The Governance Institute

Laying the Foundation for Successful Clinical Integration

Webinar
November 29, 2011, 2:00pm ET/11:00am PT

Daniel M. Grauman
President & CEO
DGA Partners, Bala Cynwyd, PA
dgrauman@dgapartners.com

Pamela R. Knecht
President, ACCORD LIMITED, Chicago, IL
pknecht@accordlimited.com
Today’s Presenters

Daniel M. Grauman, president & CEO of DGA Partners, has assisted hospitals, contracting organizations and health plans, and other healthcare businesses throughout the nation. His experience includes: strategic and business planning; mergers, acquisitions, and affiliations; medical staff development plans; community need and fair market value studies; market and financial feasibility studies for hospitals and healthcare services; business valuations; payment arrangements between providers and purchasers; and managed care and cost management strategies for providers and purchasers.

Pamela R. Knecht, president of ACCORD LIMITED, has provided consulting services to a wide range of industries and organizations over her 29-year career. She focuses on assisting the boards and CEOs of not-for-profit hospitals and health systems with governance assessment, restructuring, and development; board retreats; strategic planning; organizational diagnosis and change management; team effectiveness; physician–hospital collaboration; and merger/affiliation facilitation.
Objectives

• Clarify the terms “clinical integration” and “physician alignment”
• Provide an update on the national context
• Describe the foundation required for successful clinical integration
• Discuss the board’s role in clinical integration efforts
CLARIFYING TERMS
A Clinically Integrated Organization...

...Involves substantial collaboration and cooperation among hospitals, physicians, and payers to achieve improved quality and cost-effective care.

...Is better prepared for the current and future payment landscape.
Clinical Integration

• Clinically integrated organizations
  > Integrated delivery systems (IDSs) that align incentives and create robust systems and processes to increase coordination and cooperation across sites and providers (e.g., Geisinger Health System, Kaiser, etc.)
  > Customized models to meet the Federal Trade Commission (FTC) criteria that allow hospitals, employed physicians, and independent practicing physicians to contract together with payers (e.g., Advocate Physician Partners; TriState Health Partners)

• Hospital/health system clinical integration strategies
  > A variety of strategies aimed at increasing the coordination of care across provider settings (e.g., care pathways and protocols; disease management; case management)
Physician Alignment

- Physician Employment
  > Hospitals and physician groups that hire physicians

- Hospital–Physician Business Deals and Models
  > Hospitals and physicians that develop contractual arrangements and/or create legal entities (e.g., medical directorships; income guarantees; practice support; specialty-specific institutes; co-management arrangements)

- Hospital–Physician Alignment
  > A collaborative relationship, not a business “deal”
NATIONAL CONTEXT
Key Drivers

Drivers of Physician Alignment & Clinical Integration

Financial Pressure

- Decreasing fee for service
- Value-based purchasing

Accountable care
CMS and the Innovation Center
Bundled payments
Health insurance exchanges

Health Reform

Increasing consumer costs
Integrated health systems

Market
Pressure on Traditional Payment Levels

- No federal matching for Medicaid healthcare-acquired conditions
- Medicare Advantage program payment reductions
- Market basket productivity reductions
- Penalties for high readmission rates or infections
- Penalties for lack of quality reporting
Payers Reward Quality and Accountability

- Pay-for-performance
- Tiered networks
- Care coordination payments
- Patient-centered medical home
ACO Final Rule: A More Realistic Opportunity for Change

- An ACO is an entity that will be clinically and fiscally accountable for the entire continuum of care that a given patient population may need.¹

¹ Partners In Health

ACCORD LIMITED
## Less Onerous Requirements (Excerpt)

<table>
<thead>
<tr>
<th>Area</th>
<th>Proposed Rule</th>
<th>Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start Date</strong></td>
<td>• January 1, 2012&lt;br&gt;• Three-year program</td>
<td>• Multiple start dates&lt;br&gt;• 2012 starts; year 1 ends Dec. 31, 2013</td>
</tr>
<tr>
<td><strong>Eligible Entities</strong></td>
<td>• Professionals in group practice&lt;br&gt;• Networks of individual practices&lt;br&gt;• Hospital and professionals partnerships&lt;br&gt;• Hospitals with employed professionals&lt;br&gt;• Other approved entities</td>
<td>Same plus:&lt;br&gt;• FQHCs&lt;br&gt;• RHCs</td>
</tr>
</tbody>
</table>

1 The Advanced Payment Model financially incentivizes physician-owned providers to form Medicare ACOs.
More Reasonable Quality Reporting and Scoring

## Proposed Rule
- 65 measures; 5 domains
- Pay-for-reporting year 1
- Pay-for-performance begins year 2

## Final Rule
- 33 measures; 5 domains
- Pay-for-reporting year 1
- P4P begins years 2 & 3

### Quality Measures Scoring Methods - Example

<table>
<thead>
<tr>
<th>Domain</th>
<th># Individual Measures</th>
<th># Measures for Scoring</th>
<th>Maximum Points</th>
<th>Example Point Value</th>
<th>Domain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>3.7</td>
<td>93%</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>6</td>
<td>6</td>
<td>14</td>
<td>10.5</td>
<td>75%</td>
</tr>
<tr>
<td>Preventative Health</td>
<td>8</td>
<td>8</td>
<td>16</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>At-Risk Population</td>
<td>12</td>
<td>7</td>
<td>14</td>
<td>11.9</td>
<td>85%</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>23</td>
<td>48</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Final Quarterly Performance Score (each domain weighted at 25%) 82%

ACO Shared Savings Changes

Assuming minimum savings or loss rate is met...

Shared Losses CMS/ACO
- Track 1: ACO not responsible for losses
- Track 2: Sharing begins at the first dollar with 60% max

Shared Savings CMS/ACO
Sharing begins at the first dollar
- Track 1: with 50% max
- Track 2: 60% max

1Not applicable to ACOs that qualify as rural
Innovative Provider-Driven Initiatives vs. Legislative-Driven Demonstrations

<table>
<thead>
<tr>
<th>Provider-driven</th>
<th>Legislative-driven</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; Select Center for Medicare and Medicaid Innovation programs:</td>
<td>&gt; Select CMS programs:</td>
</tr>
<tr>
<td>• Hospital Engagement Contractors</td>
<td>• Medicaid Bundled Payment Demonstration Project</td>
</tr>
<tr>
<td>• Innovation Advisors Program</td>
<td>• National Pilot Program on Payment Bundling</td>
</tr>
<tr>
<td>• Pioneer ACO Model</td>
<td>• Medicare Shared Savings Program</td>
</tr>
<tr>
<td>• Advance Payment ACO Model</td>
<td>• Community-Based Care Transitions Program</td>
</tr>
<tr>
<td>• Comprehensive Primary Care Initiative</td>
<td></td>
</tr>
<tr>
<td>• Bundled Payments for Care Improvement</td>
<td></td>
</tr>
</tbody>
</table>
Provider–Payer Integration: An Effective Strategy to Capture Market Share

• Narrow networks
• Lower premiums
• Integrated information technology
• Robust care process management
• Integrated brand
• Ability to “guarantee” care
Provider–Health Plan Alignment Aiming to Decrease Care Costs

• Health plans purchasing hospitals
  > Highmark purchased West Penn Allegheny Health System (five-hospital system) for $475 million.

• Insurance companies merging with or employing primary care physicians
  > UnitedHealth Group merged with PacifiCare Health Systems, a California-based health service company, and Sierra Health Services, a Las Vegas-based health benefits and services provider.
  > CIGNA owns a Phoenix-based medical group and serves patients at 32 locations.
  > WellPoint, Inc. recently acquired senior-focused healthcare delivery provider, CareMore Health Group.
  > Humana bought Concentra, which has over 300 medical centers in 42 states, the largest number of urgent and occupational care clinics.
FOUNDATION FOR SUCCESSFUL CLINICAL INTEGRATION
Key Ingredients of Clinical Integration

1. Physician Alignment & Leadership
2. Care Management Programs
3. Data and Information Sharing
4. Quality Monitoring Program
5. Payment Arrangements
The Physician Alignment Imperative

“Alignment and engagement are the fundamental conditions necessary for us to work with physicians to create value.”

The Relationship Transcends Everything

DEGREE OF ALIGNMENT & INTEGRATION

Service Contracts
Medical Directorships
Income Guarantees
Practice Support

Specialty-Specific Institutes
Co-Management Arrangements

Clinically Integrated PHOs

Physician-Driven IDS

As a Last Resort Only
More Physician Employees
System-Aligned IDS/Group

Employment

Contractual Arrangements
Joint Ventures

The Relationship Transcends Everything
Physician Alignment Success Factors

1. Patient-centered mission and values
2. Clear, shared vision, strategy, and goals
3. Operational excellence and performance focus
4. Shared decision making
5. Aligned incentives and shared risk
6. Information transparency
7. Ongoing education and communication
8. Culture of teamwork
9. Trusting relationships

Active Physician Involvement & Leadership Is Key to Success

• Trusting relationships, built through doing real work together

• Active, committed physician participation in all plans and processes (e.g., vision and goal creation; clinical protocol development; quality and cost improvement processes)

• Rigorous credentialing and monitoring of participating physicians to ensure high quality

• Physicians leading all efforts (e.g., dyad management), supported by robust physician leadership development “institute”

• Physician involvement in management and governance at all levels of the organization
Opportunities for Governance Involvement/Leadership

- Health system board
- Hospital board
- Hospital-owned physician enterprise board
- Physician group practice board
- Hospital–physician group practice joint venture board
- Clinically integrated physician–hospital organization board
Targeted Guideline & Initiative Development

High-Priority Focus

- Case Management
- Clinical Quality Management
- Chronic Disease Management
- Utilization Management

Factors for Initiative Selection

Internal
- Patient demographics
- Financial considerations
- Physician buy-in and execution

External
- Publicly reported measures
- Best practice examples
- Published frameworks for priority selection
Initiative Evolution: From Disease Management to Clinical Quality/Utilization Management

Advocate Physician Partners: Initiative Type by Life Cycle Stage

- Early
  - Case Management
  - Disease Management
- Middle
  - Clinical Quality
  - Utilization Management
- Mature
  - Case Management
  - Disease Management
  - Clinical Quality
  - Utilization Management

Source: Based on DGA analysis of Advocate Annual Reports

ACCORD LIMITED
Build on Existing Practice Capabilities

Building a Successful Data Strategy

- Pop. Health
- Patient Engagement
- Provider Coordination/Communication
- Care Management
- Practice Management

FOUNDATION FOR CLINICAL INTEGRATION
Data & Information Sharing
**Key Components of a Quality Monitoring Program**

- **Metrics**
- **Report cards**
- **Financial Incentives**
- **Compliance**

<table>
<thead>
<tr>
<th>High-Level Criteria</th>
<th>Original Goals</th>
<th>Proposed Measures</th>
</tr>
</thead>
</table>
| **Clinical Quality** | • Coordination of Care  
• Clinical quality and care management  
• Preventative, proactive care | • Care plans developed  
• Care plans followed  
• Active follow-ups |
| **Utilization Management** | • Ensure appropriate use of resources  
• Decrease required inpatient admissions | • ER visits  
• Inpatient admissions  
• Limited ancillary duplication (lab, imaging) |
| **Disease Management** | • Ensure appropriate use of resources  
• Decrease required inpatient admissions | • Measures specific to disease targets |
| **Patient Satisfaction** | • Increase patient engagement, access, and satisfaction | • Timely scheduling of appointments  
• Patient satisfaction |
Payment Reform Driving Physician Alignment

Payment Arrangements

- Fee-for-Service
- Non-Payment for Complications
- Pay-for-Performance
- Bundled Payments
- ACO/Capitation

Physician Alignment & Integration

Payment Risk
## Clinically Integrated Organizations vs. Others

<table>
<thead>
<tr>
<th></th>
<th>Geisinger Health System</th>
<th>Intermountain Healthcare</th>
<th>Average Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Physician Alignment &amp; Leadership</strong></td>
<td>Physician leaders</td>
<td>Integrated clinical and financial management systems</td>
<td>Administration leads; not physicians</td>
</tr>
<tr>
<td></td>
<td>Physician involvement on board and committees</td>
<td></td>
<td>Physician involvement in governance limited</td>
</tr>
<tr>
<td><strong>2. Care Management Programs</strong></td>
<td>Initiatives and guidelines across the continuum (e.g., PCMH, navigators)</td>
<td>Care management medical home model</td>
<td>Disparate care management, minimal coordination</td>
</tr>
<tr>
<td><strong>3. Data and Information Sharing</strong></td>
<td>Wide electronic medical record use</td>
<td>Advanced EHR: reminders, care pathways, and predictive modeling</td>
<td>Hospital EMR, imaging and lab systems, physician practice management, and limited EMR</td>
</tr>
<tr>
<td><strong>4. Quality Monitoring Program</strong></td>
<td>Financial incentives for hospital and physician quality reporting</td>
<td>Physician financial incentives</td>
<td>Hospital reporting, limited physician reporting, no financial incentives</td>
</tr>
<tr>
<td><strong>5. Payment Arrangements</strong></td>
<td>Innovative payment models with integrated provider health plan (e.g., bundling, etc.)</td>
<td>Innovative payment models with integrated provider health plan (Select Health)</td>
<td>Standard FFS and some pay-for-performance; little bundling</td>
</tr>
</tbody>
</table>
THE BOARD’S ROLE
The Role of the Board

- Get and stay educated (e.g., terms and trends)
- Engage physicians and other clinicians in joint education, discussions, and planning
- Add clinicians to boards and committees (appropriately)
- Develop a baseline assessment of your organization’s clinical integration capabilities and current physician alignment (e.g., assess risk management capabilities; understand current partnerships; determine information technology needs; discuss capital needs)
- Convene strategic planning retreats to determine vision for the future (e.g., ACO, medical home) and set measurable indicators of success
- Monitor progress toward the clinical integration strategies and goals
- Hold management and physicians accountable for achieving the desired level of clinical integration and physician alignment
QUESTIONS & DISCUSSION
Contact us...

Dan Grauman  
President & CEO  
DGA Partners  
2 Bala Plaza, Suite 301  
Bala Cynwyd, PA 19004  
(800) 241-5268  
dgrauman@dgapartners.com

Pamela R. Knecht  
President  
ACCORD LIMITED  
150 E. Huron, Suite 1101  
Chicago, IL 60611  
(312) 988-7000  
pknecht@accordlimited.com

The Governance Institute  
9685 Via Excelencia, Suite 100  
San Diego, CA 92126  
Toll Free (877) 712-8778  
Info@Governancelnstitute.com