



Snowmass Institute

Clinically-Integrated Service Line Networks



San Francisco • Boston • Washington, D.C. • Chicago

Discussion Agenda

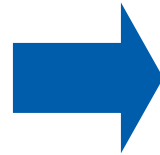
- Rationale
- Clinical integration overview
- Selected applications and case examples
 - Northeastern Healthcare System
 - Southwestern Law Firm
- Discussion

Rationale for Clinical Integration

Hospitals and physicians today are struggling to find alignment

Environmental Factors

- Decline of risk contracting; dismantling of medical management infrastructure
- Economic pressure on medical practice
 - ➔ Weak contracting leverage
 - ➔ Medicare and Medicaid rate declines
 - ➔ Malpractice crisis
- Specialty physician shortages
- Growth of dominant single specialty groups in key specialties



Implications

- Competition from physician office-based and free-standing ancillary services
- Specialty supply and access issues
- Emergency service call coverage problems
- Challenges in engaging physicians in clinical quality improvement efforts
- Demands for direct economic support

Rationale for Clinical Integration

- Market Positioning: How do you intend to relate to the market?
 - ➔ Achieve competitive differentiation
 - ➔ Advance brand in the market
- Medical Staff Development: How can you maintain a network of high-quality and strategically aligned physicians?
 - ➔ Strengthen physician loyalty
 - ➔ Ensure an adequate and self-sustaining supply of physicians
 - ➔ Respond to or avoid niche competition
- Performance Improvement: How can you achieve consistent and high quality performance among your providers?
 - ➔ Increase physician involvement in quality assurance programs
 - ➔ Increase use of technology and electronic medical records
 - ➔ Increase compliance with evidence based guidelines
 - ➔ Improve HEDIS scores
 - ➔ Reduce medication errors

Forms of Integration

Structural Integration

- Ownership
- Control

Economic Integration

- Risk sharing
- Incentive funds
- Billing and collection
- Shared facilities
- Shared debt

Clinical Integration

- Case management
- Preauthorization of services
- Concurrent and retrospective reviews
- Development of standards and protocols
- Investment of capital to purchase information systems
- Provision of reports to payers on the services provided
- Hiring a medical director and support staff
- Discipline non-performance

Standards of Clinical Integration

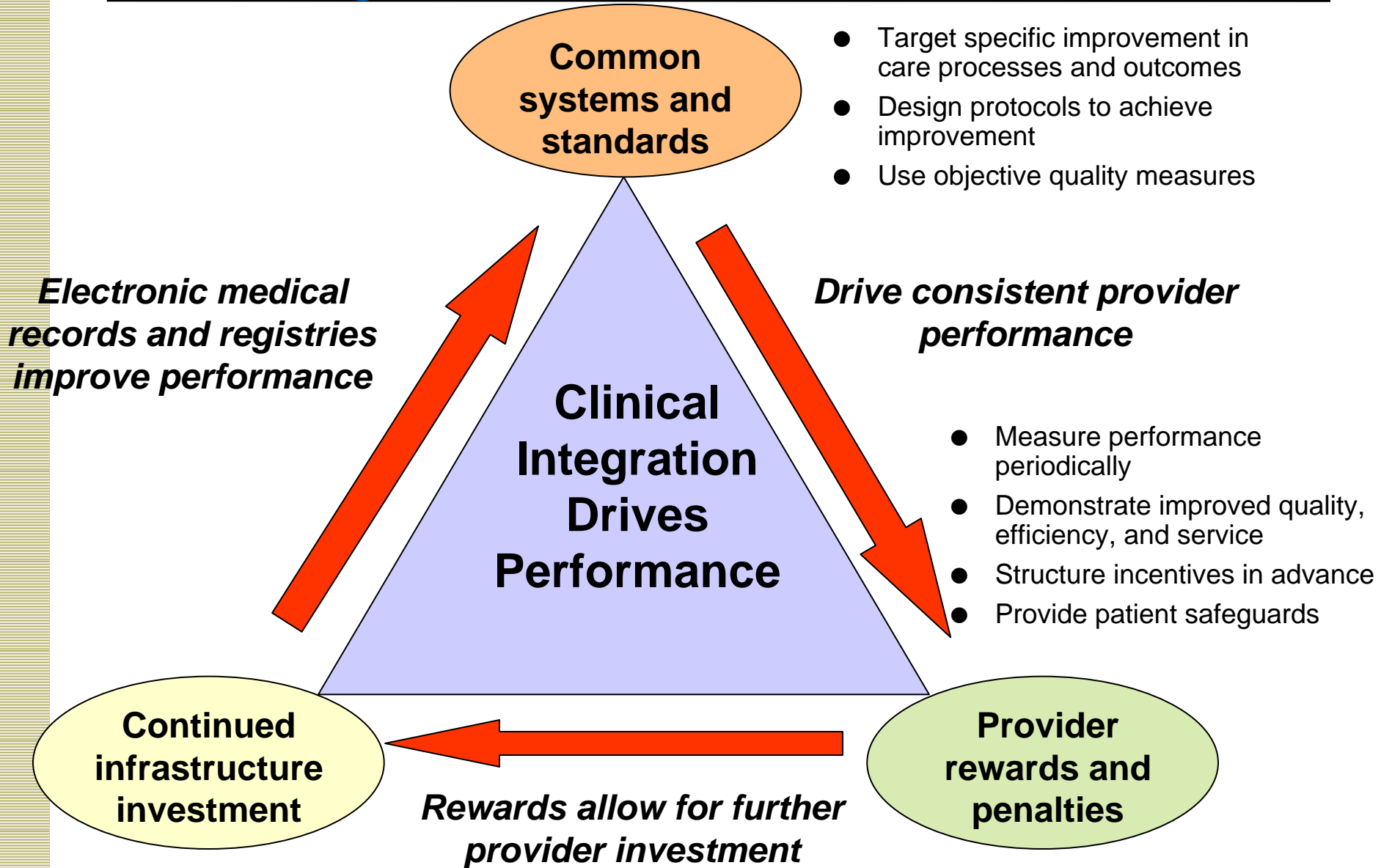
Guidance related to clinical integration is limited and also generally on physician networks.

- Active and ongoing program to:
 - ➔ Modify practice patterns of participating providers
 - ➔ Create interdependence and cooperation among providers
 - ➔ Control costs and ensure efficiency
- Incorporate systems to:
 - ➔ Monitor and control use of health care services
 - ➔ Control costs
 - ➔ Assure quality of care
- Evidenced by significant investment of monetary and human capital in infrastructure
- Joint pricing arrangements must be necessary for and ancillary to achieving the efficiencies or quality performance goals of system
- FTC's hypothetical examples (physician network and PHO) incorporate:
 - ➔ Case management
 - ➔ Utilization controls
 - Preauthorization of services
 - Review of patient stays
 - ➔ Protocols governing treatment
 - ➔ Information management system to monitor performance

Clinically-Integrated Service Line Network Definition

- Move basis of physician–hospital integration from financial risk to clinical focus
- Move toward a single, all-payer approach to medical management and care delivery
- Develop a standardized, “best practices” approach to care delivery
- Improve outcomes, patient satisfaction, and delivery costs
- Introduce new products
- Achieve higher net physician and hospital reimbursement

Clinical Integration Drives Performance



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Network Goals

Patients – *“Enhanced service and quality”*

- Participation in service and care improvement initiatives regardless of health plan choice (when selecting a Network physician)

Plans / Purchasers – *“Potential medical cost savings and enhanced member satisfaction”*

- Stable physician and hospital Network
- New service and care management program for members participating in the Network
- Utilization Management and, if strategically appropriate, hospital discounts

Physicians – *“Improved efficiency and enhanced reimbursement”*

- Consistent care management across risk and non-risk patients
- Ease of administration
- Improved reimbursement

Hospitals – *“Provide attractive physician integration platform”*

- Enhance physician integration opportunities
- High quality care management processes

Network – *“Achieve economies of scale and expand value to the Network”*

- Enhanced market influence
- Less dependency on negotiating risk contracts
- Improved reimbursement

Network Features

Contracting

- Create a network for single-signature contracting for all business
- Secure the participation of physicians in both the capitated, limited, and non-risk products

Funds Flow

- Fund clinical integration activities through a variety of methods (e.g., risk sharing, admin fees, PMPM budgets, and withholds)

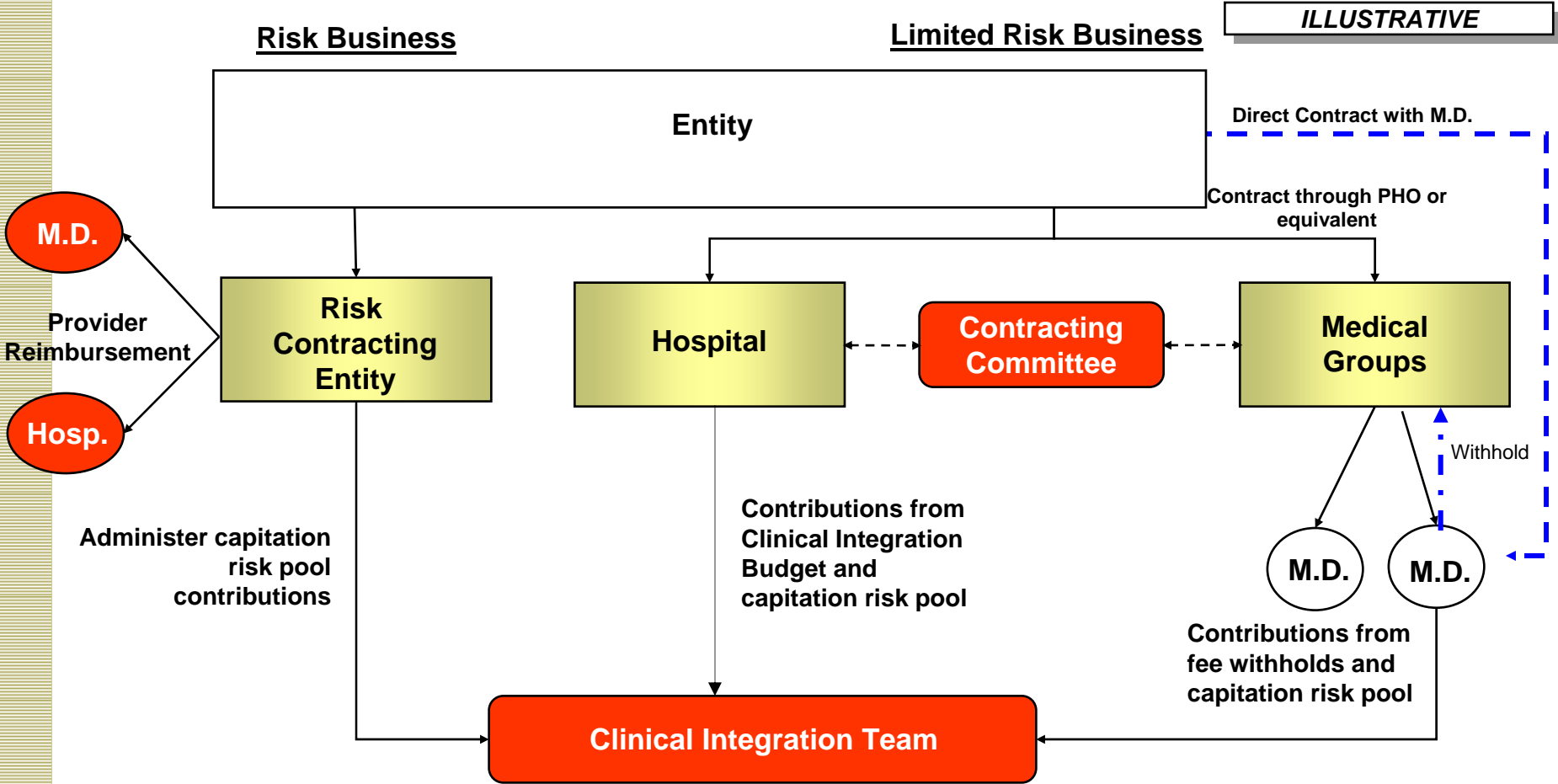
Medical Management

- Develop a single, payer-blind medical management model
- Establish a process and administrative infrastructure to facilitate clinical integration based on informatics and care coordination

Incentive Program

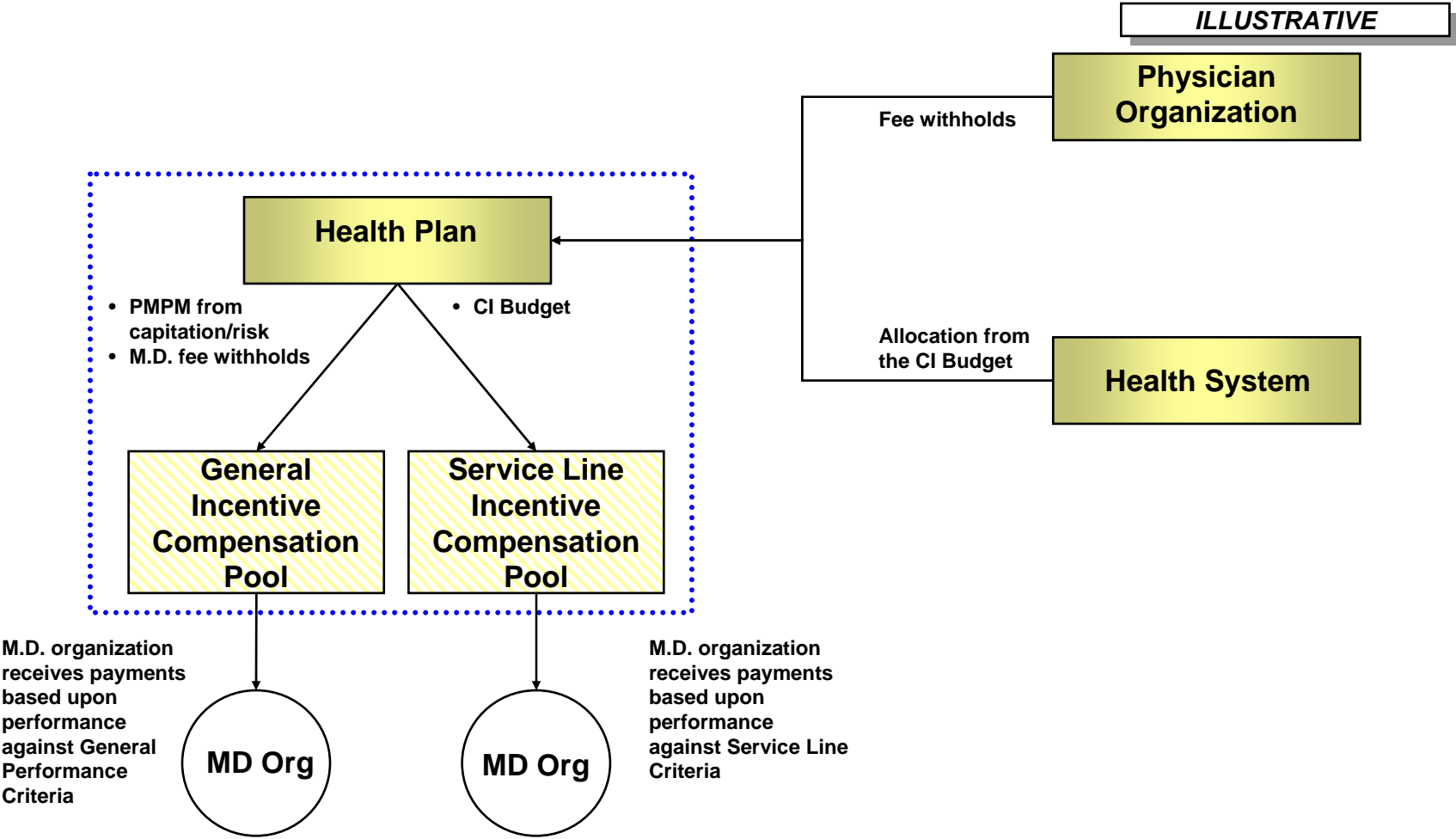
- Establish a single “pay-for-performance” incentive program
- Develop objectives for clinical integration and differentiated market position
- Distribute incentive payments and bonuses based on meeting established criteria

Sample Network Design -- Overview



Source: BDC Advisors, LLC

Sample Network Design – Incentive Pools



Sample Network Design – Performance Criteria

ILLUSTRATIVE

General Performance Criteria

- Patient satisfaction survey results
 - ➔ Inpatient
 - ➔ Ambulatory
- Data submission compliance from physicians
- Participation in electronic data interface (“EDI”) efforts
- Preventive services (chart audits)
 - ➔ Percent of patients with a completed history and physical
 - ➔ Immunization rates
 - ➔ Mammography rates
- Length of stay for hospital cases
- Nosocomial infection rates
- Frequency of adverse events in hospitals
 - ➔ Frequency of adverse drug reactions
 - ➔ Surgical and medical complications
- Readmission rates

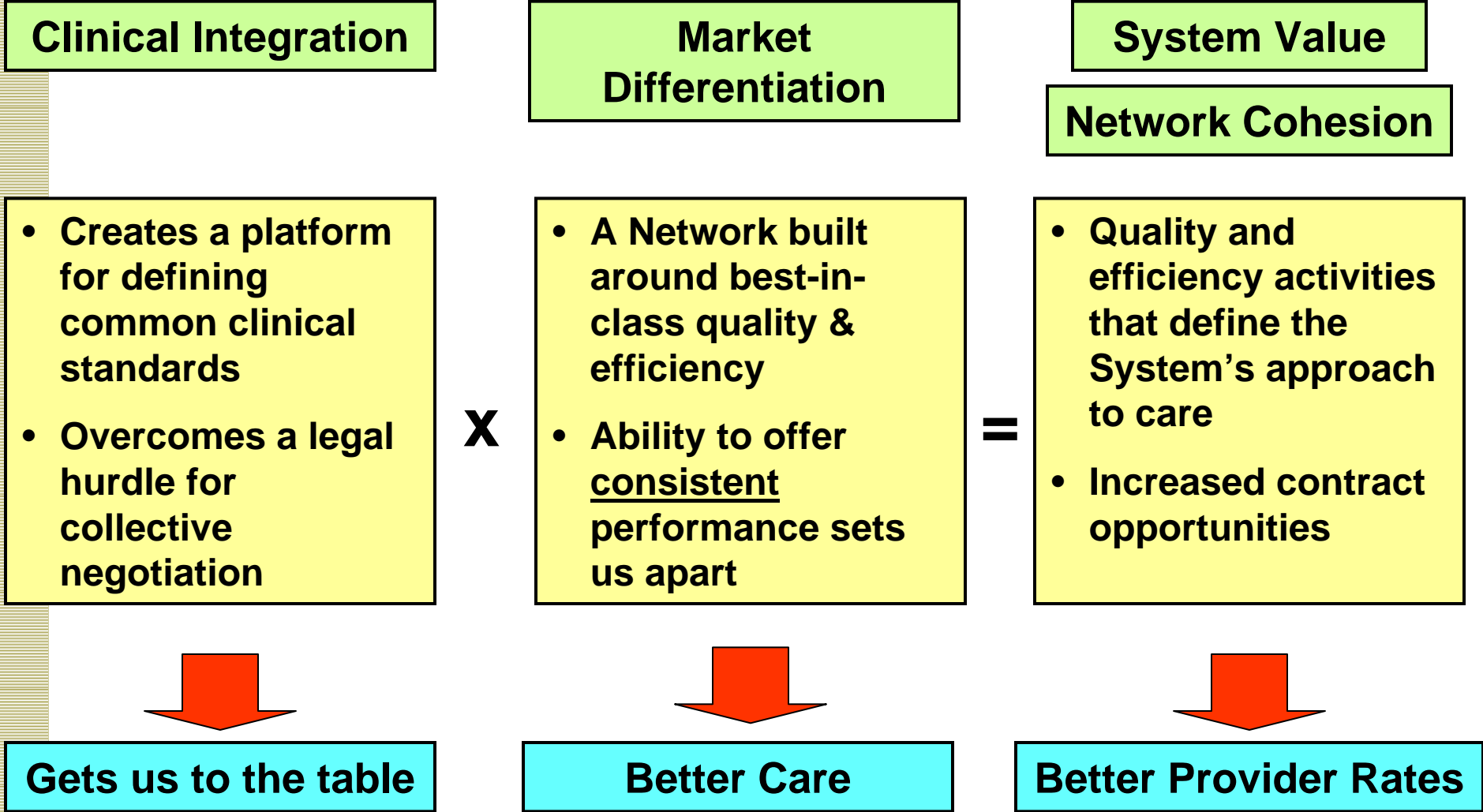
Service Line Performance Criteria

- Cardiology
 - ➔ Percent of patients meeting pathway criteria in the first two hours for Acute MI
 - ➔ Infection rate for selected procedures (e.g., catheterization)
- Obstetrics
 - ➔ Percent of patients meeting appropriateness criteria for C-Section
 - ➔ VBAC rates
- Orthopedics
 - ➔ Variable cost per case for selected procedures (e.g., hip replacement)
- Mental Health
 - ➔ Ambulatory follow-up after hospitalization for major affective disorders

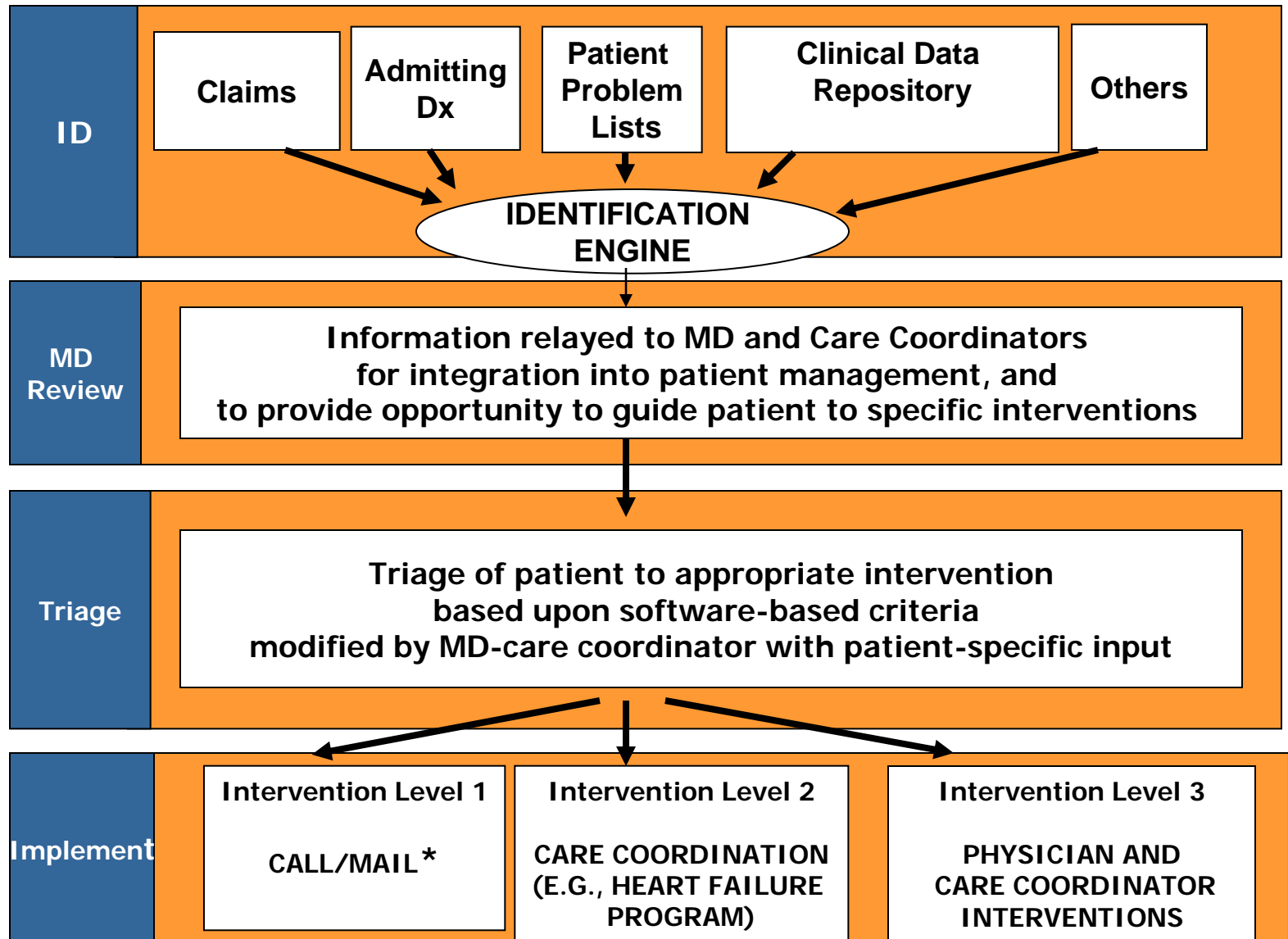
Selected Applications

- Health System achieve and advance its service line and market differentiation
- Health System and ASC Management Company create a differentiated high-quality surgical services network
- Integrated Delivery System advances non-risk provider contracting
- IPA enables joint negotiation on behalf of its member providers
- Health Plan establishes “pay-for-performance” contracting mechanism to improve clinical outcomes and patient satisfaction

Northeastern Health System: Clinical Integration Rationale



Northeastern Health System: Clinical Integration Structure



* Health System or Private-label vendor or Payer-sponsored program

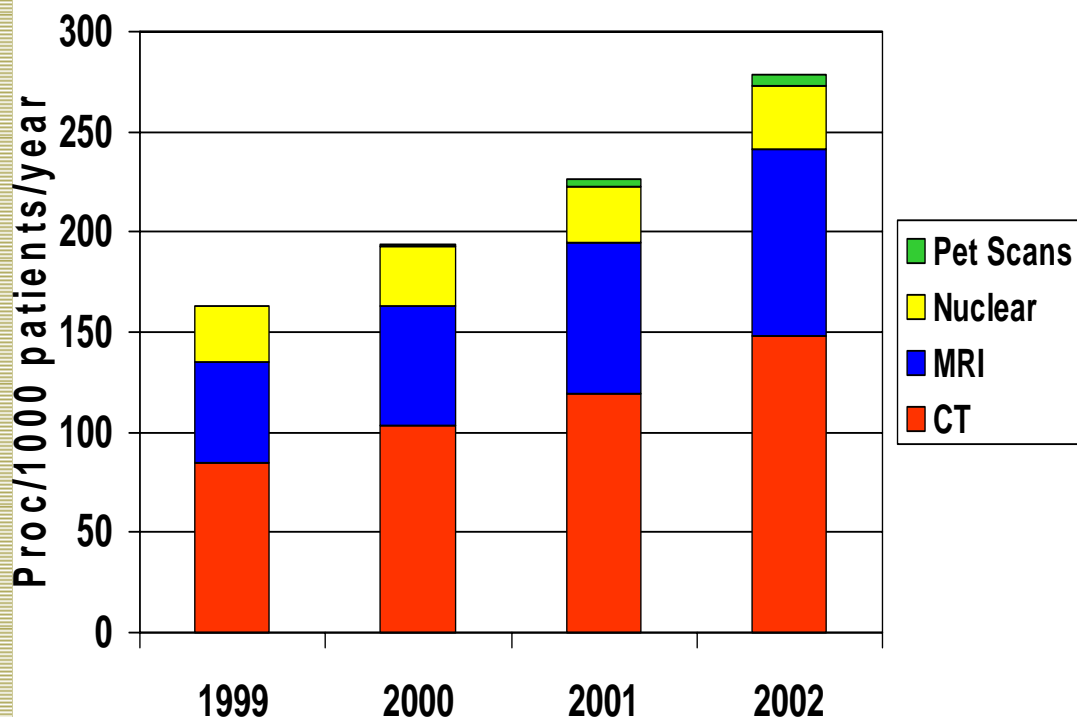
Northeastern Health System: Multiple Approaches

- “Top Down”
 - ➔ E.g., DRG 127 LOS
- “Bottom Up”
 - ➔ E.g., Radiology utilization and cost reduction

Northeastern Health System: Congestive Heart Failure

- DRG 127: Congestive Heart Failure
 - ➔ System-wide process opportunity
 - No correlation between case mix / ALOS by hospital
 - No correlation between performance and MDs based on number of cases or patient acuity
 - Variation in MD performance over time
 - ➔ Timing of echocardiograms reviewed
 - Patients having echocardiogram
 - On first day: ALOS < 4.5 days
 - Thereafter: ALOS > 4.5 days
 - Clinical pathway developed
 - Ace inhibitors, echocardiograms, patient education
 - ➔ Results
 - Readmission rates within 90 days reduced from 30% to 15% within one year
 - ALOS reduced from 6.0 to 4.5 within two years

Northeastern Health System: Radiology Trends and Threat



- Radiology costs going up 20%-30% per year
- Prior authorization companies:
 - Increase hassle
 - Deny payments for performed services
 - Move care to low cost sites
- No agreement on what “targets” should be
- Even success in meeting targets may not stave off hazards

Northeastern Health System: Radiology Medical Management

- Systemic solutions (“top-down”):
 - ➔ “Appropriate indication” for key cost-drivers:
 - Head CT
 - Head MRI
 - Spine CT
 - Spine MRI
 - Hip MRI
 - Knee MRI
 - Thallium
 - ➔ Physician has to indicate which indication or “other” when ordering test
 - If test meets indication, no further action
 - If “other” chosen, test marked for review
- Individual solutions (“bottom-up”):
 - ➔ Pilots required of all PHOs last year from one of three categories for defined population
 - Intensive education
 - Internal prior authorization
 - Limitation of test ordering to specialists
 - ➔ Pilot programs at PHOs implemented on all payer basis in 2003

Northeastern Health System: Selected Radiology Results

Success Example #1

- PHO “A” devised a system to reduce unnecessary head CTs and MRIs
- Hospital “A” neurologists agreed to expedite consults on headache patients before imaging studies were done
- In one year of this program, they reduced head CT and MRI use by 8%
- During that same year, head imaging use across the rest of the network was down only 1%

Success Example #2

- PHO “B” chose to restrict the ordering of joint MRIs to specialists (e.g., orthopedic surgeons, rheumatologists)
- PHO “B” achieved the cooperation of their local MRI center
- After one year, they had a joint MRI trend of -1%
- The network had a joint MRI trend at that time of 14%

Success Example #3

- PHO “C” chose to provide intensive education regarding chart reviews and case discussions
- Extended to both PCPs and appropriate specialists
- Concentrated on Head MRIs
- Head MRI trend after this was -10% compared to a network-wide trend of -1%

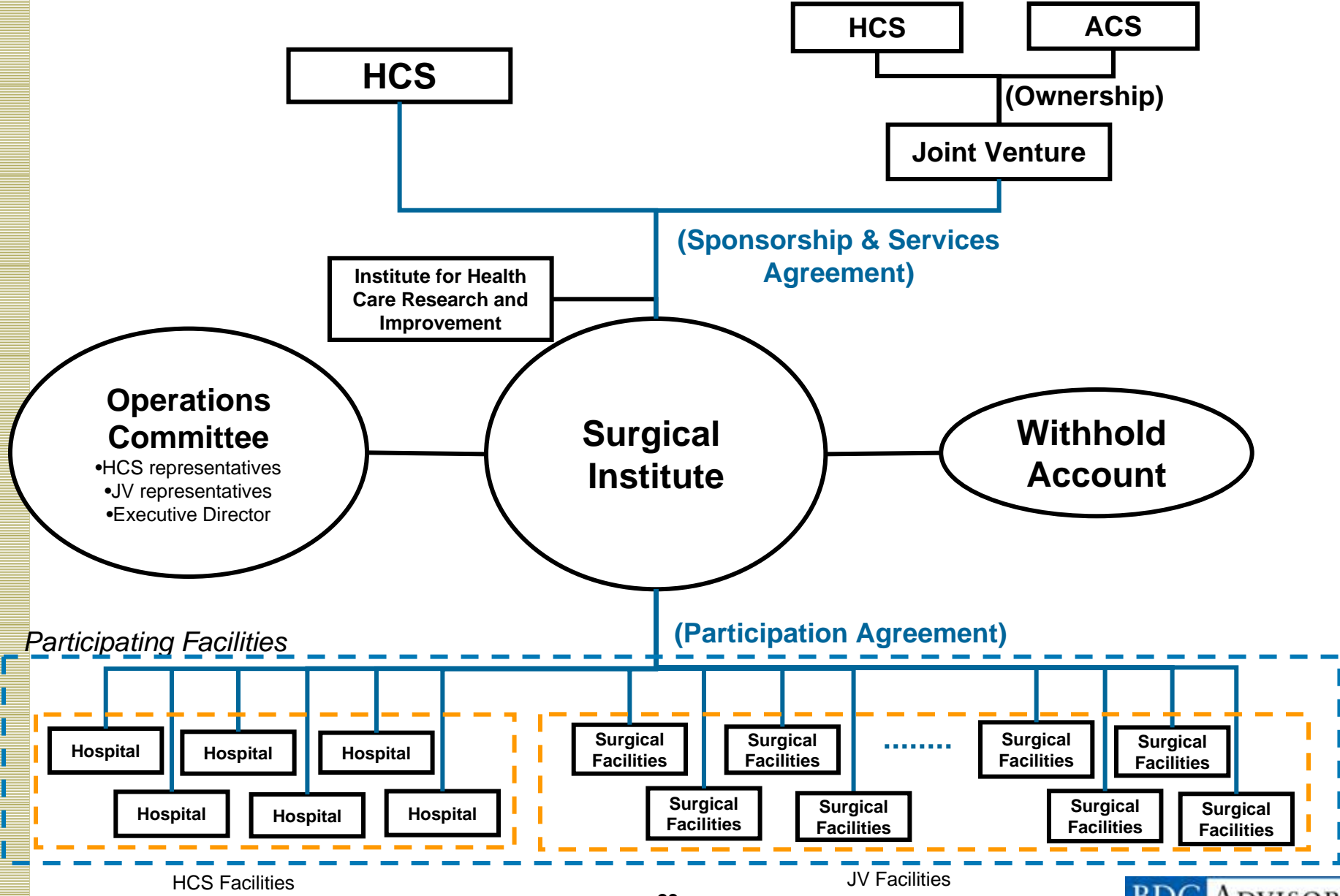
Failure Example #4

- PHO “D” implemented program for Medical Director to review all elective MRIs and CTs
- In 2002, their overall trend was 21%, while the network trend was 12%
- Likely issues include lack of specificity for criteria, overly large range of tests

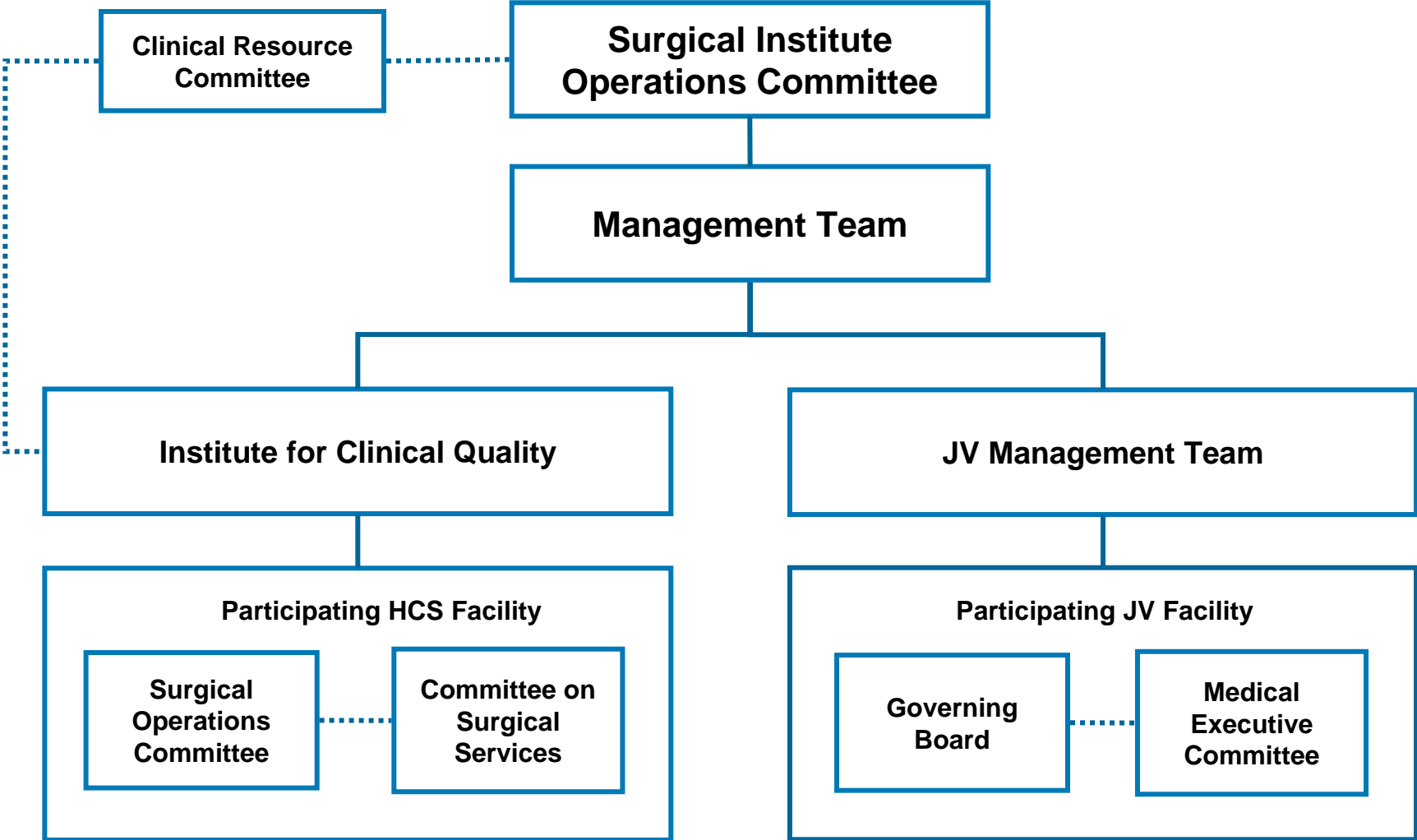
Southwestern Health System: Surgical Services Case Study

- Large, integrated delivery system formed network of 15 ambulatory surgical facilities in joint venture with ambulatory surgery management company and local physicians
- ASCs owned by separate partnerships; Health system interest varies from 9-29%
- ASCs highly successful; Health system shifts substantial surgical case volume to partner facilities, while backfilling with more complex inpatient cases
- Objectives:
 - ➔ Create a surgical network encompassing hospital and ASC surgical operations
 - ➔ Establish consistent operating and clinical system across surgical venues
 - ➔ Improve patient safety and surgical outcomes while reducing cost of care
 - ➔ Create a consistent surgical services “brand”
 - ➔ Uniform payer contracting across the network

Southwestern Health System: Governing Structure



Southwestern Health System: Management Structure



Southwestern Health System: Key Performance Measures

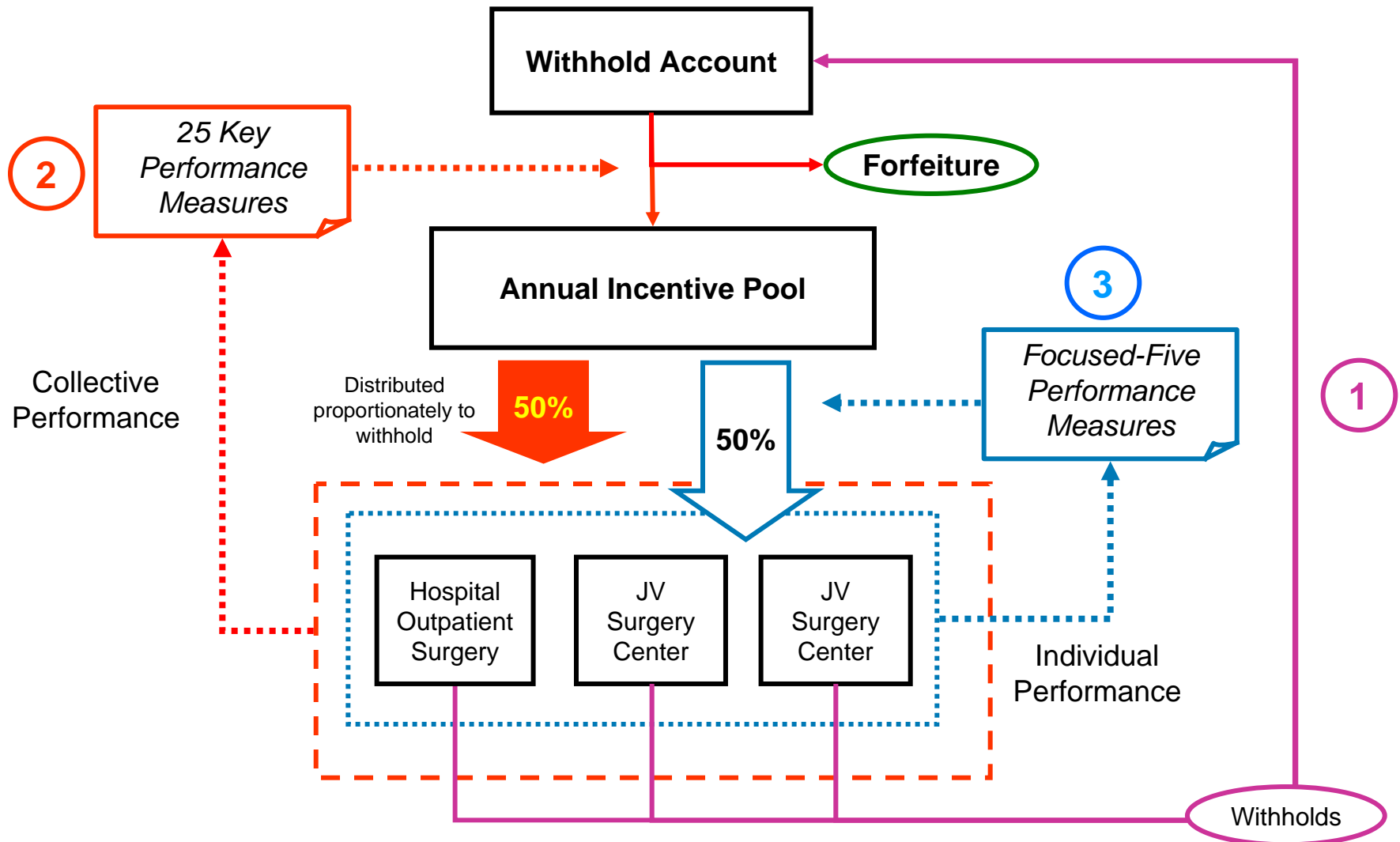
#	Measures	Current Source		Common Definition	Reporting Frequency
		HCS	JV		
Clinical Performance Measures					
1	Foreign Body Left in During Procedure	✓		HCS - AHRQ (See Attached)	Monthly
2	Iatrogenic Pneumothorax	✓		HCS - AHRQ (See Attached)	Monthly
3	Post Operative Hemorrhage or Hematoma	✓		HCS - AHRQ (See Attached)	Monthly
4	Post Operative Respiratory Failure	✓		HCS - AHRQ (See Attached)	Monthly
5	Post Operative Pulmonary Embolis or Deep Vein Thrombosis	✓		HCS - AHRQ (See Attached)	Monthly
6	Post Operative Sepsis	✓		HCS - AHRQ (See Attached)	Monthly
7	Post Operative Wound Dehiscence	✓		HCS - AHRQ (See Attached)	Monthly
8	Accidental Puncture/Laceration	✓	✓	HCS - AHRQ (See Attached) JV - Any other tissue injury to a pt such as a pinch, bruise, puncture, cut or fracture occurred.	Incident Based/Monthly
9	Reported Medication Errors	✓	✓	HCS - Voluntary reporting system JV - # times medication error occurred	Incident Based/Quarterly
10	Patient Falls with Injuries	✓	✓	HCS - Voluntary reporting system JV definition: A pt fall w/injury requiring medical attention	Incident Based/Quarterly
11	Antibiotics Started w/in 1 hr of Incision for Ankle/Shoulder Implants & Hysterectomies	✓	✓	Yes	Monthly
12	Overall Quality of Care/Service	✓		HCS - NCR Patient Satisfaction	Quarterly
13	Overall Quality of Nursing Care	✓		HCS - NCR Patient Satisfaction	Quarterly

Southwestern Health System: Key Performance Measures (cont.)

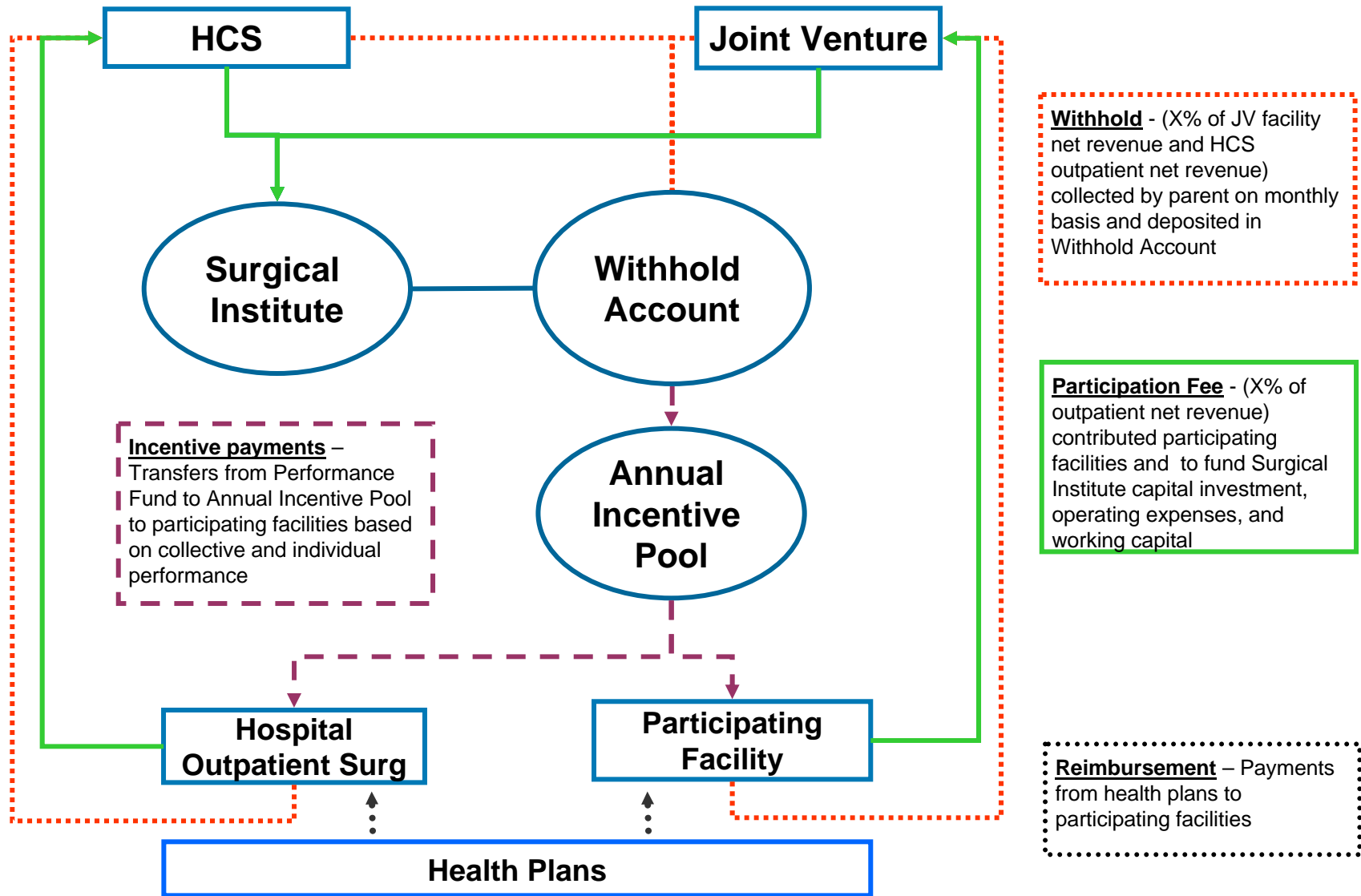
#	Measures	Current Source		Common Definition	Reporting Frequency
		HCS	JV		
14	Compliance with Wrong Site Surgery Protocol: - Surgical Site Verified - Time Out Conducted	✓	✓	Yes	Monthly
15	Wrong Site Surgery Occurred	✓	✓	Yes	Incident Based
Patient Satisfaction Measures					
16	Courtesy/Helpfulness of Registration	✓		HCS - NCR Patient Satisfaction	Quarterly
17	Satisfaction with Registration Wait Time	✓		HCS - NCR Patient Satisfaction	Quarterly
Service Efficiency Measures					
18	Handle My First Scheduling Call		✓	JV - # Scheduling requests not handled on 1st call	Daily
19	Schedule My First Choice		✓	JV - # times surgeon was not given 1st choice for date and time	Daily
20	Know What Supplies & Equipment I Want (number of cases w/o priced preference card)		✓	JV - # of cases w/o priced preference card reviewed w/in last 12 months	Daily
21	Provide the Supplies & Equipment I Want (# of cases not pulled 100% prior to Day of Surgery)		✓	JV - # cases not pulled 100% prior to day of surgery AND # cases not pulled according to preference card reviewed w/in last 12 months	Daily
22	Start My Cases on Time (Avg Elapsed Mins from OR Scheduled Time to Pt In Room Time for Scheduled Cases)		✓	JV - Averaged elapsed minutes from OR scheduled time to pt in room time for scheduled cases	Daily
23	Keep My Turnover Time to a Minimum (Avg Elapsed Mins from Time Previous Pt Left OR to In Room Time for Next Pt)		✓	JV - Average elapsed minutes from time previous pt left OR to in room time for next pt	Daily
24	Prevent CE by Calling Pts Preoperatively (# of Pts Canceled on Day of Surgery)		✓	JV - # pts cancelled on day of surgery	Daily
25	Match Employee Hours to Case Volume	✓	✓	JV - Average worked hours per case	Monthly

Southwestern Health System: Surgical Institute Incentive Plan

Funding the incentive plan is a three step process based on both collective and individual performance

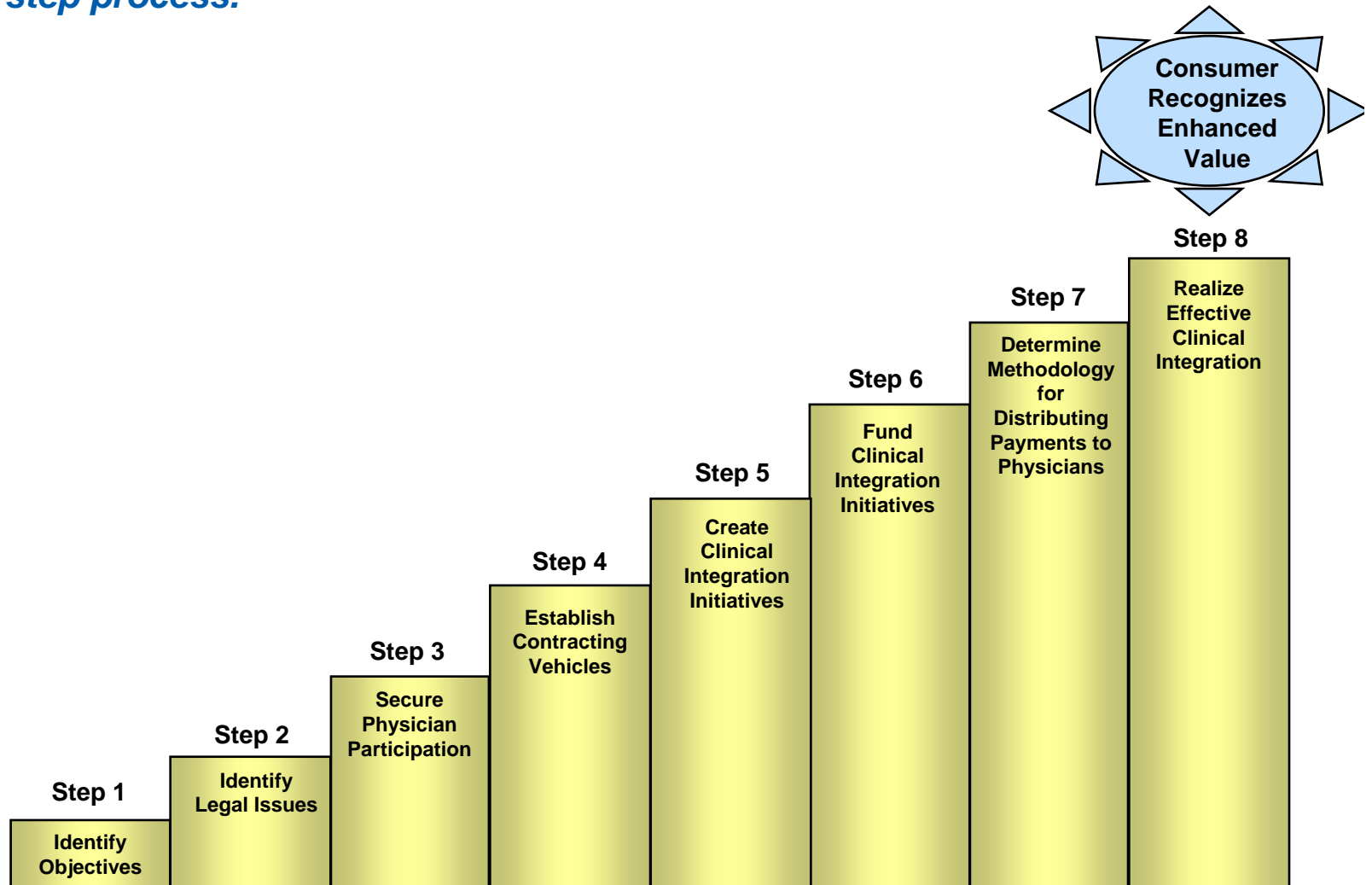


Southwestern Health System: Funds Flow



Clinically Integrated Service Line Network . . . Implementation

Achieving clinical integration to support quality and service standards will require an eight-step process.



Ground Floor:

High clinical variation, risk sharing on selected products only, and commodity products