

ACHIEVING HOSPITAL-PHYSICIAN ALIGNMENT THROUGH CLINICAL INTEGRATION

PART V – CASE STUDY – NORTHEAST HEALTH SYSTEM

This is the last in a series of five articles on achieving hospital-physician alignment through clinical integration.

Background

In the early 1990s, BDC Advisors helped a large academic health system in the Northeast develop a network of community physicians with whom they could contract across their market. At the time, capitated contracting was seen as a way to integrate physicians and hospitals to achieve higher quality and lower cost. While some global risk contracts were signed, capitation never grew into the dominant risk-sharing vehicle that was envisioned. Instead, the health system worked with its physician network using a “super-messenger” model to pursue discounted fee-for-service contracts. An MSO was developed to help network physicians manage quality of care, cost of care, and financial performance. Despite the limitations of the messenger model, the network was successful in negotiating more competitive rates, and it continued to grow, exceeding 1,000 primary care physicians and 3,500 specialists by the late 1990s.

Clinically Integrated Physician Network

In 1997, when health system management realized that capitation was stalled, BDC Advisors was again retained to design another approach to aligning risk between the health system and its physicians. Working simultaneously with this client and a large West Coast health system, BDC Advisors developed the concept of a “Clinically Integrated Physician Network” or “CLIPN” that uses incentive-based “pay-for-performance” contracts with payers to share risk around specific performance targets.

Overview

- Academic health system containing six hospitals – two principal academic centers and four community hospitals – plus affiliates
- A network of over 1,000 primary care physicians and 3,500 specialists practicing at community hospitals and academic medical centers throughout the metropolitan market
 - Physicians structured in “regional service organizations” of 15-250 physicians each
 - Total population covered by the network: 1.5 million
- Network MSO provides a variety of services to RSOs, including:
 - Medical management
 - Quality improvement programs
 - Data analysis
 - Contracting
 - Information systems
 - Financial expertise
- System recognized as an “essential provider” by area health plans

Network Vision

- Differentiate network in the market by:

- Providing highest levels of quality to all patients – e.g., 90th percentile on HEDIS Criteria
- Achieving competitive level of efficiency – e.g., at least 5% better than the market in specific utilization targets
- Use differentiated market position to justify higher provider rates and preempt health plan “tiering”

Elements of CLIPN

- Agreement on common systems, standards, and goals for network physicians
 - *Clinical information systems and evidence-based medicine* – e.g., implementation of electronic registries, CPOE for prescriptions and tests, EMRs
 - *Patient education and support services* – e.g., educational resources (interpreters, education about chronic conditions, etc.), quality measurement and improvement programs
 - *Care management programs* – e.g., chronic care programs, preventable admissions, care of high-risk conditions
- Explicit rewards and penalties for network physicians around these goals
 - Substantial percentage of physician fees at risk for performance on defined quality and efficiency goals (at least 15-20%)
 - Use of sticks and carrots (bonuses and withhold losses) in “high salience” region (+/- 10-20%)
 - Rewards focused on smallest possible unit of analysis – including individual MDs, where accurate measures can be made
- Increased investment in infrastructure
 - Automated drug prescribing
 - CPOE
 - EMRs with decision support
- Joint contracting: FTC rulings support joint contracting if parties have:
 - Collective access to / sharing of patient clinical information
 - Mandatory practice protocols to improve quality and appropriateness of services
 - Measurable performance goals linked to the protocols
 - Reporting of physician performance relative to pre-established protocols
 - Assistance to physician members in meeting goals and correcting performance issues
 - Expulsion or other negative consequences for physicians who don’t comply with protocols

Results to Date

- Performance-based contracts signed with 3 major health plans, representing 80% of private payers
- System could not prevent introduction of tiered co-pay products but succeeded in modifying criteria for co-pay tiers to include quality and efficiency, not just price
- To date, all network physicians have earned maximum performances bonuses, but this will change as criteria become tougher

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