One Size Does Not Fit All: Clinical Integration in Settings from A to Z

Health Forum and AHA Leadership Summit
San Diego, California
July 26, 2013
Clinical Integration – Aligning to Achieve the “Triple Aim”

- Patients
- Payers
- Hospitals
- Physicians
- Post-acute and Other Community Providers

Reduce Costs
- Care Management
- Aligned Incentives

Improve Experience of Care
- New Care Delivery Models

Enhance Health Status
- Health Information Technology
Paradigm for Success

Increase the Defined Population for Whom We Care
ACO/CI Opportunities

**Employees**
- Win-win to manage costs and health status of health system employees and family members
- Benefit design can promote use of the Network

**Medicare**
- No downside risk for first three years
- Qualifies Network as “clinically integrated”
- Develop exclusive relationships with primary care providers

**Commercial**
- Emerging opportunities, especially for “private label” products
- Encouraging use of their population management resources
- New products being developed for Healthcare “Marketplaces” (Exchanges)

**Self-insured**
- Shared savings and private label products
- Increasing numbers of mid-size employers moving to self-insure
Competitive Landscape

- What are your competitors doing?
  - Hospitals
  - Health systems
  - Physician groups
  - Other players
    - Pharmacies
    - Retail clinics

- Are they forming accountable care organizations ("ACOs") or similar, value-based organizations?
  - Competitors’ participation could preclude or delay your participation in the future

- What are payers doing in your market?
  - Consider the infrastructure and care coordination redesign required for value-based, shared savings contracts
Destination: Start with the End in Mind

Destination:

Hospitalist and Hospital-based Physicians
Reduce Readmissions
Bundled Payment
Patient-centered Medical Home
Transactions/Network Development
Patient Safety and Throughput
Hospital Case Management Improvement
Clinical Co-management
Physician Enterprise Restructure
System Wide Care Management Restructuring
ACO
Clinical Integration

FEE-FOR-VALUE
FEE-FOR-SERVICE
Clinical Integration: What’s In It For...Hospitals?

- Participate in new health plan products
- Improve patient care and satisfaction
- Transition to new payment models
- Improve connectivity and relationships with physicians
- Enhance quality improvement results
Clinical Integration: What’s In It For...Physicians?

- Care Management Support
- Participate in New Health Plan Products
- Financial Rewards
- Enhance Connectivity with Colleagues
- Improve Patient Health and Satisfaction
Bottom Line: Why Clinical Integration?

Don’t leave money on the table

Participate in shared savings, rather than leaving it with payers

Help with ways to improve patient care

Staff and information technology (“IT”) support for better care coordination and information to keep patients happy and healthier

Give voice to physicians and other clinicians

Models all require physician leadership and leading roles for nurses, pharmacists, and others
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
## High-level Clinical Integration Milestones

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<th>Milestone</th>
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<tr>
<td>CIN Assessment with Market Analysis, Payer Analysis, and Gap Analysis</td>
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<tr>
<td>Identification of Potential Partners and Contracted Entities</td>
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<td>Governance Structure Decisions and Board Engagement</td>
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<td>Organization Change Elements</td>
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<td>Identification of Key Work Group Capability: Network/Care Model/IT/Financial Acceptance of Charters and Role</td>
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<td>Educational System-wide Communication Plan</td>
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<td>Identify Pilot Population for Successful Clinical Integration and Begin</td>
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# Table of Contents – CI Readiness Assessment

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1. Physician Organization and Leadership

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<tr>
<th>Capability for Success</th>
<th>Findings and Conclusions</th>
<th>Implications for Action</th>
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<tbody>
<tr>
<td>A. Aligned physician organization with appropriate mix of PCPs and specialists (e.g., employed group, PHO, IPA)</td>
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<td>B. Compensation and bonus mechanisms for employed physicians reward quality outcomes</td>
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<td>C. Independent physician organization with a history of positive partnership with the MBO</td>
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Need to Build Capability  Limited Capability  Building Capability  High Capability  Best-in-Class Capability
# Readiness Characteristics by Market

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<th>Physician Organization</th>
<th>Network</th>
<th>Information Technology</th>
<th>Care Management</th>
<th>Organization Readiness</th>
<th>Payer/Managed Care</th>
<th>Market Readiness</th>
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- ◐: Need to Build Capability
- ◇: Limited Capability
- ◆: Building Capability
- ◆: High Capability
- ◇: Best-in-Class Capability
CI Business Model Process

**Phase 1**
Planning
- Gap Analysis
  - Readiness
  - Resource requirements
- Clinical Integration Roadmap
  - Network requirements
  - IT resources
  - Physician leadership
  - Care management
- Action plan
  - Milestones
  - Interim strategies
  - Potential structures
  - Governance models

**Phase 2**
Framework Established
- Create organizational structure
- Set up Governance
- Define participation criteria
- Identify IT vendor/action plan
- Care management structure
- Clinical protocol priorities
- Payer contracting opportunities
- Definitive business plan
  - Identify plans for interim as well as long-term strategy

**Phase 3**
Market Value to Payers
- Establish entity
- Create network
- Develop protocols/measures
- Implement IT
  - Process for collecting and monitoring clinical results
  - Begin data collection
- Implement related strategies
  - To be determined by organization
- Establish payer relationship(s)
The CHI Experience
About Catholic Health Initiatives

- Catholic Health Initiatives (“CHI”) is a national, faith-based nonprofit health system with headquarters in Englewood, Colorado.
- Operates in 18 states and includes 86 hospitals; 40 long-term care, assisted- and residential-living facilities; two academic medical centers; two community health-services organizations; two accredited nursing colleges; and home health agencies.
- Currently, CHI ranks as the nation’s third-largest faith-based health system.
- Annual operating revenues of more than $12 billion and approximately 85,500 employees.
- In fiscal year 2012, CHI provided more than $715 million in charity care and community benefit, including services for the poor, free clinics, education and research.
Strong Nationwide Presence

Updated June 2013
THE CAMDEN GROUP
CATHOLIC HEALTH INITIATIVES | 7/26/2013
Total Operating Revenue by Market

Local Systems of Care Organized in 32 Market-based Organizations Including Several Joint Operating Agreements and Joint Ventures
## CHI Capabilities, Companies, and Partners

### Operational Excellence
- Risk/Insurance and Captive Management Initiatives
- CHI Foundation Support Services
- Clinical Engineering
- Revenue Cycle (Conifer)
- Integrated Supply Chain management
- Treasury Services
- Payer Strategy and Operations
- CHAN
- National Real Estate, Construction, Facilities Management*

### Clinical Excellence and Innovation
- CHI Institute for Research and Innovation (CIRI)
- Consolidated Health Services (Home Care)
- Pathology Associates Medical Laboratory (PAML)
- TeleHealth/Virtual Health Services
- Population Health Management (Conifer Value Based Care)
- Care Management (Carena)
- Physician Practice Management structure
- Catholic Health Ventures
- Venture/Direct Investment Fund
Where We Started

“The New Normal”: Navigating To Future Models of Care

Maximize Clinical Operations
“Highly effective delivery systems”
(2010-2013)

Maximize performance to manage to Medicare rates
Capitalize on payment incentives
Relentless pursuit of value
• Clinical excellence
• Cost of care
• Eliminate “waste”
• Safety
Reduce variation in performance across CHI
Balance the portfolio through selective MBO and system growth

Assume Performance Risk
“Integrated health care delivery systems”
(2012-2015)

Develop interim levels of risk assumption for defined payers, complex procedures, and disease states
Manage episodes and systems of care across defined settings
Translate current financial models to greater risk assumption capability
Build physician alignment models to support integrated care delivery

Manage Population Health
“Clinical and financial risk”
(2014 +)

Move to integrated care capability and capitated models
Establish insurance risk capability
Manage and measure population health
The New Normal

Specific Capabilities are Required to Move Forward

Maximize Clinical Operations
“Highly effective delivery systems” (2010-2013)

- Demonstrate top quartile performance in quality and safety
- Reform how we do business to:
  - manage to Medicare rates
  - maximize reimbursement in VBP model
  - avoid losses from payment penalties (readmissions, serious events, sub-par patient satisfaction)
- Physician and hospital network development
- Design and implement physician alignment models required to drive value
- Measure cost and quality performance in physician office, other non-acute venues & service lines
- Develop assets and capabilities to manage chronic conditions

Assume Performance Risk
“Integrated healthcare delivery systems” (2012-2015)

- Integrated System Governance, Leadership and Culture—Ensure Physician Engagement
- Advanced IT and Communications
- Clinical Integration and Joint Contracting Capabilities—Three Part FTC test
- Patient Centered Care Capabilities
- Direct to Consumer Marketing Capabilities
- Data and analytics to ensure an understanding of how we practice today and how it must change—Clinical Data Warehouse
- Coordinate and provide services across an integrated delivery network
- Insurance Company Collaborative Models
- Direct Employer Contracting
- Statewide Geographic Coverage

Manage Population Health
“Insurance risk capable” (2014 +)

- Willingness to be financially accountable
- Capability to set rates, receive and distribute payments
- Ability to analyze and manage risk
- Sophisticated performance management systems
- Management of member health (population health) and episodes of care under PMPM model
- Develop insurance capability
- Insurance Company Partnering Models

FY12 Areas of Focus
CHI’s four core strategies and twelve strategic objectives provide the focus for our investment of human and capital resources to achieve our goals over the next five years. These objectives will be used by CHI leaders across the system to organize the urgent work required to better serve our communities with improved value, better access and convenience, and greater focus on personal and community health.
CHI will build “Accountable Care” - in its broadest definition – Capabilities:
- Clinically Integrated Network
- Care Management
- Risk Models
- Data Management

Designed to position MBOs for appropriate market accountable care/population health strategies
Strategic Focus

The Next Era of Healthy Communities
Integrated Care Delivery

- Clinically Integrated Networks
- Care Management
- Population Health Analytics
Clinically Integrated Networks

- Coordinates patient care, services and payment across a broad spectrum of functions, processes and settings.
- Legal structure with shared hospital-provider governance.
- During FY13, all MBOs will create or become part of a CIN.
  - CINs not necessarily wholly owned
Assembly of Clinical Components

Care Team
- Nurses
- Dieticians
- Health Coaches
- Social Workers
- Navigators
- Palliative Care
- Lay People, etc.
Why CINs?

- Improve the health of the specific, defined population
  - Using evidence based medicine
  - Measuring how we do
  - Keeping the patient’s point of view in design of services

- Improve collaboration among providers
  - Develop trust and alignment
  - Coordinate care
    - Improve quality and service
    - Reduce duplication and waste
CIN Requirements

- Vision and purpose
- Legal structure
- Governance model (physician-led)
- Network operations and development
- Data warehouse
- Clinical performance
- Finance and payer contracting
- Budget
Care Management Components

Ambulatory Activities
- Case management
- Disease management
- Utilization management
- Practice transformation
  - Medical home
  - Care coordination
  - Extensivist

Acute/Post-Acute Care
- Utilization management
- Readmission reduction
## Prioritizing MBO Waves

### Market Factors

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<th>Rank</th>
<th>Market Size (Revenue)</th>
<th>Market Size (Lives)</th>
<th>Future Market Size (Revenue)</th>
<th>Future Market Size (Lives)</th>
<th>Pressure</th>
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### MBO

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<th>CHI market share</th>
<th>Risk</th>
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### Key ACO Capabilities

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### Additional Data

- Are competitors moving to ACOs?
- Ability to identify, measure & manage risk?
- Ability to manage additional capacity?

### Illustrative Data

- To adopt and sustain change?

### Notes

- 1 = fourth quartile
- 2 = third quartile
- 3 = second quartile
- 4 = top quartile

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Sample Strategic Roadmap

- Launch Commercial & Medicare Episodic Bundle contracts
- Launch Managed Medicaid & Medicare Advantage gain share contracts with select payer partners
- Launch Medicare Shared Savings Program
- Launch Spend Savings for KyOne employees (ACO like model)
- Launch population risk arrangements with private payers for Commercial, MA populations
- Launch KentuckyOne-centric Individual & Small Group Exchange products
A Unified Effort

Enterprise
System-wide approach, milestones, and capabilities

Division/MBO
Local design, capabilities, and implementation

Multi-year
FY2013
Near-term
GROW CHI

Operating Income Derived from Diversified Capabilities and Sources

- FFS+ Reimbursement
- Gainshare & Risk/Capitation
- Bundled Care & Warranties
- Health Management Programs
- Health Plans (MA, HIX, Comm)
- Network Access Fees
- Health Plan & TPA Services
- Network Dev & Mgt Services
- CRM Services
- Turnkey Market Operations
Centralized + Regional Operating Model

Clinically Integrated Networks & Physician Practice Management

Payer Strategy & Operations
COLLABHEALTH MANAGED SOLUTIONS

Care Management

Licensed Health Plans

Health Plan Management

Sales & Marketing
Network Dev & Operations
Underwriting & Health Econ
CE Pricing & Contracting
Integrated Road Map
Diverse Markets – Diverse Solutions
Statewide Health Alliance in Iowa

UIHA Profile
- 17 Owned, 34 Affiliate Hospitals
- 2,294 Integrated Physicians
- 2,000+ Additional Aligned Physicians
- $4B+ Annual Net Revenues
Western Washington

Situation
- High penetration of managed care: commercial and Medicare
- Increasing provider consolidation
- Existing physician groups with experience in managed care
- Employers (Boeing) pursuing direct contracting

CI Solution
- Create integrated CI entity with multiple medical groups
- Pursue Medicare ACO and direct contracting with employers
- Acquire health plan
Southeast Market

Situation

- Competitor has large employed primary care network
- Small employed physician base, with successful, but smaller primary care practices in the community
- Medicaid market moves to bundled payment
- No significant move of commercial carriers to value-based care
- System has investment in health plan

CI Solution

- Engage successful practices in the community to form CIN
- Focus on populations the CIN can manage as soon as possible:
  - Health system employees
  - Medicare (CPCI and MSSP)
Fifty Reasons Not To Change

1. It's too ambitious.
2. It's too complicated.
3. We'll catch flak for that.
4. It will take too long.
5. We're waiting for guidance on that.
6. We can't take the chance.
7. No es mi problema.
8. It needs more thought.
9. I don't have the authority.
10. We don’t have the equipment.
11. Es imposible.
12. I'm not sure my boss would like it.
13. I'm not sure my boss would like it.
14. We don’t have the staff.
15. It needs committee study.
16. What's in it for me?
17. We don’t have consensus yet.
18. We didn’t budget for it.
19. There’s not enough time.
20. We have too many layers.
21. We've always done it this way.
22. We've never done that before.
23. We tried that before.
24. That's someone else's responsibility.
25. It won't fly.
26. It's too political.
27. We’re doing OK as it is.
28. It can't be done.
29. They won't fund it.
30. They don’t really want to change.
31. It's too expensive.
32. They’re too entrenched.
33. I don't have the authority.
34. No one asked me.
35. It's contrary to policy.
36. It's not my job.
37. Another department tried that.
38. It's not our problem.
39. No se puede.
40. There's too much red tape.
41. There's no clear mandate.
42. It's falta animo.
43. Nunca pasarfa.
44. It's too visionary.
45. If they don't care, why should I?
46. It's against tradition.
47. It will never fly upstairs.
48. I'm all for it, but...
But if We Refuse to Change…

“Even if you’re on the right track, you’ll get run over if you just sit there.”

Will Rogers