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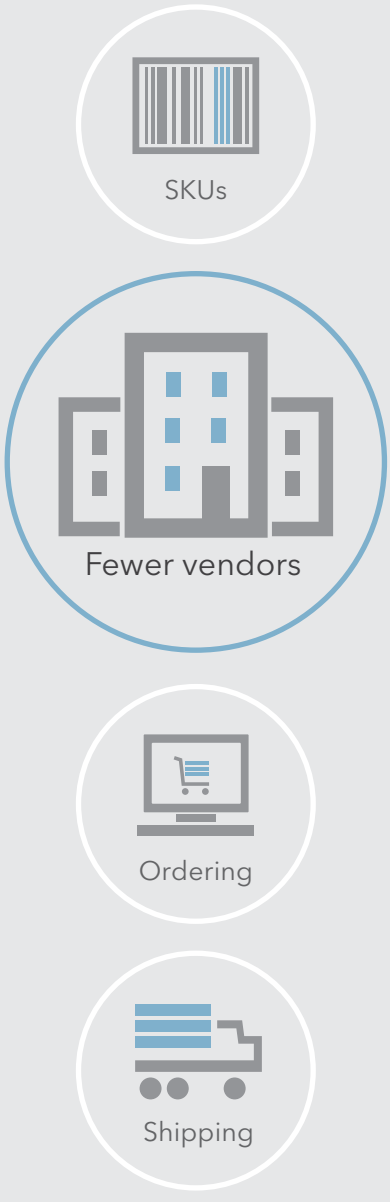

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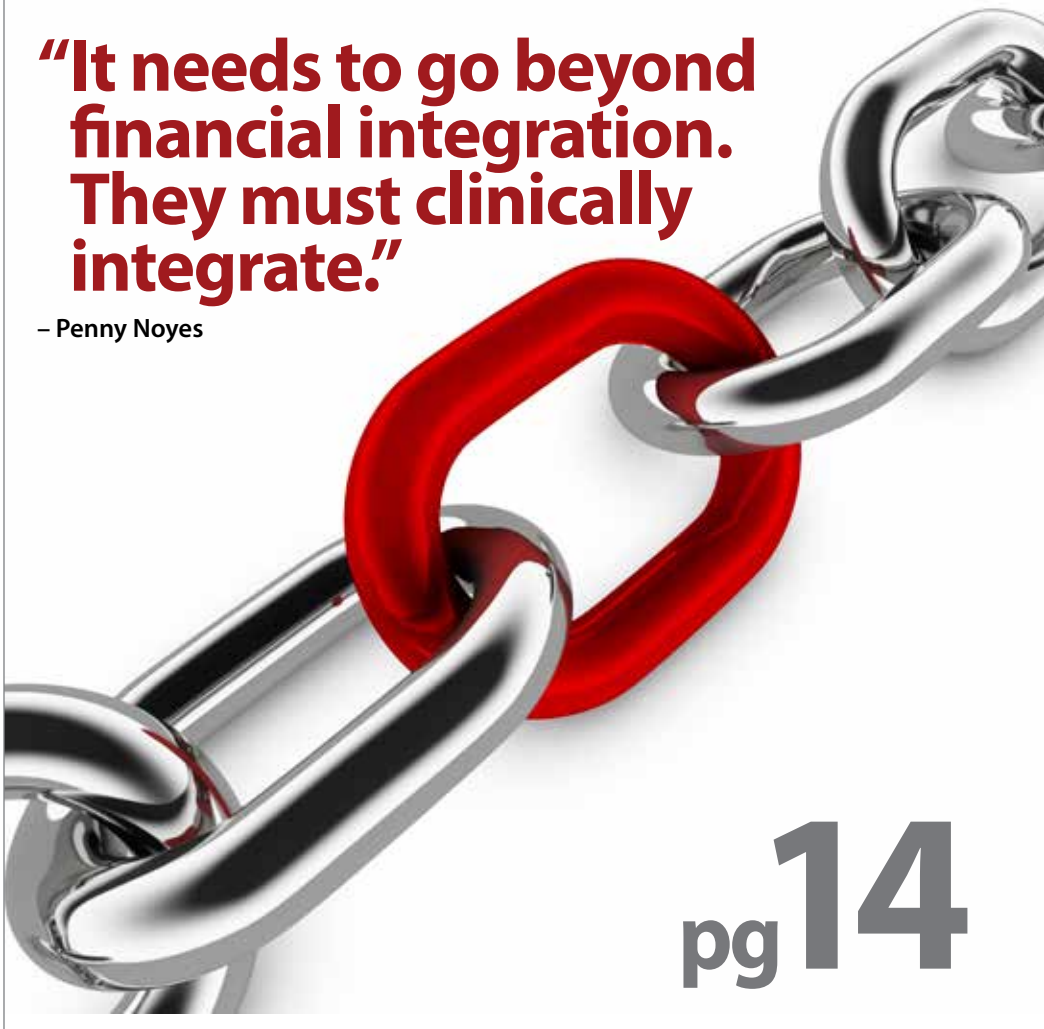

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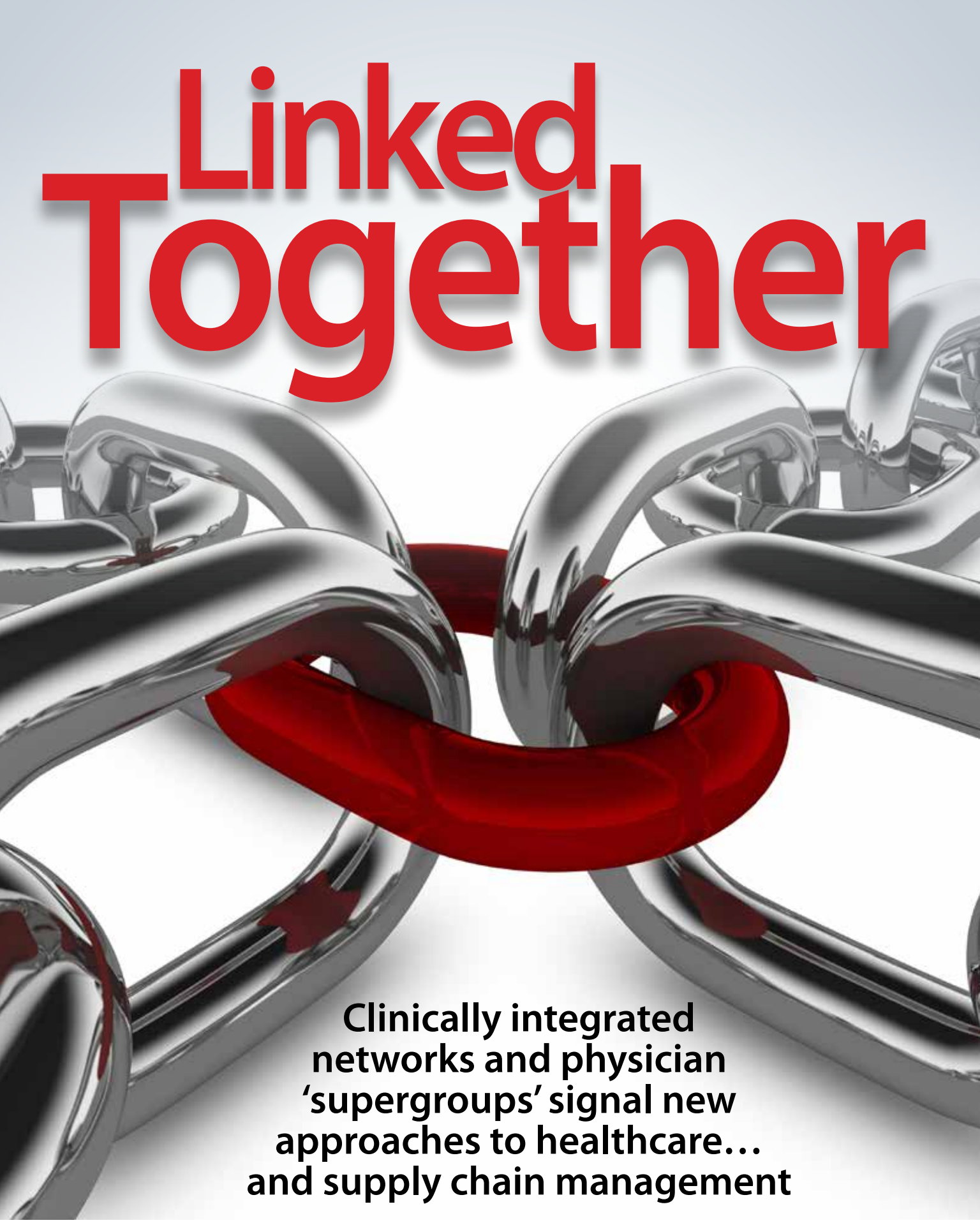

Clinically integrated networks and physician 'supergroups' signal new approaches to healthcare… and supply chain management

Clinically integrated networks: One more way hospitals and doctors are being pulled together

Hospitals and physicians are being drawn together ever more tightly, whether it is through IDNs' acquisition of physician practices, or the formation of accountable care organizations.

There is another integration game in town – the clinically integrated network, or CIN. Though perhaps not as widely known as ACOs, CINs also represent physician/hospital integration. They're growing in number, and experts believe they have staying power.

"The driver for healthcare in a value-based environment is not one that is going away," says Aimee Greeter, vice president, Coker Group, a healthcare advisory firm in Alpharetta, Ga. "I don't think our fee-for-service system is sustainable. Whether it's called a clinically integrated network or something else, I think the focus on value will be a lasting concept."

The clinically integrated network, or CIN, is not a new concept. It was defined by the Federal Trade Commission and the Department of Justice as far back as 1996, explains Michael Schweitzer, MD, MBA, vice president, VHA Southeast, who spoke on the topic of clinically integrated networks at VHA's "Navigating to Excellence Forum" last spring.

That definition? "A network implementing 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."

Transform healthcare

Like accountable care organizations, or ACOs, clinically integrated networks have the potential to transform healthcare, says Schweitzer. "The focus of both the ACO and CIN is collaboration and coordination of care through quality improvement and cost reduction," he says. ACOs and CINs both rely on: 1) an IT infrastructure to facilitate exchange of patient information among physicians and other providers, 2) adherence to evidence-based medicine guidelines, 3) well-defined goals for performance improvement, and 4) a system to monitor physician /provider performance against those goals.

Ten years after the FTC and Department of Justice defined the clinically integrated network, fewer than 20 CINs existed, says Schweitzer. "But the healthcare climate has changed significantly since then." The number of CINs has skyrocketed, he says. "Most important, our patients and nation deserve to experience this transformation of care to better quality at a lower cost."

ACO's twin

The clinically integrated network is the ACO's twin, explains Thomas D. Anthony, attorney at law, Frost Brown Todd LLC, Cincinnati, Ohio. But they serve different markets. ACOs were established under federal statute within the Medicare/Medicaid program – principally Medicare, he says. By definition, then, patients participating in an ACO are primarily Medicare enrollees age 65 or over. CINs, on the other hand, focus on the commercial or self-insured market, that is, primarily people under the age of 65.

Both ACOs and CINs create alignment strategies involving physicians and hospitals, continues

Anthony, who is the former CEO of PacifiCare of Ohio. But that's where the similarities end.

"ACOs are rigid and fixed," he says. Federal statute has pretty well defined how an ACO operates. CINs, on the other hand, "are highly flexible and organic, and they can change over time," he says. Participating providers – hospitals, outpatient facilities, physicians, and/or any combination thereof – align themselves and build their structure based on their goals and the needs of the particular geographic market in which they operate.

Says Greeter, the Medicare ACO program is "like a black box," with a well-defined set of boundaries and rules. "That's good and bad," she says. "It's good in that you know the rules going in, and you know what's expected of you. But there's not a lot of flexibility."

CINs, on the other hand, can be structured in multiple ways, yet still be compliant with the law, she says. "That's good and bad, too. It's great in that you have that flexibility. But it also makes it difficult, if you're creating an organization without any prior experience. You don't have a definitive ladder to climb."

Another key difference between ACOs and CINs is the financial risk they are allowed to take.

If the ACO meets all the quality benchmarks, and the population's cost of care is below an established threshold, the ACO can share in the "savings," that is, the difference between the actual cost and benchmark cost, says Schweitzer. A clinically integrated network, on the other hand, cannot accept financial risk for the cost of care, though it can negotiate higher base fee-for-service rates or performance incentives with commercial payers.

Unlike the ACO, the CIN isn't required to take on coordination of the full continuum of care and population health management responsibilities, continues Schweitzer. As CINs mature, however, they often address more complex goals, moving toward managing the health of a broader population.

Physicians' hopes…and fears

Some physicians see forming or joining a CIN as a viable alternative to getting acquired by a hospital system or IDN.

"It is one of the primary ways independent medical groups are maintaining their independence, while managing to align and befriend hospital systems," says Anthony. "CINs are flexible enough to accommodate both employed and independent physicians. It can work, and work exceedingly well."

Says Schweitzer, forming or joining a CIN or an ACO is a way for physicians to collaborate with others to improve quality and patient experience, decrease the cost of care, and benefit financially. That said, physicians may have some reservations about joining a CIN, including these:

- Some are concerned about what they perceive to be the high cost of the technology infrastructure required to exchange their practice's health information and data with other providers.
- Many balk at the significant investment of time needed to develop and maintain a CIN.
- Some fear they may be asked to comply with "cookbook" medicine instead of using their own judgment or protocols.
- Some are concerned that the CIN will restrict their ability to refer patients to the specialist or facility of their choice.
- Some physicians have concerns that sharing their

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Hospitals and doctors: Marriage of convenience

Clinically integrated networks bring physician groups and hospitals together to provide a full continuum of care to a patient population. That can lead to an uneasy – but necessary – alliance.

"Interestingly, there was a predominance of hospital-sponsored CINs" in past years, says Aimee Greeter, vice president, Coker Group. "But over the last two or three years, we have seen more private, entrepreneurial physicians creating their own CINs." They are doing so for two reasons: 1) to compete with a hospital's clinically integrated network, or 2) to fill a void where a CIN is lacking.

Even if the CIN is hospital-led, its organizers must encourage heavy physician involvement from the outset, she says. And they must give more than lip service to the concept.

Once the hospital system and physicians have their clinically integrated network off the ground, they will continue to face some thorny questions. "There is perceived value in providing services in the lowest-cost facility," says Greeter. But hospital administrators wonder how they can be successful in a CIN if they can neither 1) be the low-cost facility, or 2) own the practices of the physicians who are making treatment decisions.

data with other providers may be misinterpreted or reflect poorly on their practice.

- A small percentage of physicians worry that a CIN may eventually exclude them from the network, restraining their ability to practice.

Physicians who participate in a CIN quickly learn that data transparency is an important part of clinical integration, says Greeter. With outcomes and expense data in hand, participating physicians may question their colleagues about the clinical effectiveness and cost-effectiveness of their practice. "We have seen some tough conversations because of that," she says.

The prospect of contracting collectively with payers can help some physicians overcome their reservations about joining forces with others in a CIN, she says. But an even greater enticement is the possibility of participating in something that can lead to better care for patients. "You truly do have the ability to make a difference in the quality of care provided," says Greeter.

Data-sharing

Expectations for CINs to lead to improved quality and reduced costs are high. But it's unlikely these organizations can meet those expectations without a solid IT infrastructure.

"Process improvement is driven by data," says Schweitzer. "A common electronic medical record is helpful, but not a requirement. More important is the sharing of meaningful and timely information about the patient. Further, a robust reporting system to support the clinical and operational performance metrics to drive improvement is essential. Usually, much time and money is spent on the IT infrastructure to create this health information exchange. Hospitals and health systems can be indispensable partners in this initiative."

Organizers may face a quandary, however: Physician groups considering joining the CIN may

be reluctant to toss out the EMR in which they have invested a couple of hundred thousand dollars and months of training, says Anthony. "There's strong loyalty in each medical group or hospital to their existing IT platform."

One way CINs address the issue is by acquiring or building a data registry or warehouse, in which all the participating groups can load their performance data. These registries can categorize information, which users can manipulate to generate the reports that they – and their payers – are seeking. Over time, as the licenses for each of the original groups expires, they can move to a common platform.

Will payers bite?

Payers are showing interest in CINs, according to experts.

"The conversation around CIN development has actively engaged payers and payees in robust discussions," says Greeter. Payers are attracted to CINs that can build a solid business case – backed by data – around improved quality and cost efficiency.

Some payers are just beginning to put their toes into the ACO and CIN waters, says Anthony. But others, such as Aetna, are much more advanced. "They are moving very quickly into these new payment structures, and moving away from traditional fee-for-service arrangements," he says.

Says Schweitzer, "The success of a CIN in obtaining payer contracts will depend on each payer's willingness to negotiate for improved quality through financial incentives for physicians and the physicians' ability to achieve improved quality and efficiency…. Likely goals for better quality and reduced costs will include efforts designed to facilitate and improve chronic disease management, care episode management (for a bundled payment), communication among primary care physicians and specialists, and communitywide care coordination." **JHC**

Physician mistrust: CIN's biggest hurdle

Forget about all the costly capital investments, governance hassles, payer negotiations, etc. Rather, the biggest hurdle facing the young clinically integrated network may very well be the physicians themselves.

"Someone said that independent physicians are the last American cowboys," says Thomas D. Anthony, attorney at law, Frost Brown Todd LLC, Cincinnati, Ohio. When it involves matters of medical judgment or technique, they can communicate with colleagues with trust and openness. But when it comes to money and business relationships? "They often have a suspicion or lack of trust for their fellow practitioners," he says.

"When we put these together, we spend a lot of time on process," says Anthony. "The first several meetings are really about getting to know one another, and developing trust and relationships." When they started their medical practices, few physicians have ever felt the need to do that, and fewer actually relish the thought.

"But this is a new ballgame," he says. ACOs and CINs are a new way of approaching the delivery of healthcare. Working as a group is a way to maximize opportunities. "It's not easy for them," he says. "But they are getting there."

Physicians Group Up

Hospital systems aren't the only ones consolidating

Rabidly independent. That's how some would describe the typical physician. True, many doctors have agreed to sell their practices to the neighboring hospital system or IDN. Yet others are following a different track. They are joining forces with other practices to form large integrated physician groups. Some call them "supergroups."

Consolidation is definitely heating up, says Denise Wittmer, director of physician practice integration, Joseph P. Melvin Co., Philadelphia, which facilitates and guides the integration of physician practices throughout the country. "Many see it as a way to maintain some stability in their world," she says. They fear losing their autonomy if they were to be acquired by a hospital system, whereas, in a practice – even in a large one – they can maintain their independence and make the same day-to-day decisions they always have.

Most physicians would prefer to avoid being employed by a hospital, fearing a loss of independence and the ability to run their practice, says Penny Noyes, CEO and founder of Health Business Navigators, Bowling Green Ky., whose mission is to assist medical practices in sustaining independence and achieving an improved bottom line through payer contracting and credentialing solutions. "Most doctors want to feel they make a difference, and it may be harder to find that satisfaction in a hospital-owned practice."

Discussions about merging with other practices aren't new, she continues. But today, physicians are moving beyond the "interested" stage and are actively exploring their options, and the requirements and consequences of exercising those options.

"In my experience, physicians are ferociously independent," says Bill Pickart, CEO, Integrated Medical Partners LLC, and Integrated Radiology Partners LLC, Milwaukee, Wisc. "When they allow their practices to be acquired by the hospital, it's an indication they didn't envision any other viable option to remain independent."

"It needs to go beyond financial integration. They must clinically integrate."

– Penny Noyes

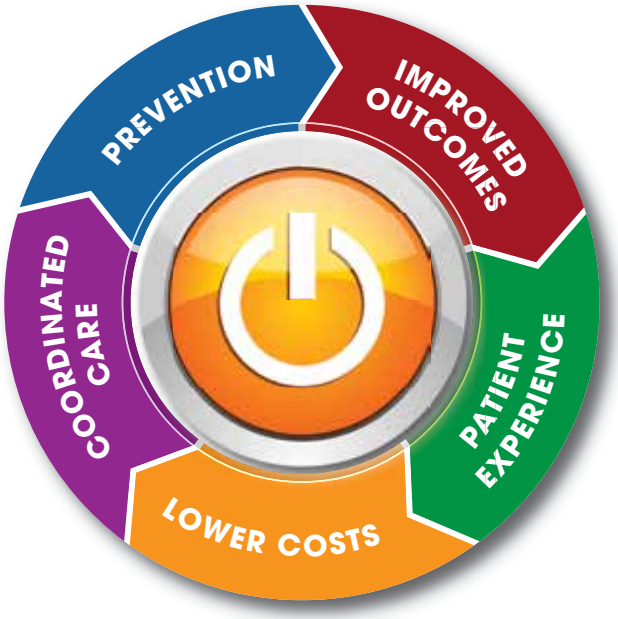
Doctors in group practices want their practices to survive and thrive for the long run, he says. To do so, they need to generate more – and more comprehensive – data about patient outcomes. "The model we are promoting in the marketplace allows them to maintain independence, but also provide analytics and information back to the hospital systems they serve."

Wittmer, Noyes and Pickart spoke about physician practice integration at the 2014 Annual Conference of the Medical Group Management Association.

Cost. Quality. Both?

Rather than using the term "supergroup," Wittmer and her firm believe a more accurate moniker is "physician integrated group." In fact, Joseph P. Melvin works with integrated groups of many sizes – from 20 or 25 doctors, up

SEKISUI DIAGNOSTICS



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to 150. "The size really depends on the market, the specialty and their goals," says Wittmer.

Many physician groups join forces to generate new revenue streams and provide services that they might not be able to perform as small, 3-to-5-doctor practices, continues Wittmer. A large, integrated urology group, for example, might build a radiation therapy center for prostate cancer. It can also increase efficiencies and eliminate redundancies in its operations, including locations.

Information systems are key, she adds. Small practices can face difficulties affording good systems to measure quality. But large groups can share the cost of electronic systems to set up quality measures and then measure performance against them. "Ultimately, [integrated physician groups] can make themselves more appealing to large insurance companies, who are also trying to figure out how to measure quality among physicians," she says.

"Most doctors want to feel they make a difference, and it may be harder to find that satisfaction in a hospital-owned practice."
– Penny Noyes

Traditionally, physician groups have come together to seek financial leverage, says Pickart. They have sought to use their increased size to obtain discounts for products, equipment and services, as well as to improve their bargaining position with payers. "But what we believe will become more important – and one of the key drivers to the formation of the supergroups we facilitate today – is banding together to provide information on the clinical studies, outcome studies, and the research around them."

"It needs to go beyond financial integration," says Noyes. "They must clinically integrate.

"Most [consolidated groups] are still too new to prove their effectiveness, and payers are not as ready as they perhaps should be to roll out and test some specialty models beyond the meager metrics related to, 'How many patients of a certain age or sex had 'X' test done," she says. But large groups should be prepared to gather more robust information about prevention and efficiency in their treatment protocols.

Overcoming mistrust

Considering many physicians' fear of losing their autonomy, some consultants are guiding them to a structure that is something short of a full-blown merger. The question, as Pickart stated prior to his MGMA conference is, "How can groups accustomed to operating independently align themselves for sustainability?"

On the one hand, groups have difficulty swallowing the concept of merging with competitors, points out Wittmer. "Once you start talking about a full merger, it scares the heck out of them." On the other hand, they fear the loss of autonomy should they sell their practice to an IDN.

That's why Wittmer and the Melvin staff steer their clients toward an integration model. An LLC allows each of the founding groups to maintain their identity, decision-making authority, billing systems, etc. "They are still running their own businesses. The model provides an initial step that enables members to collaborate and eventually move to a full merger."

Says Noyes, "Most times, physicians have run their businesses for a very long time, doing things their way." For them, consolidation amounts to nothing less

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EMR: A must-have for integrated groups

Healthcare providers are looking at the prospect of getting reimbursed for their services based on the quality of the care they provide, not the quantity. Generating quality data calls for automated systems as well as people who can analyze it. That's why the electronic medical record is "one of the foundational elements" of the integrated groups with whom Integrated Medical Partners works, says CEO Bill Pickart.

"We are on the very front end of payers structuring reimbursement programs that pay based on outcomes," he says. That gives practices some time to build their information systems and develop the tools to analyze the data they generate.

But systems that provide the predictive and prescriptive patterns the industry is searching for are expensive, he says. So are the people who manage and support them. "It requires a significant amount of scale to make the investment in people and the underlying technology platforms to secure the data and provide the analytics that groups require going forward."

Large integrated groups and, says Pickart, collaborative groups facilitated with the assistance of Integrated Medical Partners, may be the only ones able to generate that kind of scale.

than "letting go of the baby they raised." Practice managers in the consolidated practice may experience difficulty as well. "Most seem to retain their positions but may have a new non-clinical boss to answer to," she says.

But in most cases, physicians in the newly consolidated practice continue to work in their current physical locations. Doing so is convenient for them and for their patients. That said, they may consolidate specialty testing and procedures requiring costly equipment. Additionally, they may seek savings by using a single practice management system and revenue cycle management process.

"Banding groups together is difficult, because there is the necessity to merge cultures," says Pickart. The new group may bring together practices that have been competing with each other for years. Yet participating members are told that transparency and trust is important to the success of the new entity.

To overcome some of the barriers caused by mistrust and fear, Integrated Medical Partners advocates a structure that allows groups of physicians to band together and collaborate without forcing them to deal with culture and valuation issues, says Pickart. "We have developed a legal structure and supporting analytic capabilities that underpin the formation [of a large group], yet sidestep some of these very difficult matters." Participating groups can continue to bill under their individual tax IDs. This gives them time to build trust and transparency, so that in the future, if they want to form a practice under a single tax ID, they can. "Our model promotes the highest degree of sustained clinical, financial and operational independence by allowing physicians to come together, take advantage of scale, pool outcomes data, and provide sophisticated patient outcome results for the betterment of care." **JHC**

By Dan Nielsen

Your Leadership in 2015

Prepare yourself for an unprecedented year. This year will be filled with almost unbelievable technological and other rapid, dramatic change in every industry and every organization in the world, including every healthcare organization.

2015 will bring incredible opportunities for personal, professional, and organizational success. The new year will also bring many difficult personal, professional, and organizational challenges in every organization and in every area of our economy and society.

But at least one thing will not change but will remain an absolute reality. That reality is that "leadership excellence is the ultimate strategy for success!"

Bottom line, leadership excellence really is the ultimate strategy for success. In every organization throughout the entire world, leadership excellence results in great success. Lack of leadership excellence results in not achieving full potential and maximum success. Poor leadership always results in poor performance and poor results.

2015 will bring incredible opportunities to excellent leaders who engage, inspire, and empower those they lead. That is why I am well into writing a book that will be published mid-2015 titled Be An Inspirational Leader: Engage, Inspire, Empower.

For those of us with big dreams, big goals, and a sincere desire to make a difference and leave a positive legacy, 2015 provides a clean slate and limitless opportunity. Achieve your big dreams, big goals, and your sincere desire to make a difference and leave a positive legacy. Pursue leadership excellence. Be an inspirational leader, and engage, inspire, and empower! **FI**


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Worth Watching

Headlines and trends in healthcare

The following are some of the leading stories the Major Accounts Exchange (MAX) monitored in recent months, and worth paying attention to in early 2015.

CMS releases proposed rule changes for MSSP ACOs

CMS (Baltimore, MD) issued a proposed rule designed to improve its Medicare Shared Savings Program. Among the changes are a proposed longer lead transition time for participating ACOs to transition from a no-risk to a shared-risk model and a Track 3 option that would incorporate aspects of the Pioneer ACO program, such as higher rates of shared savings and a defined list of beneficiaries for each performance year. Other proposals include changing the way beneficiaries are assigned to ACOs by paying more attention to primary care services and allowing some specialist providers to participate in multiple ACOs and redefining the methodology for ACO benchmarks to better reflect its local market rather than its past performance alone. The rule has a 60-day comment period.

Jefferson University System, Abington Health announce merger agreement

Jefferson University System (formerly Jefferson Health System) (Radnor, PA), Thomas Jefferson University, and Abington Health (Abington, PA) signed a letter of intent to merge. The deal would create the largest healthcare provider in the region, with five hospitals and more than 13,000 employees. Stephen Klasko MD, Jefferson's president and CEO, is expected to serve as president and CEO of the combined organization. Under the shared governance model, Jefferson and Abington will each appoint an equal numbers of members to a combined board, which will also have a few independent trustees. The health systems expect to execute a definitive agreement in 120 days, and the deal will close sometime in 2015.

FDA begins requirement for medical device manufacturers/health facilities to use electronic tracking

In September 2014, the US Food and Drug Administration (FDA) (Silver Spring, MD) began the long-awaited move requiring electronically readable unique medical-device labels for high-risk devices. Broader use will take up to seven more years. In the past, medical-device manufacturers said it didn't make sense to mark their products with unique identification numbers since hospitals and other healthcare providers are not required to use the system, but that's no longer the case. The FDA now requires reports on adverse events leading to a patient death, and high-risk medical devices (such as implants) must include a unique device identifier (UDI) if the safety failure occurs at specified facilities such as hospitals, ambulatory surgery centers, or nursing homes. Those medical facilities are required by law to report cases of patient deaths related to a device to the FDA and now are required to report the UDI as well. Manufacturers also must notify the FDA.

Sutter Health announces restructuring

Sutter Health (Sacramento, CA) will undergo a major restructuring in 2015, consolidating its five-region model into two divisions: Bay Area and Valley. A Sutter

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[1]Hayden, M. K., et. al. . A Randomized Cross-Over Clinical Trial to Compare 3.15% Chlorhexidine/70% Isopropyl Alcohol (CHG) vs 70% Isopropyl Alcohol Alone (Alcohol) and 5s vs 15s Scrub for Routine Disinfection of Needleless Connectors (NCs) on Central Venous Catheters (CVCs) in an Adult Medical Intensive Care Unit (ICU), Oral Abstract Presented at 2014 ID Week Conference, October 11, 2014, Philadelphia, PA.

[2]2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections, Healthcare Infection Control Practices Advisory Committee, US Centers for Disease Control and Prevention, 2011.

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Health official said the change came, in part, due to the response Sutter received when it asked thousands of company managers for input on how to improve the health system and prepare it for the changing healthcare environment. Sutter also created several new positions, including SVP for patient experience and SVP for medical and market networks, a role that focuses on the system's health insurance products and health management services. Stephen Lockhart, currently CMO for Sutter Health's East Bay Region, will become system CMO. The restructuring will also create a new office of innovation to develop new care delivery models.

CMS launches new ACO initiative for rural, underserved areas

CMS (Baltimore, MD) announced a new ACO initiative that is designed to encourage new ACOs to form in rural and underserved areas, and for current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. The initiative is called the ACO Investment Model, and will build on the experience with the Advance Payment Model. CMS will provide up to $114 million in upfront investments to up to 75 ACOs across the country. The model is in response to stakeholder concerns and some research which suggests some providers lack adequate access to the capital needed to invest in infrastructure necessary to successfully implement population care management. Participation in the ACO Innovation Model will be limited to the following groups:

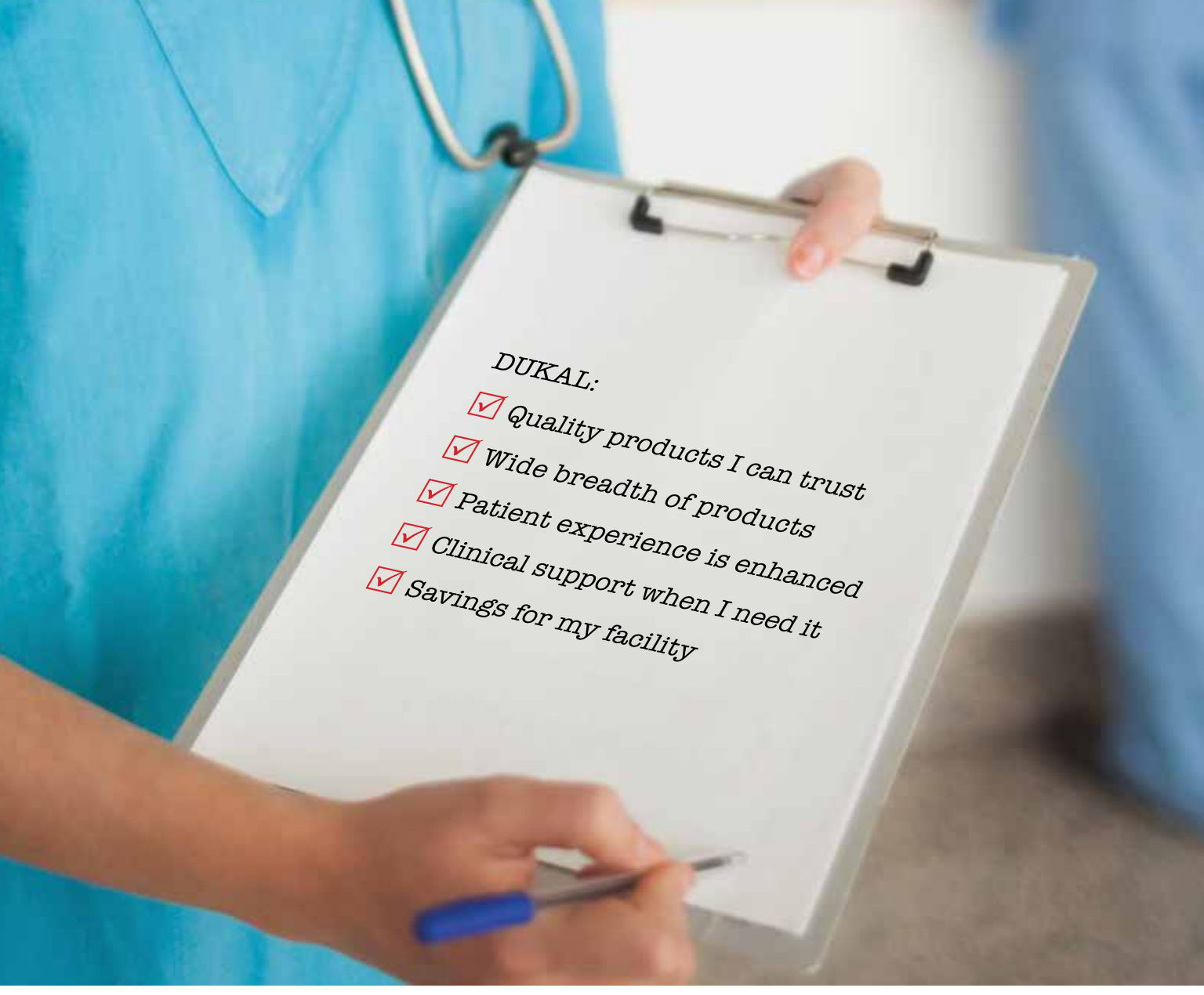
New Shared Savings Program ACOs joining in 2016: The ACO Investment Model seeks to encourage uptake of coordinated, accountable care in rural geographies and areas where there has been little ACO activity, by offering pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments.

ACOs that joined Shared Savings Program starting in 2012, 2013, and 2014: The ACO Investment Model will help ACOs succeed in the shared savings program and encourage progression to higher levels of financial risk, ultimately improving care for beneficiaries and generating Medicare savings.

The application deadline for organizations that started in the Shared Savings Program in 2012 or 2013 was December 1, 2014. Applications will be available in summer 2015 for ACOs that started in the Shared Savings Program in 2014 or will start in 2016.

Advocate Health Care, NorthShore University HS plan merger

In September, Advocate Health Care (Downers Grove, IL) and NorthShore University HealthSystem (Evanston, IL) announced plans to merge and form a new integrated system to be called Advocate NorthShore Health Partners. The new system will be the largest in Illinois and 11th largest in the country, serving over 3 million patients each year. Advocate Health Care CEO James Skogsbergh and NorthShore CEO Mark Neaman will jointly lead the organization. The new system should officially launch in early 2015 after regulatory approvals. **FI**



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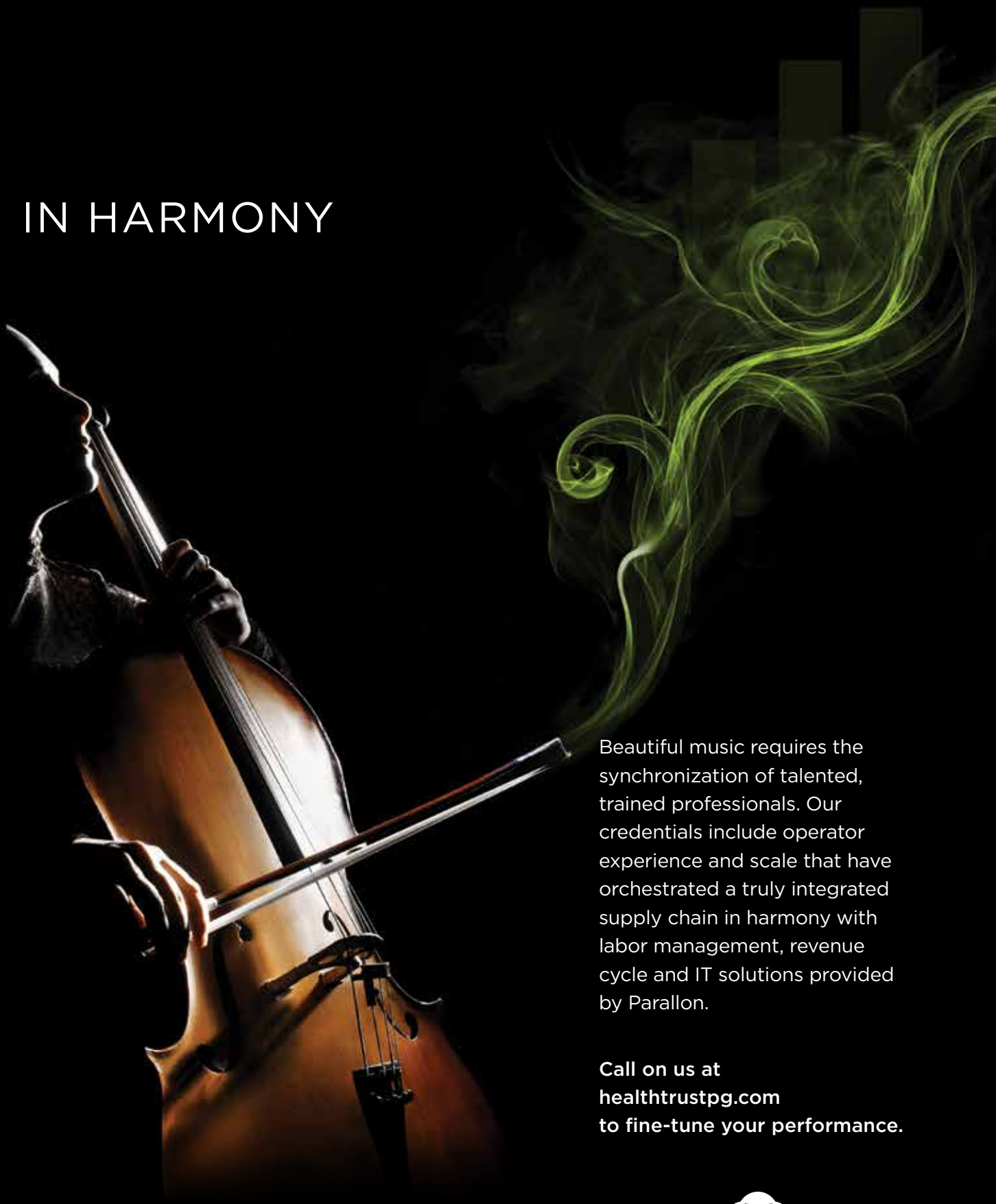

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