Clinical Integration as Catharsis: Overcoming Barriers to Hospital-Physician Affiliation

The American Hospital Association
2013 Leadership Summit
July 22, 2014
Session Objectives

- Discussing why a Learning Organization is critical to success under healthcare reform
- Defining what Clinical Integration is and why it is an improved mechanism for hospital/physician affiliation and creating the Learning Organization
- Understanding the importance of a consensus-based approach to building a true clinically integrated network
- Structuring a clinically integrated network for maximal impact
- Learning how a hospital system with deeply entrenched historical distrust between administration and physicians overcame that dynamic to create a viable clinically integrated network encompassing both employed and independent physicians.

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Moderator:

Phil Polakoff MD, Senior Managing Director/Chief Medical Executive, FTI Consulting

Clint Matthews, President & CEO, Reading Health System, Reading, PA

George Jenckes, MD, CEO & Senior Medical Director, Reading Health Partners

Gerry Meklaus, Senior Managing Director, FTI Consulting
WHO Definition of Health

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
Healthcare will consume over **20% of the US GDP** at a **cost exceeding $3 trillion**
- **30M** more insured including **10-12M** additional Medicare enrollees
- Inpatient revenue growth will remain flat (+2%)
  - Sources of revenue changing as **outpatient growth increases to approx 20%** (reduced inpt elective procedures, increased risk burden)
- Value based reimbursement will put **6-10%** of current hospital and physician income at risk
- Reimbursement will transfer from a production/”fee for service” model to one predicated on outcomes and population health management
- Many **payers** will also be providers
- **Physician shortages** will range from **150,000 – 170,000**

**Competition will increase** as healthcare providers **compete on cost and quality**, respond to new measures of value and face greater stakeholder expectations
- **Innovation and competition** will increasingly come from firms outside traditional healthcare **boundaries** (e.g., from retail and web-based firms)
- **Employers** will be an increasing force in the delivery of **preventative services** and health care
- **Consumer engagement** will be an increased focus for payers and providers
- Major technology advances will dramatically change healthcare: **electronic medical records (clinical information systems, patient management systems)**, mobile applications and genomics
We can't solve problems by using the same kind of thinking we used when we created them.

– Albert Einstein
Seven Core Health Delivery Principles to Achieve Success

- Innovation
- Leadership
- Trust/Transparency
- Quality of Care
- Value Proposition
- Financial Strength
- Collaboration/Cooperation
“Systems Thinking is ... concerned with a shift of mind from seeing parts to seeing wholes, from seeing people as helpless reactors to seeing them as active participants in shaping their reality, from reacting to the present to creating the future.”

- Peter Senge
Building the Learning Organization

5 “Component Technologies”:

- Systems Thinking
- Personal Mastery
- Mental Models
- Building Shared Vision
- Team Learning

*Organizations that can truly learn can continually enhance their capacity to realize their highest aspirations*

Patient Care Is a Team Sport Now

Today

Tomorrow
## Engaging Doctors in the Health Care Revolution

<table>
<thead>
<tr>
<th>Motivation</th>
<th>How to Apply It</th>
<th>Example</th>
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</thead>
<tbody>
<tr>
<td>To engage in a noble, shared purpose</td>
<td>Appeal to the satisfaction of pursuing a common organizational goal</td>
<td>The Cleveland Clinic reinforced its commitment to compassionate care by launching a same day appointment policy.</td>
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<tr>
<td>To satisfy self-interest</td>
<td>Provide financial or other rewards for achieving targets</td>
<td>At Geisinger Health System, 20% of endocrinologists’ compensation is tied to goals such as improving control of patients’ diabetes.</td>
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<td>To earn respect</td>
<td>Leverage peer pressure to encourage desired performance</td>
<td>Patients’ ratings of University of Utah physicians are shared both internally and on public websites to drive improvements in patient experience.</td>
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<tr>
<td>To embrace tradition</td>
<td>Create standards to align behaviors, and make adherence a requirement for community membership</td>
<td>At the Mayo Clinic, a strict dress code and communication rules signal the “Mayo way of doing things”.</td>
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Adapted from Max Weber by Toby Cosgrove, MD and Thomas Lee, MD, Harvard Business Review, June 2014
Clinical Integration Defined
A CLIO is a physician-led, legal entity that joins our community of physicians in an organization that enables:

- Identification and adoption of best practices for the treatment of patients
- Development of systems to monitor performance
- Collaboration with hospitals to improve processes of care
- Negotiation with payers as a network with a focus on quality and best practices
Clinical Integration in Comparison to other Approaches

<table>
<thead>
<tr>
<th>Physician/Hospital Organization</th>
<th>PHO</th>
<th>ACO</th>
<th>IPA</th>
<th>CLIO</th>
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<tbody>
<tr>
<td>Physician Developed</td>
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<td>![Existing and fully functional]</td>
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<tr>
<td>Necessary Infrastructure</td>
<td>![Existing and fully functional]</td>
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<td>Patient-Centric, Quality Focused</td>
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<td>Payer Contracting</td>
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<td>Shared Savings Opportunity</td>
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- **Does not exist**
- **Partial**
- **Existing and fully functional**
Clinical Integration Conceptual Alignment

Independent and Employed Physicians

Clinical Integration Participation Agreement

Health System
Home Health Care
Diagnostic Center
Procedure Center
Acute Care Center
Post-Acute Care Center


Selective Physician Partnerships

Comprehensive Improvement Initiatives

Performance Improvement Architecture

Collective Negotiation for Efficiencies & Quality Improvement

Payers

Employers
Alignment Models

» Regional Clinical Integration Colaboratives

Source: Hogan Marren, Ltd.
A National Movement
Vision:
To deliver world-class healthcare to patients through outstanding physician leadership, innovation and quality outcomes.

Mission:
To optimize the wellbeing of the communities we serve through improved quality care and collaborative health management to maximize value for the patients.

To be accomplished through one physician-led, clinically integrated organization.
Location: Chicago area and downstate Illinois

Established: 1995

Number of Physicians: Over 4,500 physicians, and 2,700 of these are independent

Number of Patients: Over 1 million patients

Number of Hospitals: 12 hospitals and over 250 sites of care

Number of Health Plan Participants: 13 insurers

Number of Patients under Value-Based Contracts: 553,000 patients

Accomplishments:

Asthma Outcomes – APP achieved a control rate of 66% for patients with asthma, exceeding the national control rate of 50%; this saved $6.2 million annually in direct and indirect medical costs above the national average; it also includes an additional 26,801 days saved from absenteeism and lost productivity annually

Diabetes Outcomes – Control outcomes for HbA1c saved $6 million above the national performance levels.
**Location:** Greater Houston area and Southeast Texas

**Established:** 2006

**Number of Physicians:** Over 2,000

**Number of Primary Care Physicians:** Over 500

**Number of Specialties:** 40

**Number of Hospitals:** 12

**Number of Patients under Value-Based Contracts:** 100,000 commercial lives

**Accomplishments:**

*Order Sets Usage Savings* – MHMD has had over $1 million in cost savings through nearly 100% compliance with Order Set usage with the following 6 conditions: GI Bleeding, Heart Failure, Chest Pain, Sepsis, Pneumonia, and Acute MI

*Patient-Centered Medical Home* – Developed the largest networked medical home in the region
Location: Marietta, GA

Established: in progress 2014

Number of Physicians: Over 1200

Number of Primary Care Physicians: Over 500

Number of Specialties: 40

Number of Hospitals: 12

Number of Patients under Value-Based Contracts: 65,000 lives

Accomplishments:

Physician Engagement – Over 45 physicians participating (gratis) in all aspects of design

Governance– Rationalized the roles of the ACO and the CLIO, developed new governance structures

Infrastructure – Building complete infrastructure to support Quality Improvement, Disease Management and Population Health capabilities
Benefits of forming a CLIO

**Patients**
Gain access to high quality, integrated, comprehensive healthcare services

**Physicians**
Gain opportunity to develop and measure best practices, improve outcomes and be rewarded for successes

**Health Systems**
Gain a stronger aligned group of physicians working to control costs and improve quality

**Payers and Employers**
Gain partners who share their goals of better quality and cost efficiency
Rationale to Join a CLIO

- Locally developed best practices for patient care leading to **improved quality and efficiency**
- **Physician-led**, run and governed organization
- Health system organizational and financial support
- Collective single-signature contracting to support improvements in quality and efficiency
- **Enhanced coordination/communication** among physicians and WellStar
- Access to analytical tools such as patient risk identification
- Assistance with **meaningful use**
- Increased capabilities for managing quality and cost of care
The Reading Health Partners Story
Reading Health System Overview and Strategic Priorities

Reading Health System is an integrated system of care

- Serves a five-county market north-west of Philadelphia.
- Total Physicians - 670
  - Employed Physicians - 394
  - Independent Physicians – 337

The Primary Service Area is shaded yellow.

Six secondary service areas, defined by number of inpatient discharges, competitive set, and road access.
Two distinct and diverse populations - Berks County, City of Reading
Aging population and medical staff
Recruitment challenges
Reimbursement decline and uncertain payment reform
Challenged ratings from physicians, associates, and patients
Shift toward population health management care model
Need for stronger community relationships

The Transition To Value-Based Payments

### Pressing Market Factors

<table>
<thead>
<tr>
<th>Consumers</th>
<th>Employers</th>
<th>Payers</th>
<th>Government</th>
<th>Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced household incomes and squeezed personal finances; need convenience, coordination, and lower cost care.</td>
<td>Demanding lower cost and better quality options to compete effectively in marketplace.</td>
<td>Looming Medicare &amp; Medicaid payment cuts and performance based payments. Commercials have followed.</td>
<td>State and Federal Regulators challenge premium increases.</td>
<td>Pressure to provide higher quality of care in an environment of rising costs and narrowing margins.</td>
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</tbody>
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### The Transition To Value-Based Payments

**Volume-Based First Curve**
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

**Value-Based Second Curve**
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives, encouraged coordination

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Source: AHA “Hospitals and Care Systems of the Future.” Sept. 2011 p.10. Figure 1: First Curve to Second Curve.
Why Clinical Integration?

- Don’t Leave Money on the Table – Negotiate Shared Savings with Payers
- Prepare for Forthcoming Pay-for-Performance Methods
- Respond to Employer Demands for Value (Demonstrated Efficiency and Quality) – Retaining and Growing Market Share
- CI Models Require Physician Leadership and Governance
- Improve Patient Satisfaction and Clinical Care
- Clinical & Financial Integration Allows a Hedge Against Decreasing CMS and Commercial Payers Declining Reimbursement.
- Over 700 Successful Clinically Integrated Healthcare Systems Across the United States
Project Design Flow

**CORE PROJECT TEAM**

- Reading Clinical Integration

**Teams and Responsibilities**

1. **Team 1** - Continuum of Care Coordination
2. **Team 2** - Physician Value Proposition
3. **Team 3** - Technology Architecture Analytics
4. **Team 4** - Operating Model & Support
5. **Team 5** - Business Planning

**Design Summit Outputs**

- Finalize straw models, determine interdependencies, and obtain senior leadership validation

**ACO/Clinical Integration Education & Comparative Organization Study**

**Clinical Integration Program Design**
# Project Design Team Assignments

The following individuals have been selected to participate in the Design Teams

<table>
<thead>
<tr>
<th>Team 1</th>
<th>Team 2</th>
<th>Team 3</th>
<th>Team 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuum of Care Coordination</strong></td>
<td><strong>Physician Value Proposition</strong></td>
<td><strong>Operating Model</strong></td>
<td><strong>Technology, Architecture &amp; Analytics</strong></td>
</tr>
<tr>
<td>Facilitators: Peter Boland, PhD, Gary Smalto, MD &amp; Linda Fitzpatrick, RN</td>
<td>Facilitators: Gerry Meklaus &amp; Dalia Ahmed</td>
<td>Facilitators: Gerry Meklaus, Dalia Ahmed, John Marren, &amp; Thomas Babbo</td>
<td>Facilitators: Gary Smalto, M.D., &amp; Chris Carson</td>
</tr>
<tr>
<td>Joseph Grennan, M.D.</td>
<td>Brent Wagner, M.D. - Independent Medical Staff President/Radiologist</td>
<td>Joseph Grennan, M.D.</td>
<td>Jorge Scheirer, M.D., CMIO Internal Medicine</td>
</tr>
<tr>
<td>VP &amp; CMO</td>
<td></td>
<td>VP &amp; CMO</td>
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<tr>
<td>Wall Bohnenblust, M.D.</td>
<td>George Jernikes, M.D. Medical Director, BHP</td>
<td>Bob Brigham, M.D. Dept Chair of Surgery - RPO BoD</td>
<td>Mac McKnight, CIO</td>
</tr>
<tr>
<td>Director, Hospitalist Services</td>
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<tr>
<td>David George, M.D.</td>
<td>Lee Radosh, M.D. Family Medicine</td>
<td>George Neubert, M.D. Dept Chair of OB/GYN</td>
<td>Joseph Grennan, M.D. VP &amp; CMO</td>
</tr>
<tr>
<td>Chief Academic Off</td>
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<tr>
<td>Deb Leveongood Quality</td>
<td>Nick Cammarano, D.O. OB/GYN</td>
<td>Greg Lutz, Executive Director The Reading Hospital Medical Group</td>
<td>Dawn Dreibelbis, R.N., CCM BHP Director of Health &amp; LM</td>
</tr>
<tr>
<td>Cecelia Smith, D.O. Dept Chair of Medicine</td>
<td>Ron Nulning, M.D. Cardiothoracic Surgery</td>
<td>Chuck Wills President &amp; CEO BHP</td>
<td>Vinod Chacko, M.D. Internal Medicine</td>
</tr>
<tr>
<td>George Jernikes, M.D. Medical Director, BHP</td>
<td>Marc Aynardi, M.D. Internal Medicine</td>
<td>Dave Steffy, M.D. - RPO BoD</td>
<td>Udai Daskar, M.D. Cardiothoracic Surgery</td>
</tr>
<tr>
<td>BHP</td>
<td>Ezzat Hanna, M.D. Family Medicine</td>
<td>John Travers, M.D. - RPO BoD</td>
<td>Brian Le, M.D. Pathology</td>
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<tr>
<td>BHP Director of Health &amp; LM</td>
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<tr>
<td>Paul Brockman, M.D. Physical Medicine &amp; Rehab</td>
<td>Stephen Longenecker, M.D. Ortho Surgery</td>
<td>Vince Moffitt, M.D. - RPO BoD</td>
<td>Adam Spiegel, D.O. Trauma &amp; Surgical Critical Care</td>
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<tr>
<td>Debra Zimmerman, D.O. Internal Medicine</td>
<td>Mark Reuben, M.D. Pediatrics</td>
<td>James Restrepo, M.D. - RPO BoD ENT</td>
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<tr>
<td>Charles Barbera, M.D. Emergency Medicine</td>
<td>Michael Avdissian, M.D. Cardiology</td>
<td>John Casey, M.D. Ortho Surgery</td>
<td>John Dougherty, M.D. OB/GYN</td>
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<tr>
<td>Andy Donato, M.D. Hospitalists</td>
<td>Cliff Reed, M.D. Neurology</td>
<td>Alec Platt, M.D. Pulmonary &amp; Critical Care Medicine</td>
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<tr>
<td>Forrest Fernandez, M.D. Trauma &amp; Surgical Critical Care</td>
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<tr>
<td>Bob Jones, D.O. Infectious Disease</td>
<td>Nader Rahmannian, M.D. IM/Geriatric Medicine</td>
<td>Robert Pattillo, M.D. Cardiology</td>
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<tr>
<td>Surendra Sivarajah, M.D. Endocrinology</td>
<td>Robert Hippet, D.O. Primary Practice</td>
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<tr>
<td>Kurt Bamberger, M.D. General Surgery</td>
<td>Robert Early, M.D. Anesthesiology</td>
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<tr>
<td>Jean Prayer, M.D. OB/GYN</td>
<td>Susan Probst, M.D. OB/GYN</td>
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<tr>
<td>Rocco Santarelli, D.O. Pulmonary and Critical Care</td>
<td>Louis Borgatta, M.D. Cardiology</td>
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<tr>
<td>Sanand Menon, M.D. Pediatrics</td>
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<tr>
<td>Stephen Banco, M.D. (or designee) Ortho</td>
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<tr>
<td>David O'Rourke, M.D. OB/GYN</td>
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<tr>
<td>Bill Finneren, M.D. Cardiology</td>
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**KEY**
- **Employed**
- **Independent**
- **Administration**
- **BHP**
Why Participate in Clinical Integration with Reading Health Partners?

Reading Health Partners...

- is physician-led, run, and governed
- improves quality of care
- allows for continued patient care at physician-owned facilities
- maintains existing physician payer contracts
- provides a 90-day "out" clause
- allows for additional upside financial reward for meeting quality and cost goals
- reduces patient leakage
Barriers of Clinical Integration

- Difficulty perceiving the value of Clinical Integration absent clear payer imperatives that are yet to come.
- Resistance to changing the business model of FFS which has been highly lucrative for some.
- Inability to overcome the paradigm of the past (RHS mistrust issues).
- Lack of understanding that physician reimbursement from CMS and Commercial Payers will continue to decrease.
- Belief that Fee-for-Service payment models are NOT going to be replaced with Fee-for-Value reimbursement.
- Inability to understand the new healthcare environment.
- Failure to believe that physicians and hospital systems can align their mutual interests.
Physician Leadership Drives RHP Design and Development

Clinical Integration

Provider Network, Credentialing and Enrollment

Population Health Management

Quality Improvement and Clinical Integration

Finance & Contracting

Clinical Informatics
Organizational Structure and Governance

13 RHP Board Members

10 Reading Physician Organization Members
- 8 Independent Physicians
- 2 Employed Physicians

Reading Health Partners Management Team (Non-Voting)
- Chief Executive Officer/Senior Medical Director
- President

3 Reading Health System (RHS) Members
- CEO, Reading Health System
- CMO, Reading Health System
- Private Lay Board Member from Reading Health System Board
- Other Non-voting members
What’s In It For Physicians

• Care Management and Ancillary Services Support
• Financial Rewards with Future Payment Methodologies – Shared Savings
• Enhanced Communication and Interaction with Colleagues
• Improved Patient Health and Satisfaction
• Ability to Participate in New Health Plan Products
• Health System Support for Provider Clinical Improvement Projects
• Increase Practice Efficiencies to Reduce Provider Overhead
• IT and EMR Support
• Increase Patient Volume by Increasing Quality and Service and by Decreasing Leakage
Physician Participation Update

Signed Participation Agreements
Employed Physicians – 394; Independent Physicians – 337; Total Physicians – 670

Specialty Representation (50 Specialties)

- Allergy & Immunology
- Anesthesiology
- Cardiothoracic Surgery
- Colon & Rectal Surgery
- Dermatology
- Diagnostic Radiology
- Emergency Medicine
- Endocrinology
- Family Practice
- Geriatric Medicine
- Gynecological Oncology
- Hematology/Oncology
- Hospitalist Service
- Infectious Disease

- Internal Medicine
- Intervention Radiology
- Neonatology
- Neurological Surgery
- Neurology
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pain Management
- Palliative Medicine
- Pathology
- Pediatrics
- Psychiatry

- Physical Medicine & Rehabilitation
- Plastic Surgery
- Podiatry
- Psychiatry
- Psychology
- Pulmonary Disease
- Quick Care Centers
- Radiology
- Radiation Oncology
- Sleep Services
- Trauma Surgery
- Vascular Surgery
- Weight Management
- Wound Healing/Hyperbaric Med.
Lessons Learned

• The leading message on the benefits of CI is quality and efficiency outcomes for the patient- you must build a shared vision around these key motivators

• There is likely to be much misunderstanding and historical resistance – you will raise issues you thought long buried. Look at this as the opportunity to finally work through all those concerns

• CI leadership requires much passion and integrity- exhibited by all, from the Board of Directors, through key executives. The enthusiasm must be contagious
Results

- Reading Health Partners (CLIO) created as a physician-led subsidiary of Reading Health System
- 630 employed and independent physicians participating in the clinical network
- 80+ quality metrics tracked
- Population Health IT infrastructure in place
- Fully FTC Compliant
- Reading Health employees and dependents serviced by the network (10,000 lives)
- Large, local self-insured employer serviced under full capitation
- Pursuing commercial contracts
- Founding member of AllSpire - a regional collaborative