Clinical Integration: The Road to Accountable Care

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Self-Test: Are You an ACO?

Is an Emergency Hospital Admission...

A Good Thing!?

Fill a bed, take x-rays, do a procedure

OR

..an Ambulatory Sentinel Event?

• Missed appointment?
• Unable to get into clinic?
• Failed to fill prescription?
• Unable to get Rx refill?
• PC / specialty miscommunication?
• Patient misunderstanding
• Failure to listen to patient?
• Missed lab or x-ray report?

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What is Accountable Care?

Accountable care and value-based payment systems are inextricably linked.

Source: The Commonwealth Fund, 2008
The Greatest Challenge in Health Care

Crossing the Crevasse

FEE FOR SERVICE

- Focus on patient in front of your face
- Incentive to do more
- Few quality indicators
- Fragmentation
- Cross-subsidies everywhere

VALUE-BASED PAYMENT

- Focus on long-term patient welfare
- Incentives for quality, affordability, patient experience
- “Bundled payments”
- Joint contracts with payers
- Importance of data
Building Accountable Care Organizations

Clinical integration is a critical stage in a health system’s transition to “accountable care.”

- **H** = Hospital
- **P** = Physicians
- **I** = Insurers

**Payment Structures:***
- FFS
- P4P / Asymmetric
- Shared Savings
- Bundled Payments
- Partial / Global Cap
- Population Coverage

**Abbreviations:**
- CIN = Clinically Integrated Network
- ACO = Accountable Care Organization
- VIPPS = Virtually Integrated Payer-Provider System (e.g., Kaiser Permanente)
Core Competencies by Stage

**CIN Competencies**
- Provider network development
- Data analytics
- Care management
- Quality / cost management
- New care delivery vehicles
- MD comp / performance incentives
- Performance risk contracting

**For each competency:**
- Build or buy?
- If buy, from whom?

**ACO Competencies**
- Customer needs assessment
- Enrollment & eligibility
- Product & benefit plan design
- Pricing and actuarial analysis
- Insurance regulation, risk mgmt
- Reinsurance
- Financial management
- Government relations

**VIPPS Competencies**
- Marketing
- Sales / account management
- Underwriting
- Member services
- Claims / transaction processing
- Outside contracting
- Integrated data management

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Clinically integrated networks are provider organizations with well defined structures.

**Key Structural Elements**

- **Clinical management infrastructure**
  - Sharing information in support of higher quality and lower cost for system as a whole
  - Evidence based clinical protocols to reduce variation in care

- **Rewards and penalties** for joint agreed on attainable goals (Payer-blind – System administers carrots and sticks)

- **Joint contracting** for hospital and physicians (employed and private) to enable sharing value for improved performance

- **New physician governance construct** to support hospital physician decision making, flow of information, quality initiatives
Clinical Integration: Legal Underpinning

Clinical integration is fundamentally different from 1990’s “messenger model” contracting and has been well defined in FTC and DOJ writings.

Clinical Integration

“... an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

This program may include:

(1) Establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care;

(2) Selectively choosing network physicians who are likely to further these efficiency objectives; and

(3) The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”

Source: FTC/DOJ - Statements of Antitrust Enforcement Policy - 1996
Clinical Integration: Value Proposition

A clinically integrated network delivers a different product than fragmented providers can deliver.

Clinical Integration

- Creates a platform for defining common clinical standards.
- Overcomes a legal hurdle for collective negotiation

Market Differentiation

- A network built around best-in-class quality & efficiency.
- Ability to offer consistent performance sets us apart.

Sustainable Position

- A package of quality and efficiency activities that defines the System’s approach to patient care.

\[ \text{Clinical Integration} \times \text{Market Differentiation} = \text{Sustainable Position} \]

Gets us to the table

Delivers better care

Justifies higher rates

Clinical Integration: Implementing Performance Risk-Sharing

Performance risk can be introduced slowly and grow over time.

Portion of total increase that is “at risk”
- MDs who achieve targets will be rewarded with a greater net increase.
- MDs who don’t achieve targets will receive guaranteed increase, but will see a lower net increase.

Key Point: To achieve highest overall increases, physicians have to put a substantial % of fees at risk for performance against defined quality / efficiency targets.
Building a CIN: Three-Phase Work Plan

Phase 1: Assessment / Strategy
- Begin aligning exec team, Board, MDs
- CIN / ACO readiness assessment
  - Health system
  - Market
- Network strategy
  - Geography
  - Size / mix
  - Existing groups
  - Link with other initiatives (e.g., EMR / EHR)

Phase 2: Design
- Structure
- Governance
- Institutional relationships
- Management organization
- Participation agreement
- Business plan
- New shared values

Phase 3: Implementation
1. Align Board, executive team
2. Build collaborative culture
3. Develop Board, committees
4. Develop network mgmt team
5. Recruit / credential participants
6. Create CI program
7. Select / deploy CPRS*
8. Engage practices in CI
9. Design incentive program
10. Develop payer strategy
11. Negotiate value-based contracts

Timing: 2-4 months 2-4 months ~1 Year

*CPRS = Clinical Performance Reporting System
Clinical Integration at Allina

Bob Wieland, MD
Discussion Topics

- Allina’s Background
- Allina’s Physician Integration Strategy
- Lessons Learned
Region’s Leading Health Care System

- 32% inpatient market share in the Twin Cities
- 11 hospitals (1,706 staffed beds)
- 62 clinics and 27 specialty hospital-based clinics
- Specialty Operations: Transportation, Pharmacy, Lab, Homecare/Hospice
- About 22,800 employees, including 1,200+ employed physicians
- 2010 key statistics:
  - $3.1 billion in revenue
  - 5.8 million+ work RVU’s
  - 109,000+ inpatient admissions
  - 1.0 million+ outpatient admissions
Physician Integration Strategy

Three core approaches to integration:

1. Employment

2. Professional Service Agreements (PSA)

3. Clinically Integrated Network (CIN)
Employment

- Focus on Primary Care

- Selected Specialties
  ➔ Clinical Service Lines
Employment Lessons

- Primary Care = Asset
- Paired leadership model
- Create “staffing tool”
- Transparent performance data
- EMR – forces standardized work flows
- New acquisitions – “quarantine”
Professional Service Agreement (PSA)

- Asset acquisition
- Long term contract
- Fair Market Value compensation
- Support staff – employ or lease
PSA Lessons

- Maintain physician independence
- Investment and growth vehicle
- Preserve ancillary revenue and real estate LLC’s
- Growing interest with specialists
Clinically Integrated Network (CIN)

- Legal structure
- Links physicians together
- Organizational structure that engages independent physicians in shared leadership and decision-making
- Purpose: improve quality and reduce cost
- Can negotiate contracts with payers and share in financial rewards of controlling costs while delivering high quality care
Allina Integrated Medical Network (AIMN)

Formally launched December, 2010

Physician Membership Overview

Total Physicians on Allina Medical Staffs ~ 5,000

AIMN Physicians = ~ 2,100

Independent AIMN = 900

Employed / Affiliated = 1,200
AIM Network Governance Structure

Legal Structure: subsidiary of Allina, not for profit 501(c)(3) tax-exempt org.

Governance Structure: maximizes physician leadership role within legal requirements
How Does a CIN Work?

- Define clinical initiatives and performance goals
  - Generic utilization
  - Optimal diabetes
  - Asthma
  - Colon cancer screening
  - Breast cancer screening
  - Induction of labor
  - CG – CAHPs
  - Re-admissions
Clinical Performance Agenda (Advocate Physician Partners)

APP’s clinical performance agenda has grown in breadth and depth each year.

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Source: Advocate Physician Partners, Feb. 2011
Shared Data Warehouse via IT Vendor

- Clinical Practice Management
- Other Data
- Lab
- Payers
- Pharmacy (PBM)
- Electronic Health Record
- Shared Data Warehouse
Patient Registries

- Diagnosis specific
- Procedure specific
- Emergency Room utilization
- Complex patients
- Re-admissions

Actionable Reports & Physician Performance Report Cards
Payer Strategy

Fee for Service example –

► Clinical Integration fee –
  1% attributable, allowed charges

► Paid to Network
Incentive Model

- Goal performance defined
- Each clinical initiative is weighted by specialty
- Also weighted by group vs individual performance
What’s the Value for Physicians?

- Reporting infrastructure
- Legal structure for “value” reimbursement
- Works with all reimbursement models
- Better alignment with Hospital
- Incentives compensate for additional work
- Physician-led
CIN Lessons

- 12 – 24 months to launch
- Physician engagement essential
- Consider 501(c)3 status
- FTC advisory opinion
- CIN → ACO
- Costs
  - Yr 1 $ 1 – 2 M
  - Yr 2 $ 2 – 3 M
  - Yr 3 $ 3 – 5 M
- Consider system employee health plan before commercial contracts
Clinical Integration in the Yakima Valley

Richard Spiegel, MD
Who We Are

- Yakima Valley
  - 4,300 sq miles, 240,000 people (90,000 in City of Yakima)
  - Largest industry is agriculture: Apples, Wine, Hops
  - Median household income – $41,000 (22% of pop below poverty line)
Who We Are

- Yakima Valley Memorial Hospital
  - 226 beds, 14,000 admissions
  - 2/3 public pay or indigent
  - 300 MDs on medical staff, ~ 75 employed (~ 50 in Memorial Physicians, PLLC, a wholly owned subsidiary of YVMH)
  - YVMH is largest employer in the County

- Competitor: Yakima Regional Hospital
  - Purchased from Sisters of Providence in 2002 by HMA
  - About half as large as YVMH
  - Has sole CON for open heart surgery in the County

- Central Washington Healthcare Partners (CWHP) – a Clinically Integrated Network
Phase I of our clinical integration plan was kicked off last fall.
Original Project Organization

*Phases I and II were guided by an Oversight Committee and a physician Steering Committee.*
Network Goals & Objectives

Goals and objectives for the network were set by the physician Steering Committee.

Coordinate Care and Lower Costs
- Coordinate care for patient populations to improve quality, satisfaction and lower cost
- Improve access to care, particularly preventive care…while reducing overall cost
- Develop multiple quality and cost focused incentive programs and improve them over time

Improve and Preserve the Quality of Practice
- Allow area physicians to respond pro-actively to government and commercial reform pressures by developing their own approaches to improving quality and delivering more efficient clinical care
- Provide physicians who wish to remain independent a path to preserve private practice
- Chart a course to preserving physician income by prudently assuming a growing degree of risk…and managing it successfully
- Reduce uncompensated non-clinical workload on physicians, and reward those who participate in value-added non-clinical tasks

Other Objectives
- Develop patient-centered medical home and other innovative pilot models
- Encourage/enable participation in state and national reform efforts
- Support YVMH’s commitment to providing charity care and educating the next generation of physicians and other health professionals
## ACO Readiness Assessment

A readiness assessment was conducted in 14 areas. Our scores ranged from 27% to 88%. Importantly, we scored high on leadership readiness (#1, #2 & #3).

| 1. System Governance                  | 8. Quality and Safety |
| 2. Executive Leadership               | 9. Strategic Alliances |
| 3. Clinical Leadership                | 10. Clinical I/T      |
| 5. Primary Care                       | 12. Financial Position / Cost Mgmt |
| 6. Provider Network                   | 13. Payer Relations / Market |
| 7. Care Management                    | 14. Market Conditions  |
We reviewed a number of structural models and chose to become a subsidiary of YVMH, in order to have as much financing flexibility as possible.
In order for CWHP to be a 501(c)(3) corporation, we designed a two-level governance structure, with a small governing Board that meets IRS requirements for tax-exempt status and a large Operating Committee dominated by physicians. The Board has reserve powers, but has delegated day-to-day management and policy decisions to the Operating Committee.
Operating Committee Composition

The composition of the Operating Committee balances the interests of different physician constituencies.

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YVMH Board of Trustees

- CWHP Board
- Rick Linneweh, CEO, YVMH

Dr. Richard Spiegel, CEO, CWHP

- CWHP Operating Committee
  - Dr. Gary Bos, Medical Director, CWHP
- Shawnie Haas, Executive Director, CWHP
- Quality Team
- Data Team
- Communications

Membership Chair
Pharmacy Chair
Membership Chair
Quality Chair
Committee Initiatives

**Quality**

**Chair: Dr. Bennett**
- Metric selection
- Metric retirement
- Evaluate measure efficiency
- Scorecard
- Operational definitions
- Attribution standards
- Physician Panel Admin
- Data correlation
- Policies related to quality

**Implementation**

**Chair: Dr. Angulo**
- Scorecard development
- Physician and physician office education
- Attribution standards
- Data correlation
- Development of education materials
- Policies related to implementation

**Pharmacy**

**Chair: Angie Stewart**
- Generic prescribing
- Academic detailing
- Hospital purchasing initiatives
- Formulary consolidation
- Policies for all issues related to pharmacy

**Membership**

**Chair: Dr. Waber**
- Membership application review
- Denials
- Terminations
- Appeals
- Credentialing
- Policies for all issues related to membership, credentialing and appeals
Implementation Initiatives

A number of implementation activities are being pursued in parallel.

- Leadership development
  - Advocate Physician Partners
  - Institute for Clinical Quality and Value
  - CIN Collaborative
- Membership agreement and recruitment
- Clinical performance reporting system – Intelligent Healthcare
- Clinical improvement program – First year measures
- Physician incentive plan
- Payer strategy
Clinical Improvement Program: Early Lessons Learned

- Involve the right people in the process
- Don’t invent…implement
- Don’t overreach
- Process measures first, outcome measures next
- Start with measures that are relatively easy to implement
- Include measures with fast payback
- Consider the cost of implementing a measure
- Consider the clinical and financial impact of measures
- Ask payers, employers what they want
- Don’t forget your hospital’s employee benefit plan