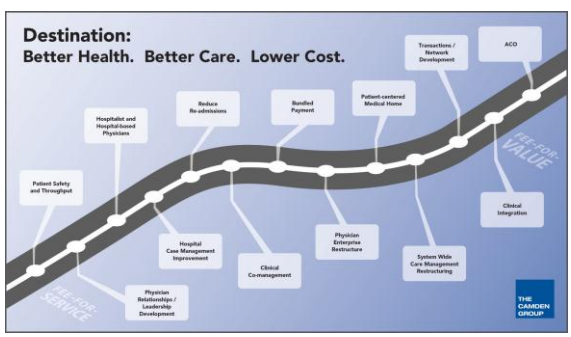
Value-based Payment Models

VBP Models	Advantages	Disadvantages
Pay-for-Performance ("P4P")	▪ Well established measures ▪ Programs are available through Medicare and private payers ▪ Builds competencies for clinical quality management	▪ Modest investment in processes and systems to gather data ▪ Bonus payments are small
Medical Home	▪ It works! Improves quality while reducing costs ▪ Patients and families love it ▪ Improves physician and staff satisfaction	▪ Culture change to team-based care ▪ Significant investment in resources for clinical support staff ▪ Less applicability in small practices because of resource requirements, but virtual models are being created ▪ Payment models are not always aligned to cover infrastructure investments
Co-management	▪ Physician partnership in management functions around quality, cost management, and operations ▪ Improved physician satisfaction	▪ Limited financial incentives

Value-based Payment Models

VBP Models	Advantages	Disadvantages
Bundled Payment	▪ Improves quality and physician satisfaction ▪ Can move market share ▪ Increases physician payment ▪ Improves efficiency and cost	▪ Not appropriate for every market ▪ Requires additional IT and infrastructure development
Clinical Integration	▪ Aligns independent and employed physicians ▪ Improves quality and cost	▪ Requires establishment of clinical care management capabilities including care protocols and monitoring ▪ Substantial investments in IT for disease registries and patient and physician portals
Accountable Care Organization	▪ Improves costs and quality ▪ Meaningful financial incentives ▪ First move-advantage in some markets	▪ Model only works with volume increases or cost reductions ▪ Significant culture change ▪ Capital requirements for IT and staff are substantial

Clinical Integration/Accountable Care Roadmap



Definitions of Clinical Integration

"Clinical Integration is defined as the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units so as to maximize the value of services delivered. Clinical integration includes both horizontal integration (the coordination of activities at the same stage of delivery of care) as well as vertical integration (the coordination of services at different stages)."

Shortell, S.M.: *Remaking Health Care in America: Building Organized Delivery Systems*, First Edition, Jossey-Bass Publishers, 1996.

"An ***active*** and ***ongoing*** program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of ***interdependence*** and ***collaboration*** among the physicians to ***control costs*** and ***ensure quality***."

FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care, #8.B.1 (1996)
http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm

What the FTC Looks For (No Cookie-cutter Approach)

Components of CI:

- Mechanisms to monitor utilization, control costs, and assure quality of care
- Selectively chooses physician participants
- Significant investment of monetary & human capital*
- "The use of common information technology to ensure exchange of all relevant patient data
- The development and adoption of clinical protocols
- Care review based on the implementation of protocols
- Mechanisms to ensure adherence to protocols."**

The Agencies: FTC & DOJ

- Are committed to eliminating unlawful restraints on vigorous price and non-price competition in physician markets
- Do not suggest particular structures with which to achieve clinical integration

*FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care, #8.B.1 (1996)
**FTC/DOJ, Improving Health Care: A Dose of Competition Ch. 2, p.37 (July 2004)

CI Infrastructure: What it Takes

- Goals of improving quality and efficiency
- Multi-specialty network
- Functioning physician committees
- Guideline (protocols) agreed upon for all participating specialties
- Performance standards and metrics
- Monitoring of performance
- Performance incentives
- Sharing of clinical data across network
- Referral tracking and management
- Health information exchange and disease registry with analytic capabilities
- Care coordination and management
- Accountability
- Commitment to continual redesign of care processes

Clinical Integration - What's in it For…

Health Systems?

- Enhance linkage and alignment with physicians
- Facilitate implementation of quality improvement initiatives
- Consistent "branding" to patients and payers
- Expand physician leadership in clinical care redesign
- Opportunity to earn additional compensation from shared savings
- Increase ability to deliver outcomes, quality care, and patient satisfaction

Physicians?

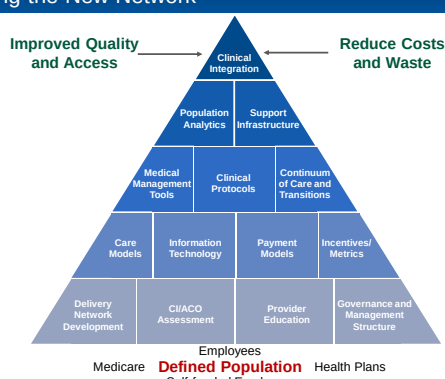
- Access to electronic tools to enhance patient care efficiency
- Opportunity to earn additional compensation from shared savings
- Enhance market positioning and "preferred" network
- Enhance satisfaction with clinical delivery model
- Increase ability to deliver outcomes, quality care, and patient satisfaction

CI – Market Drivers and Organizational Strategy

Why Pursue CI Development

- Form a partnership between physicians and hospitals to achieve better patient care and reimbursement
- Community and payer recognition for quality of physicians
- Provide an alternative to employment for physicians
- Stabilize and improve income for all
- Enable physicians and other providers to earn payment and performance incentives for effective patient care
- Establish the network and infrastructure that enables coordinated care and sets stage for "accountable care" and whatever comes next
- Attract new independent physicians, especially primary care physicians ("PCPs")
- Attract new patient populations and increase market share
- Increase access to IT infrastructure and systems to support CI and population health management

Building the New Network



Success Factors

Lessons Learned

- Is important to be **physician-led, physician driven**
- Engage the administrative and clinical leaders in the organization who have **insight, persuasive capability, and enthusiasm for accountable care** and the steel to motivate and navigate the collective through the challenges ahead
- Do not underestimate the challenges and importance of **robust IT connectivity/infrastructure along the continuum of care**
- **Decide upon the philosophy and goals for the delivery system first** (e.g., care models to be primary care-focused), then design the economic incentives to support the behaviors
- Weave financial model planning and implementation with care model/protocol development and execution so that each supports and reinforces progression of the other

Clinically integrated delivery systems are a work in progress that take relentless focus, diligence, and ongoing communication

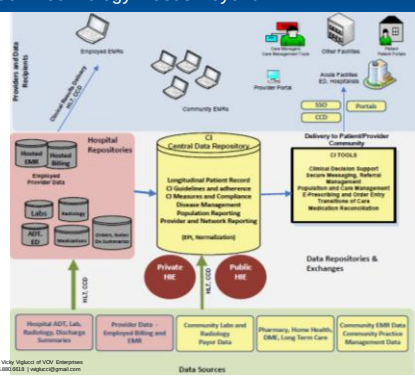
Critical Success Factors New Models

- Care delivery network
  - Full spectrum of physician specialties, hospital and sub-acute care
  - Other diagnostic/treatment services
  - Care management
  - Incentive/Payment structure, and organizational comfort with managing risk
- Infrastructure
  - Physician leadership
  - Data warehouse/population management capabilities
  - Ability to capture financial and clinical data
  - Real-time reporting and alerts
  - Entity for contracting and distributing payments
- Willing payer
  - Incentives for shared savings, P4P
  - Shared risk (narrow network products)
- **Focus on redesigning clinical care delivery across the continuum to find new ways of improving efficiency, service, and quality.**

Critical Success Factors for Engaging Physicians

- Emphasis quality, but with increased reimbursement for extra work
- Provide assistance with technology cost and adoption
- No mandate to adopt full EMR or manual entry of data into registries
- Early education regarding…why and what's in it for me/us?
- Multiple contacts at medical staff, departmental, practice group meetings and paper/fax/email communications
- Multiple small group meetings with presentation on concepts, discussion by physician and hospital system leaders, chance to ask questions and hear what colleagues have to say
- Including physicians in meaningful roles in every step
- Each planning committee should be predominantly composed of physicians
- physicians leaders should be chosen from all major areas of the service continuum and should have the respect of their peers and the skills to be good communicators of complex concepts
- must be armed with the tools to be able to clearly explain the impetus, goals, and value proposition to colleagues
- Schedule meetings at times convenient to physicians and assuring that agendas are meaningful
- Strong leadership, including physicians, to set and enforce parameters

Information Technology Needs Beyond EMR



Sourced and created by Vicky Viglucci of VGV Enterprises
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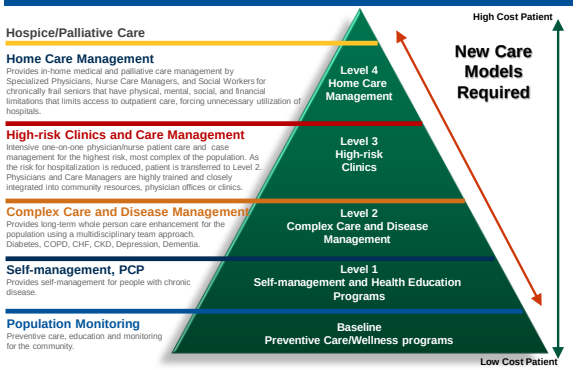
Shared Infrastructure Development

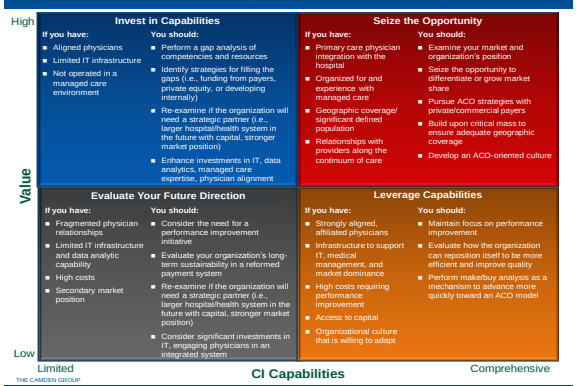
Infrastructure	Co-management	Medical Home	CI	ACO/Managed Care
Clinical Quality Reporting	◑	●	●	●
Disease Registries	◑	●	●	●
Physician Leadership	◑	●	●	●
Electronic Medical Record		◑	◑	●
Evidence-based Guidelines	◑	◑	●	●
Central Data Repository		●	●	●
Care Model Redesign		●	◑	●
Care Management Resources		◑	●	●
Patient Portal/Secure Messaging		◑	◑	●
Preferred Specialists and Hospitalists		◑	●	●
Clinical Decision Support at Point-of-Care		◑	●	●
Disease Management		◑	●	●
Health Information Exchange/Provider Portal			●	●

○ Low ◑ Moderate ● Substantial

Not As Simple As "Inpatient" and "Outpatient" Anymore



CI Action Plan – Where are you and What should you do?



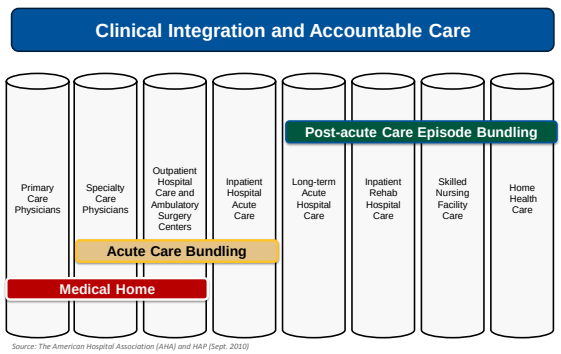
Recommended Strategies Need to Align with Evolving Payment System

	Short-term (One year)	Mid- and Long-term (2 to 5 years)
Goal	Heads in beds	System CI
Key Objectives	■ Build trust ■ Increase loyalty ■ Expand and strengthen primary care base ■ Solidify specialist relationships at each hospital	■ Access new patient populations ■ More effectively manage current populations across the continuum ■ Increase market strength and financial performance

Strategies	2011	2012	2013	2014	2015
Support Services	Primary Strategy	Secondary Strategy			
Service Agreements	Primary Strategy	Secondary Strategy			
Employment	Primary Strategy				
Clinical Integration	Plan/Implement	Primary Strategy			
ACO	Plan/Implement	Primary Strategy			

Payment Systems: FFS → Incentives → Capitation

Addressing the Full Continuum



Source: The American Hospital Association (AHA) and HAP (Sept. 2010)

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