The Accountable Physician Enterprise

Partnering with Physicians to Transform Care Delivery

Presentation to Mid-Atlantic Physician Recruiter Alliance

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March 3, 2011

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HEALTH CARE ADVISORY BOARD

Road Map for Discussion

Physicians at the Precipice

Dual Pressures of Economy and Reform Creating Sense of Instability

Twin Challenges for Physicians

Faltering Practice Economics

- Volume decline
- Ancillary reimbursement cuts
- Professional fee cuts
- Rise in practice costs

Uncertainty Around Health Care Reform

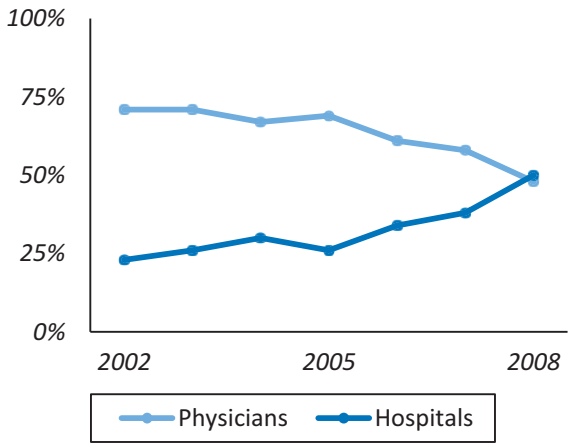
- Change in incentives
- Emphasis on value of care
- Increased payment risk
- Demand destruction

Source: Health Care Advisory Board interviews and analysis.

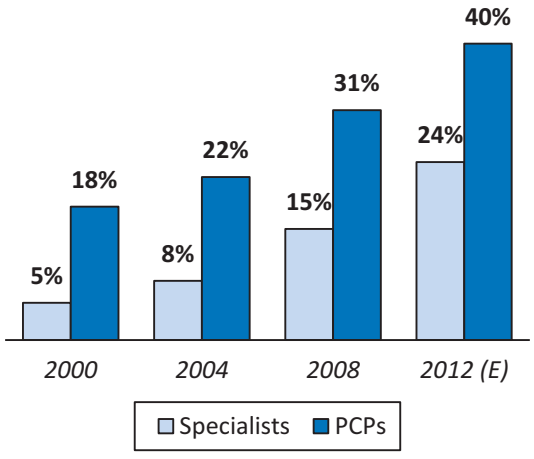
Turning to Hospitals for Shelter

Majority of Physician Practices Now Owned by Hospitals

Physician Practice Ownership
2002 - 2008



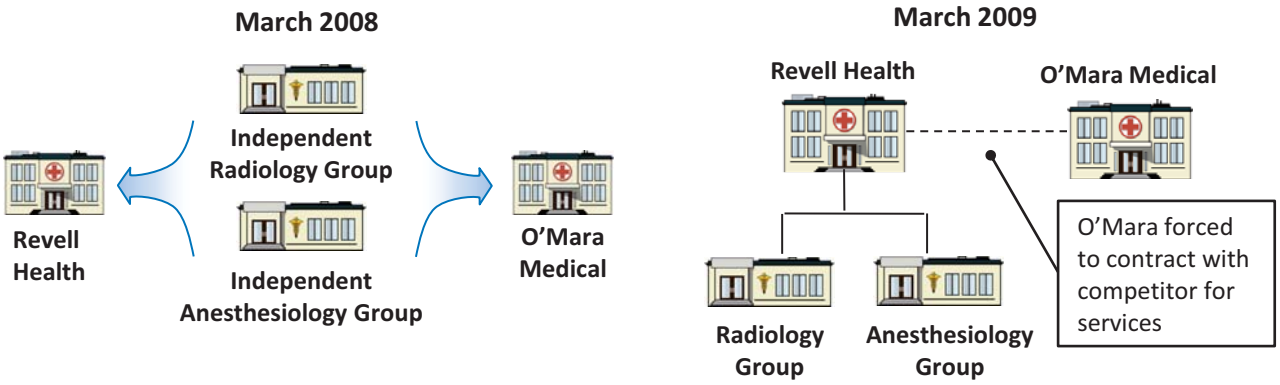
Percentage of "Active" Physicians Employed by Hospital



Source: Harris G, "More Doctors Giving Up Private Practices," *New York Times*, March 25, 2010; Health Care Advisory Board 2008 Survey on Physician Employment; Health Care Advisory Board interviews and analysis.

Playing a Zero-Sum Game

Delaying Too Long Means Losing Out Entirely



Case in Brief: Revell Health[1] and O'Mara Medical[1]

- Medium-sized, competing health systems in the Midwest
- Revell recently acquired large, independent radiology and anesthesiology groups, the only providers of those services in the market
- O'Mara forced to contract with Revell for radiology, anesthesiology services needed at its main facility

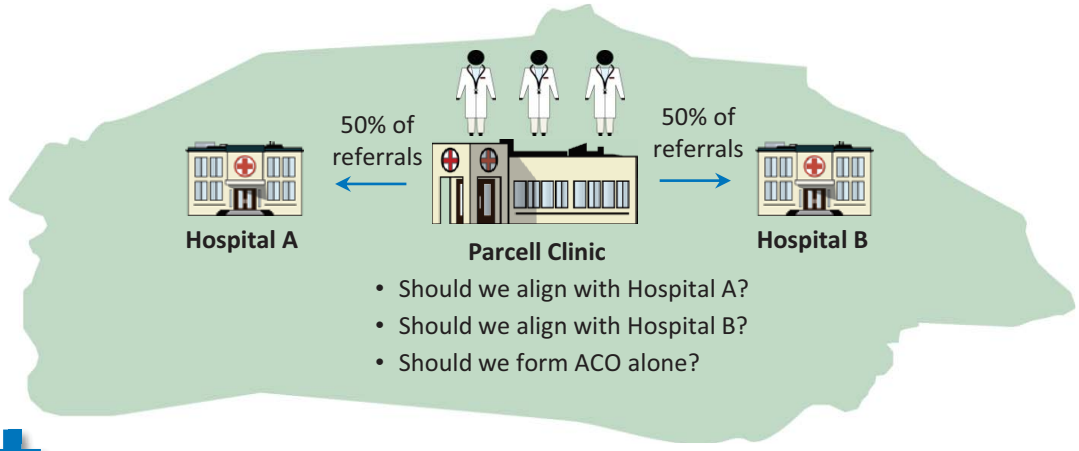
1 Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Physicians Willing to Go It Alone?

Independent Groups Leveraging Dominance

Physicians at the Center of the ACO?



- Should we align with Hospital A?
- Should we align with Hospital B?
- Should we form ACO alone?

Case in Brief: Parcell Clinic[1]

- 350-physician, multispecialty practice in the Southwest
- Practice referrals split 50/50 between two main competitor hospitals; referrals represent 80% of all inpatient admissions in market
- Senior executives in series of high-level talks with both hospitals about acquisition, but clinic considering remaining independent, forming ACO without hospital involvement

1 Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Reform Bill Allows Physicians to Take Lead

Definition of ACO Allows Physician Participation Without Hospital

The Patient Protection and Affordable Care Act

H.R. 3590

One Hundred Eleventh Congress of the United States of America

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled

The following groups of providers are eligible to participate as an ACO:

- Physicians and other health practitioners in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or JVs between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Others as determined by Secretary

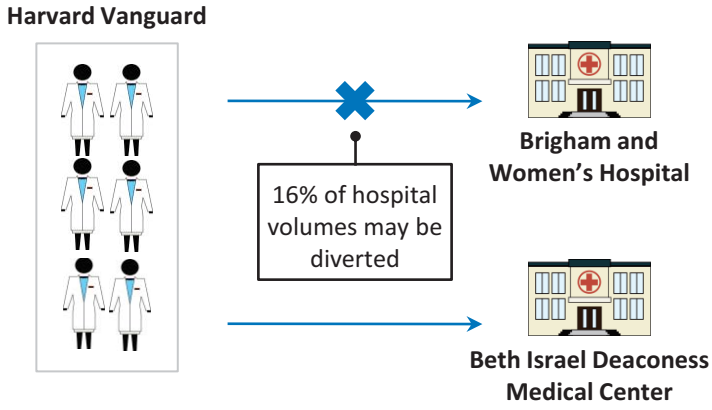
Source: US House of Representatives, "Amendment in the Nature of a Substitute to H.R. 4872, as Reported," March 18, 2010; US Senate, The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act," December 24, 2009; Health Care Advisory Board interviews and analysis.

Can We Afford to Lose?

Steering Away From High Cost Providers…

Physician Groups Inflecting Price Pressures on Hospitals

Physician Referral Pattern



Case in Brief: Harvard Vanguard Medical Associates

- Largest physician group in Massachusetts, part of Atrius Health
- Decided to make fewer referrals to Brigham and Women's Hospital, instead referring to Beth Israel Deaconess Medical Center citing reduced costs and improved care coordination
- Group accounts for 16% of Brigham and Women's medical and surgical volumes

Source: Gavin R, "Brigham and Women's Trims Costs: Hospital Aims to Cut $35M in Front of New Regulations," *Boston Globe*, April 24, 2010; Kowalczyk L, "Doctors Group to Focus on One Hospital: Harvard Vanguard Cites Improved Care," Boston Globe, Feb. 25, 2010; Health Care Advisory Board interviews and analysis.

…and Destroying Our Demand

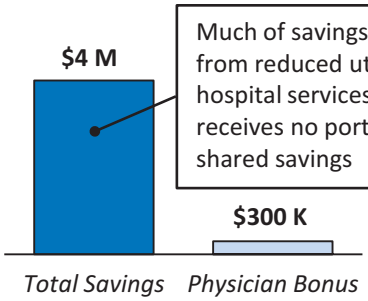
Physicians Have Potential to Reduce Demand, Pocket the Savings

Physician-Only ACO

Botwin Medical Group[1] IPA[2]

Local Hospital

Impact of IPA-ACO



Case in Brief: Botwin Medical Group[1]

- Clinically integrated, multi-specialty IPA located in the South
- Formed physician-only ACO to provide health services to local employer, including local hospital's self-funded employee health benefit plan
- Paid per member, per month fee, fee-for-service, bonuses for quality
- Saved employer $4 million from reduced care utilization

1 Pseudonym.
2 Independent Practice Association.

Source: Health Care Advisory Board interviews and analysis.

The Future We Cannot Afford

Physician Alignment More Essential Now Than Ever

Key Threats to Effective Physician Partnerships

The Risk of Underperformance

- Selecting the wrong physician partners
- Under-leveraging financial incentives
- Under-investing in performance improvement infrastructure

The Risk of Marginalization

- Mistiming response to market cues
- Failing to emerge as prime physician aggregator
- Allowing physicians and competitors to coalesce into independent ACOs

Source: Health Care Advisory Board interviews and analysis.

The Accountable Physician Enterprise

Partnering with Physicians to Transform Care Delivery

I

Creating a Culture of Value-Based Partnership

Selecting Premium Physician Partners

1. Identify physicians with shared strategic vision
2. Ensure cultural compatibility in all partnership decisions

Engaging Physicians in Governance and Leadership

3. Empower dynamic physician leaders with tools to succeed
4. Enfranchise frontline physicians in leadership and governance
5. Unite with physicians around shared culture and responsibilities
6. Formalize shared control in governance and management

II

Ushering Physicians into the Performance-Based Market

Extending Resources for High Performance

7. Support PCP transition to team-based care
8. Lay the groundwork for data exchange

Crafting Strategy-Aligned Physician Incentives

9. Introduce independent physicians to performance-based incentives
10. Revamp compensation to target accountable care objectives

Investing in Performance Management

11. Deploy principled referral management infrastructure
12. Invest in robust performance management systems

III

Organizing for Shared Accountability

Building Next-Generation Physician Relationship Platforms

13. Develop strategy-aligned contracts with "ACO Partners"
14. Design joint contracting-capable model with "ACO Principals"
15. Deploy common performance-focused infrastructure across alignment platforms

Source: Health Care Advisory Board interviews and analysis.

Road Map for Discussion

I Land Grab for Leverage

II Building the Accountable Physician Enterprise

III Enterprise at a Crossroads

Building the Accountable Physician Enterprise

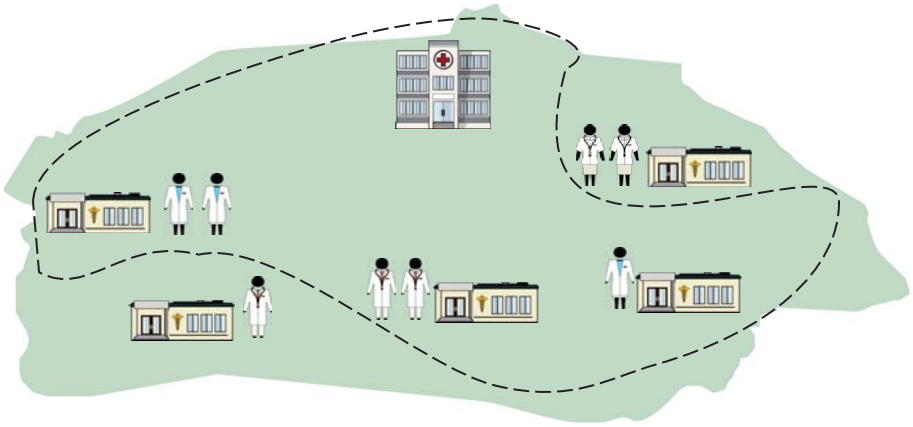
Creating a Culture of Value-Based Partnership

Selecting Premium Physician Partners

Identifying Strategic Physician Partners

New Partnerships Create Opportunities for Selectivity

High-Performing Physician Network



Separating the Wheat from the Chaff

"We're going to have an abundance of physicians in certain areas, and there will be some losers. The ones who are willing to be more efficient, most cost-effective, and work closely with the groups in the ACO will be the winners."

Chief Executive Officer
Large Physician IPA[1]

1 Independent practice association.

Source: Health Care Advisory Board interviews and analysis.

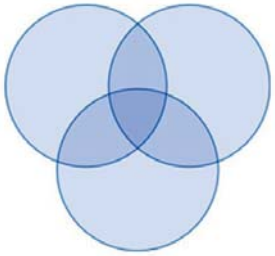
Defining Desirable Partners

Accountable Care Placing a Premium on Compatibility

Attributes of Ideal Physician Partners

Strategically Important

- Expands primary care access
- Brings needed specialty service to community
- Increases capacity to match community demand



High-Performing

- Provides high-quality, low-cost patient care
- Standardizes devices, clinical protocols
- Works collaboratively to manage chronic disease

Culturally Compatible

- Collaborates with hospital, other physicians
- Willing to address strategic priorities
- Shares organizational vision

Source: Health Care Advisory Board interviews and analysis.

Lesson #2: Ensure Cultural Compatibility in All Partnership Decisions

Building a Selective Physician Network

Rigorous Evaluation Excludes Undesirable Candidates

Is the physician we are considering…

Critical?

Does this physician fill a strategic need for the health system?

Capable?

Does this physician have a track record of providing high-quality, high-value care?

Compatible?

Will this physician fit well within our organization's culture and be a collaborative partner moving forward?

Case in Brief: NorthShore University HealthSystem Medical Group

- 670-physician medical group within NorthShore University HealthSystem, a four-hospital health system based in Evanston, Illinois
- Created three-step candidate screening process to identify ideal physicians for employment
- Process evaluates strategic importance, performance quality, and cultural fit of each physician

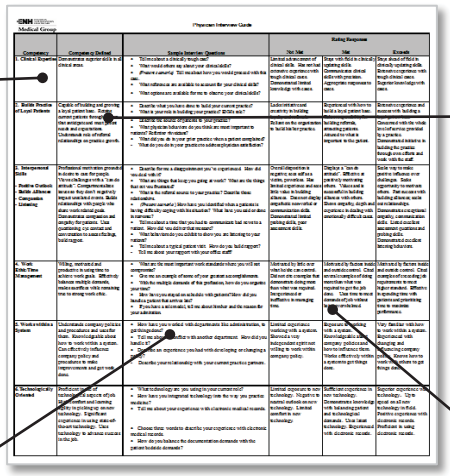
Source: Health Care Advisory Board interviews and analysis.

Focus on Physician Compatibility

Behavioral Interview Guide Standardizes Evaluation

Physician Interview Guide

Physician evaluated on six categories, including:
- Clinical expertise
- Ability to build loyal patient base
- Interpersonal skills
- Work ethic/time management
- Ability to work within a system
- Technological competence



Competencies clearly defined to ensure understanding of evaluation criteria among interviewers

Sample questions provided, as well as insight on interpreting answers, to aid infrequent interviewers in assessing the candidate

Physician responses evaluated on scale of having "Not Met," "Met," or "Exceeded" organizational standards and expectations

Source: Health Care Advisory Board interviews and analysis.

Ensuring Fit Drives Long-Term Stability

Preempting Problematic Relationships

Candidate Evaluation Form

Name: Dr. Maulik Pancholy[1]
Specialty: Gastroenterology

☑ **Strategic Importance**

Meets an important community need and will be a valuable source of referrals

☑ **Performance Record**

Maintains strong reputation and historically high performance on quality metrics

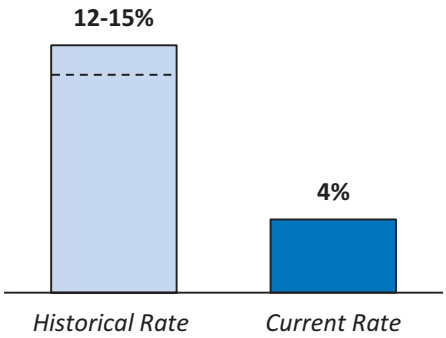
☒ **Cultural Compatibility**

Exhibits self-centered attitude, unreasonable expectations, and lack of willingness to work collaboratively

Hired **Not Hired**

Employed Physician Annual Turnover Rate

NorthShore University HealthSystem Medical Group



1 Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

Elevating Physicians in System Governance

Ample Physician Leadership Opportunities Across Enterprise

NEA Baptist Healthcare System Board

Corporate: 33%
Community: 33%

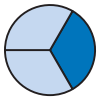
Physician: 33%

NEA Baptist Clinic Board

Physician: 100%

NEA Baptist Memorial Hospital Board

Corporate: 33%
Community: 33%



Physician: 33%

Case in Brief: NEA Baptist Healthcare

- 100-bed hospital merged with 90-physician clinic in Jonesboro, Arkansas, in 2010
- Terms of merger give physicians substantial representation in system governance
- Clinic physicians invited to participate in leadership committees with substantial decision-making autonomy

Source: Health Care Advisory Board interviews and analysis.

Elevating Physicians in System Management

Physician-Led Management Team Oversees Market

NEA Baptist Clinic Dyad

NEA Baptist Memorial Hospital Dyad

NEA Baptist Healthcare System Dyad

System Leadership Group (SLG)

SLG in Brief

- Composed of the three physician-administrator dyads from across the system
- Responsible for steering the hospital and clinic, reports to Baptist's corporate office
- Meets twice each month to discuss operational issues across entire market
- Three dyads are *ex-officio* members of each others' boards, cross-pollinating leadership across all three entities

Source: Health Care Advisory Board interviews and analysis.

Creating a Culture of Value-Based Partnership

Takeaway Lessons for Hospital Executives

Lesson #1: Identify physicians with shared strategic vision

Partner only with physicians willing to collaborate on the delivery of high-quality, low-cost care; work jointly with these physician partners to develop and codify standards of mutual hospital-physician accountability

Lesson #2: Ensure cultural compatibility in all partnership decisions

Design candidate selection processes to ensure that physician partners not only meet strategic and quality objectives, but also fit organizational culture, and can work collaboratively with hospital and physician partners

Lesson #3: Empower dynamic physician leaders with tools to succeed

Cultivate and empower motivated physician leaders who can recruit their peers to drive accountable care initiatives; support them with needed administrative and financial resources

Lesson #4: Enfranchise frontline physicians in leadership and governance

Design leadership roles that allow frontline physicians to develop processes to improve practice performance and care delivery; create an organizational structure that maximizes their impact on practice-level decisions

Lesson #5: Unite with physicians around shared culture and responsibilities

Create a common hospital-physician culture focused on prioritizing patient needs; design all governance, management and incentive structures to reinforce this culture of mutual accountability

Lesson #6: Formalize shared control in governance and management

Maximize hospital-physician integration by sharing control with physician leaders; physicians must actively participate alongside administrators at all levels of health system governance and management

Source: Health Care Advisory Board interviews and analysis.

Building the Accountable Physician Enterprise

Ushering Physicians into the Performance-Based Market

Scoping the Ambition

Rewarding a New Set of Performance Metrics

Transition of Care Delivery

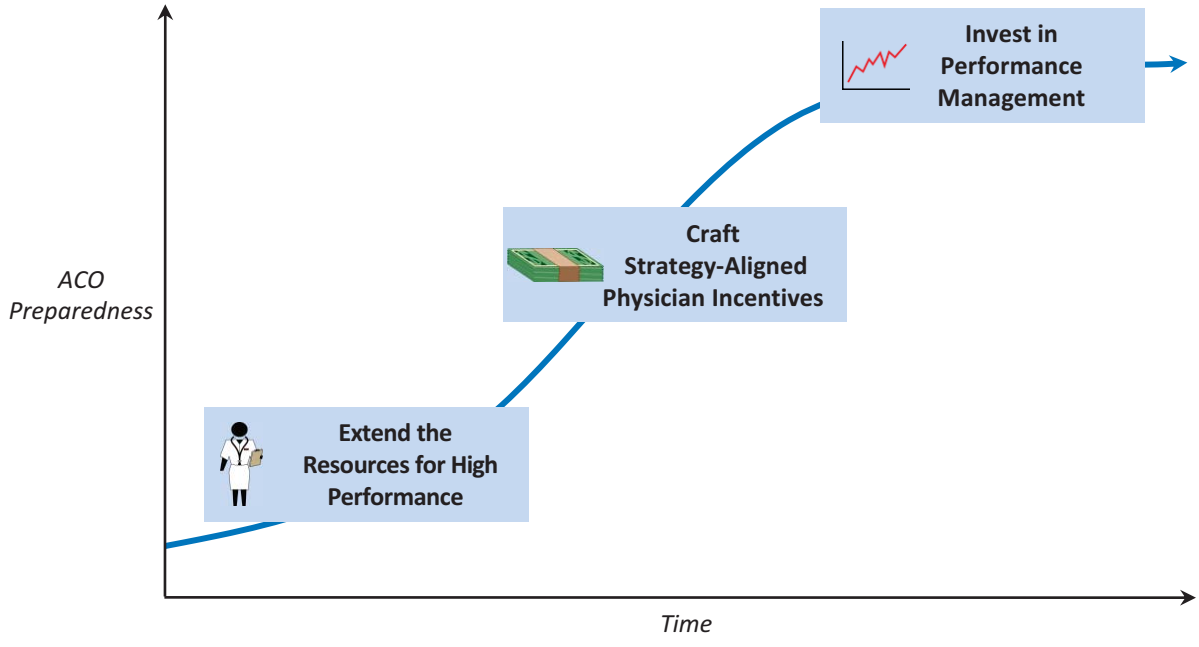
Performance Category	*Fee-for-Service Imperatives*	*Accountable Care Imperatives*
Utilization	Maximize volumes of procedures with strongly positive contribution margins	• Limit inpatient utilization to acute services not capable of being managed outpatient • Minimize inappropriate or duplicative care delivery • Triage both acute and chronic care services to low-cost sites of care
Clinical Outcomes	Adhere to limited P4P initiatives; minimize hospital-acquired conditions and eliminate never events	• Minimize preventable readmissions via integration with PCPs, post-acute care providers • Proactively manage chronic illness to prevent low-margin inpatient utilization • Promote community wellness for all at-risk populations
Expense Management	Control expenses associated with DRGs or case rates	• Standardize care pathways across care continuum • Streamline acute care episodic costs • Develop economies of scale across continuum for all growth service lines

Source: Health Care Advisory Board interviews and analysis.

Usher Physicians Into Accountable Care

Elements for a Successful Transition

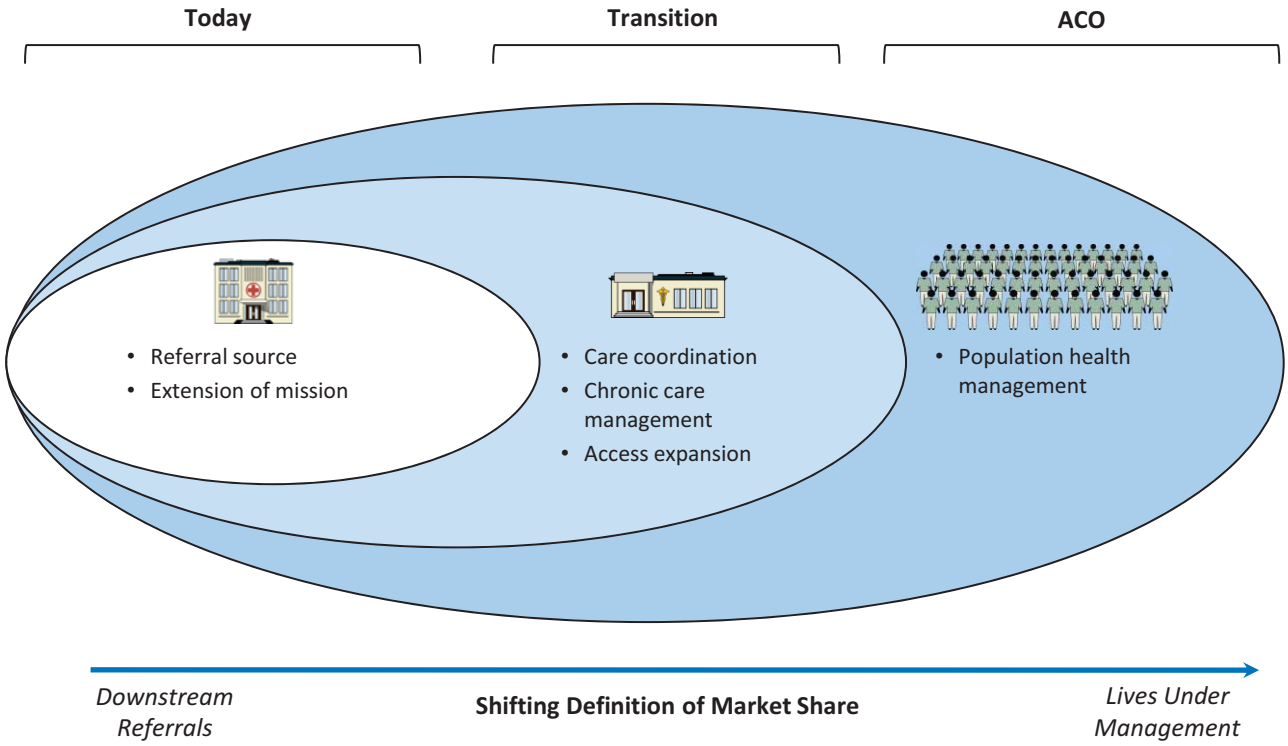
The Path Toward an Accountable Physician Network



Source: Health Care Advisory Board interviews and analysis.

The Expanding Role of Primary Care

Evolution of PCP Strategic Value to the Health System

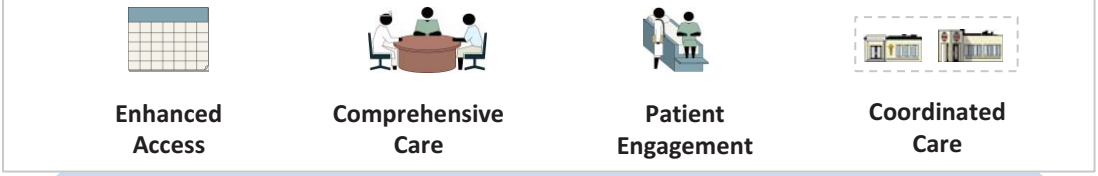


Source: Health Care Advisory Board interviews and analysis.

Medical Home Facilitates Primary Care Enhancement

Practice Transition Results in Tangible Benefits for Hospital

The Medical Home



Team of Providers

Additional non-physician providers support medical home's ability to provide additional services

Disease Registry

Provides patient metric data to track and monitor patients for improved management

Key Benefits to Hospitals

Improved Clinical Quality

- Better chronic disease management, preventive care for patients
- Reduction of "preventable" chronic disease admissions, ED visits

Economic Gain to ACO

- Stronger margins for employed practice from improved productivity
- Increased network referral capture
- Reduced hospital readmissions

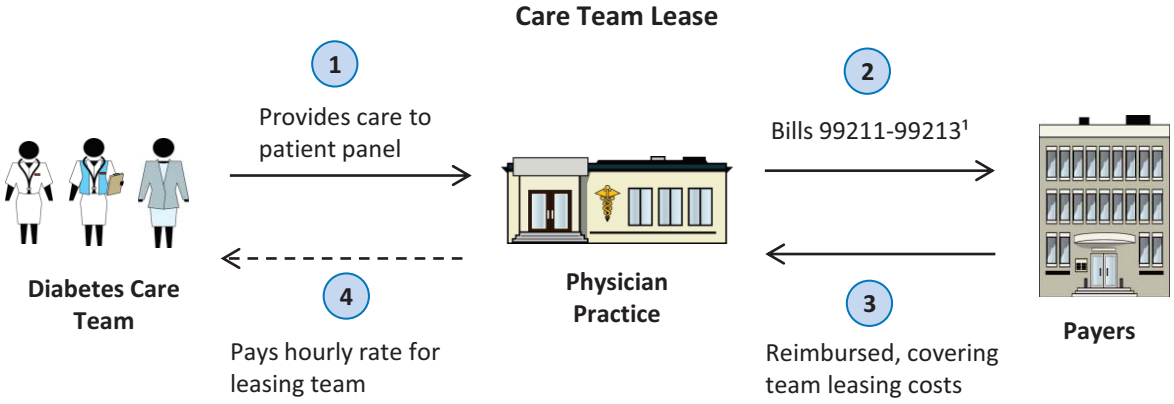
Improved Physician Satisfaction

- Greater retention, easier recruitment
- Less burnout for employed PCPs

Source: Health Care Advisory Board interviews and analysis.

Costs of Care Team Distributed Across Practices

Leasing Diabetes Team Prevents Costly Investment



Case in Brief: Carondelet Health Network

- Four-hospital system based in Tucson, Arizona
- Growing diabetes population prompts comprehensive outpatient diabetes strategy
- System leases diabetes team—RN and registered dietitian who are Certified Diabetes Educators—to practices at an hourly rate
- Team also includes a Diabetes Navigator, a community health outreach worker, covered by grant funding

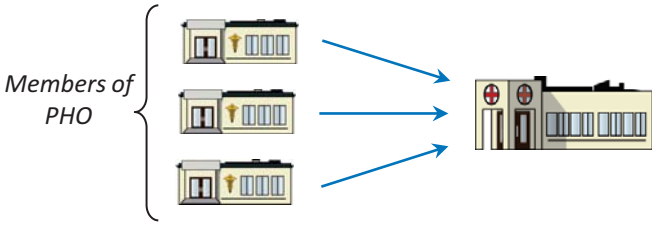
1 Visit coded as 99213 would include physician.

Source: Health Care Advisory Board interviews and analysis.

Centralizing Resources at System Level

Hospital Facilitates Access to Resource Through PHO

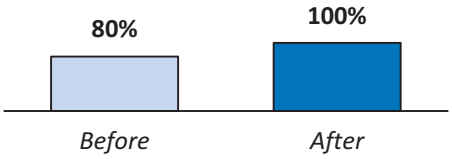
Center for Chronic Care Management



- Physicians refer patients to center
- Center provides intensive education to patient
- Care managers keep referring PCP apprised of patient progress
- Patient graduates from program once self-management achieved

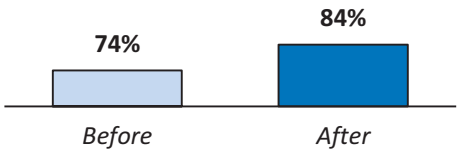
Knowledge of Disease Symptoms

Percentage of CHF Patients



Annual HbA1c Level Test

Percentage of Diabetes Patients



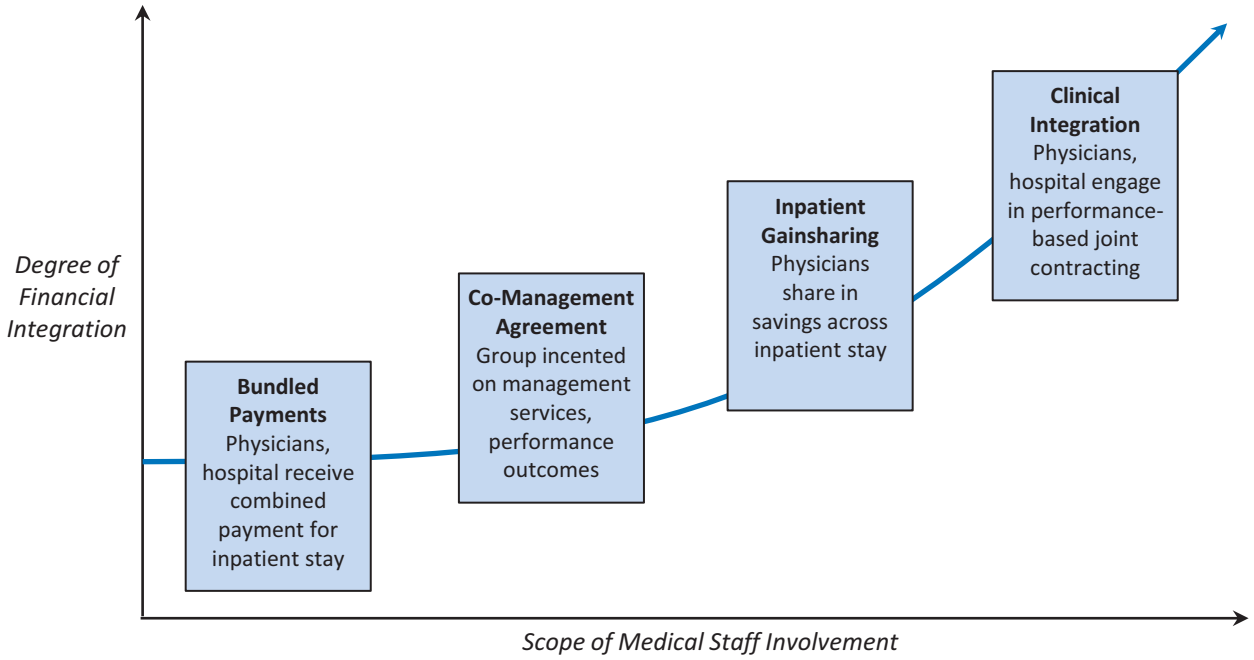
Case in Brief: Middlesex Hospital

- 150-bed hospital in Middletown, Connecticut; Medicare Physician Group Practice Demo participant
- Through physician-hospital organization (PHO), created Center for Chronic Care Management to assist PCPs in managing patients with chronic disease, history of tobacco use
- Created 10 years ago in anticipation of capitation; continued because of improved outcomes

Source: Health Care Advisory Board interviews and analysis.

Transitioning Physicians to a New Compensation World

Range of Possible Incentive Models for Independents



Source: Health Care Advisory Board interviews and analysis.

Enabling Shared Accountability for Inpatient Care

Bundled Payments Put Physicians' Skin in the Game

Limited Connection at Outset

Limited physician visibility into cost and quality performance

No formal hospital-physician relationship structure

General physician distrust of hospital leadership

Medicare Acute Care Episode (ACE) Demonstration

- Pays single bundled price for Medicare Part A, B to participating hospitals to better align provider incentives toward improved quality, lower cost of care for 28 cardiac, 9 orthopedics DRGs
- Participating hospitals selected based on quality, volume, discounted bid for bundle price

Case in Brief: Vanguard Baptist Health System

- Five-hospital health system based in San Antonio, Texas
- Launched cardiac, orthopedic bundling program in 2009 as part of Medicare ACE Demo
- Created a culture of collaboration during phased implementation of demo
- Realized substantial device savings, increased order set compliance, stronger physician alignment around service line growth

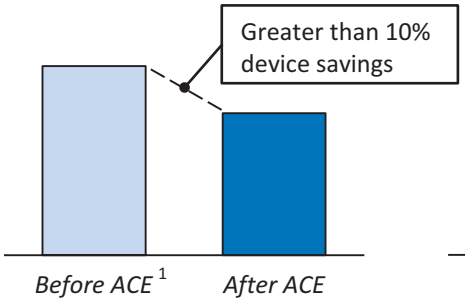
Source: Health Care Advisory Board interviews and analysis.

Capitalizing on Tighter Alignment

Physicians, Hospital Both Benefit From Shared Accountability

Reduced Costs

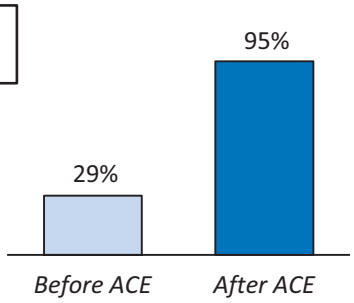
Device Cost Savings



[1]

Improved Clinical Quality

Aggregate Order Set Compliance



Enhanced Relationship

Physician access to performance data

Trust and communication between hospital, physicians

Potential for increased market share

1 Acute Care Episode Demonstration.

Source: Health Care Advisory Board interviews and analysis.

Inadvertently Preventing Care Redesign

Compensation Model Discourages Investment in Practice

PCP Compensation Formula

2009

Work Relative Value Units: _____

X

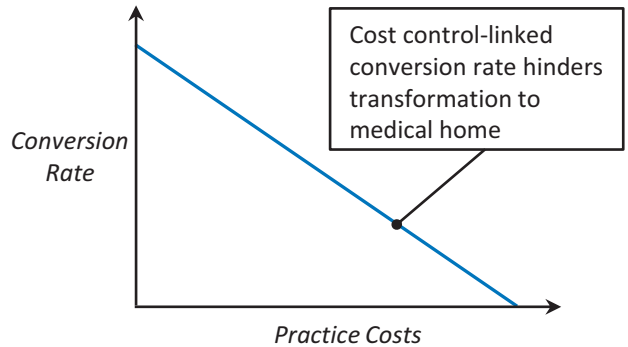
Conversion Rate $: _____

=

Total Compensation: _____

Conversion Rate Calculation

Zeroed In on Practice Cost Control



Case in Brief: Tracy Health System[1]

- 11-hospital system located in the South preparing to create an accountable care organization
- Initial compensation model focused on increasing RVU productivity, controlling costs
- Increased costs of medical home implementation drove down physician compensation
- No commercial payer reimbursement for additional costs of medical home activity, certification
- New model focuses on panel size, mid-level staff efficiency, and PCP performance metrics

1 Pseudonym.

Source: Health Care Advisory Board interviews and analysis.

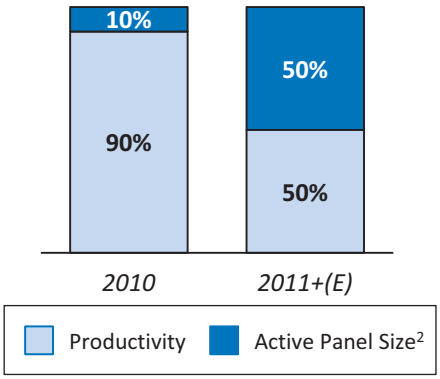
Overhauling Incentive Model to Advance Strategic Goals

New Model Eliminates Conflicting Messages

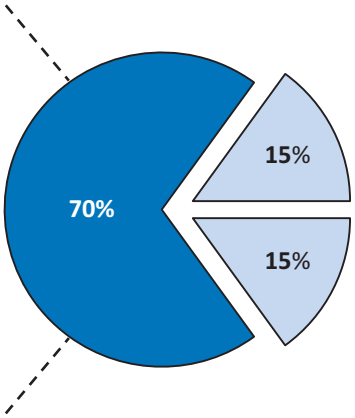
Revised PCP Compensation Model

Base Salary Composition[1]

Doubling Down on Panel Size



2010



Mid-Level Performance

- Incents efficient use of mid-level staff
- Ultimately seek up to 1:1 ratio of mid-levels to PCPs

PCP Scorecard

- Nine performance metrics incent PCPs on clinical performance and efficiency
- $26,000 initial scorecard pool

PCP Scorecard Metrics

Access Target 15%	New Patients 10%	Diabetes Management 15%
Patient Satisfaction 5%	Expense per RVU 10%	Hypertension 15%
Budget Target 10%	RVU Production 10%	Medical Home 10%

1 Fixed compensation rate per RVU and per panel member. 2 Patient contact in last 18 months.

Source: Health Care Advisory Board interviews and analysis.

Ushering Physicians Into the Performance-Based Market

Takeaway Lessons for Hospital Executives

Lesson #7: Support PCP transition to team-based care

Acknowledge the expanding role of primary care in the ACO; given limited levers available to align with PCPs, foster practice transformation by extending resources for team-based care to employed and independent PCPs

Lesson #8: Lay the groundwork for data exchange

Recognize the importance of data exchange in delivery of high-value care across the continuum; foster physician-hospital connectivity through principled ambulatory EMR subsidization

Lesson #9: Introduce independent physicians to performance-based incentives

Design creative opportunities to expose independent physicians to performance-based incentives; leverage all contractual relationships to reinforce the connection between high-value care and financial success

Lesson #10: Revamp compensation to target accountable care objectives

Evolve employed physician compensation to reinforce delivery of high-value, coordinated care; structure compensation to balance physician productivity and emerging accountable care goals

Lesson #11: Deploy principled referral management infrastructure

Recognize the continued importance of referral management in the ACO to ensure delivery of high-quality, low-cost care; leverage data to track referral patterns and empower physician leaders to address shortfalls

Lesson #12: Invest in robust performance management systems

Deploy robust performance management infrastructure across the enterprise; leverage data to identify high-impact performance gaps, and engage underperformers to improve using data transparency and peer reinforcement

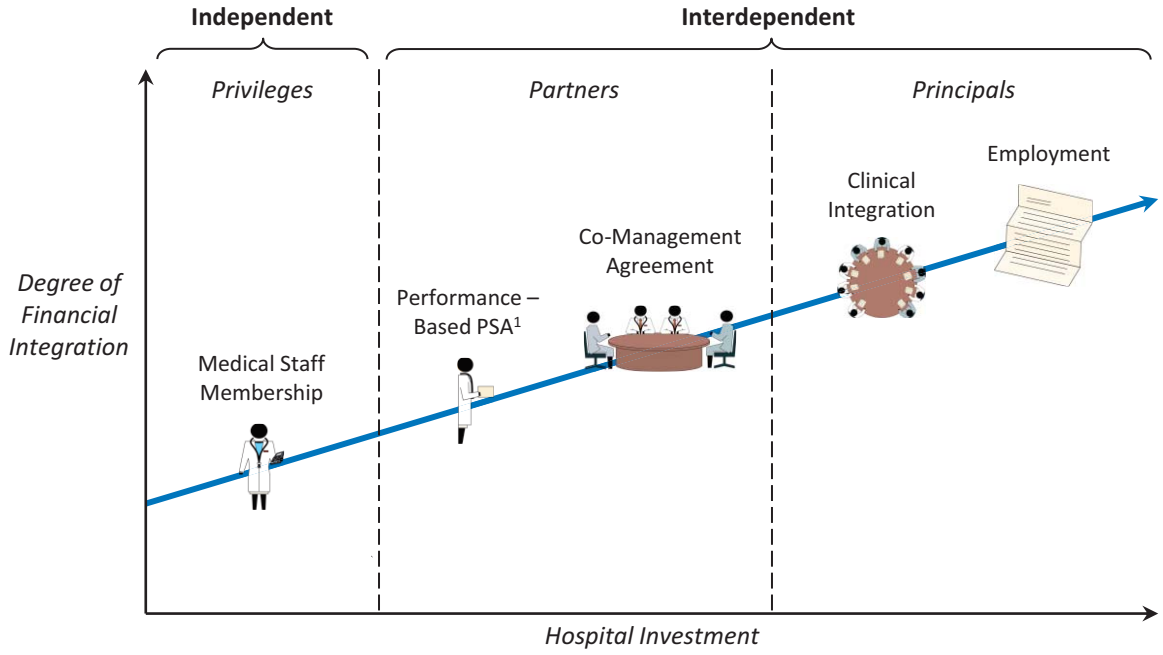
Source: Health Care Advisory Board interviews and analysis.

Building the Accountable Physician Enterprise

Organizing for Shared Accountability

Transitioning from Independent to Interdependent

Hospitals, Physicians Strengthening Formal Relationships



1 Professional services agreement.

Source: Health Care Advisory Board interviews and analysis.

The Emergence of Two Key Enterprises

Segment Physicians According to Role in ACO

The Accountable Physician Enterprise

Community Contractors

Dermatology
Ophthalmology

Hospital-Based Non-Admitting Specialists

Radiology
Anesthesiology
Pathology
ED Physicians

Proceduralists

General Surgery
Cardiac Surgery
Neurosurgery
Orthopedics

Primary Care

Internal Medicine
Pediatrics
Family Medicine
Hospitalists

Community-Based Medical Specialists

Cardiology
Medical Oncology
Endocrinology
OB/GYN

Minimal Relationship

"ACO Peripherals"

Efficient Procedural Enterprise

"ACO Partners"

Effective Care Management Enterprise

"ACO Principals"

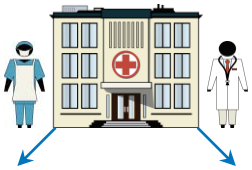
Source: Health Care Advisory Board interviews and analysis.

Building Next-Generation Physician Relationship Platforms

Structure Contracts Based on Physician Responsibilities

Physician Function Key to Selecting Among Contract Models

The Accountable Physician Enterprise



Efficient Procedural Enterprise

- Deliver high-quality, low-cost procedural services
- Develop standing protocols to drive quality, cost control
- Increase reliability of procedures
- Standardize devices to increase vendor negotiating leverage

"ACO Partners"

Effective Care Management Enterprise

- Coordinate care among full range of providers
- Streamline patient handoffs
- Drive robust chronic disease management
- Foster patient education, engagement in care processes

"ACO Principals"

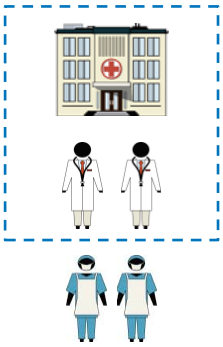
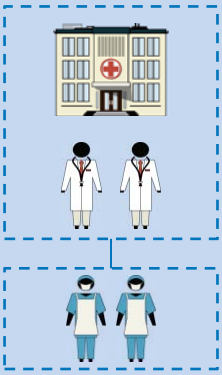
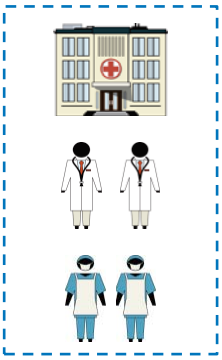
Source: Health Care Advisory Board interviews and analysis.

Three Approaches to Aligning With Proceduralists

Level of Physician Involvement a Flexible Decision

"ACO Partner" Relationship Options

Low — *Degree of Financial Integration* — *High*

Function Independently	Enter Into Separate Performance-Based Contracts	Include in Risk-Bearing Organization
		
Hospital maintains minimal relationships with physicians outside risk-bearing entity	Hospital forms performance-based relationships with physicians outside context of risk-bearing entity	Hospital includes all interested physicians in risk-bearing entity

Source: Health Care Advisory Board interviews and analysis.

In Need of a Hospital-Physician Performance Platform

Current Contracting Models Insufficient

Employed Physicians

Limited Scale

- Represent fraction of medical staff; restrained by hospital resources, physician interest
- Often lack strategy-aligned compensation model, performance improvement infrastructure

Independent Physicians

Limited Levers

- Antitrust, regulatory barriers restrain financial incentives
- Limited data sharing, performance improvement infrastructure
- Collection of stakeholders too diffuse for organized performance achievements

Performance-Focused Integration Platform

Key Characteristics

- Selective, scalable membership
- Commitment to evidence-based, standardized care
- Care coordination infrastructure
- Performance management system
- Legal, meaningful performance-based incentives
- Capable of joint contracting with commercial payers

Source: Health Care Advisory Board interviews and analysis.

Limited to Two Viable Models

HCAB Assessment of Models' Potential Ability to Achieve Key Objectives

Model	Selective Membership	Care Standards	Coordination Infrastructure	Performance Management	Meaningful Incentives	Joint Contracting[1]
Extensive Employment	●	●	●	●	●	●
Clinical Integration	●	●	●	●	◕	●
Co-Management	◕	◕	◔	◑	◕	○
Gainsharing	◔	◕	◑	◕	◑	○
Bundled Payment	◔	◕	◑	◕	◑	◑
PSA[2]	●	◑	◔	◑	◕	○
Joint Venture	◑	◔	◔	◔	◔	○

○ No Ability ◔ Minimal Ability ◑ Moderate Ability ◕ Significant Ability ● Complete Ability

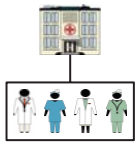
1 For commercial contracts. 2 Professional services agreement.

Source: Health Care Advisory Board interviews and analysis.

Testing Vertical vs. Virtual Integration

Brookings/Dartmouth Pilot Evaluates Both ACO Approaches

Extensive Employment



Carilion Clinic

- Moving toward a fully employed physician base
- Capable of leveraging compensation to drive physician performance

Clinical Integration

Tucson Medical Center

- Operating in an almost entirely independent marketplace
- Will use CI[1] incentives to drive physician performance

Case in Brief: Brookings/Dartmouth ACO Collaborative

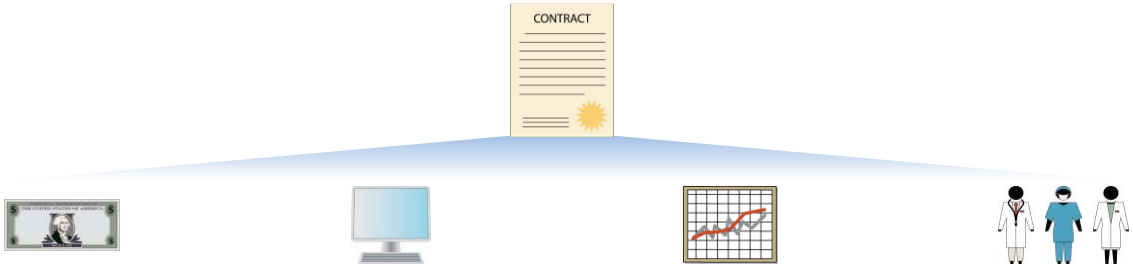
- Joint effort by Brookings Institution Engelberg Center for Health Care Reform and Dartmouth Institute for Health Policy and Clinical Practice to test replicable ACO models
- Provides technical assistance in ACO creation, facilitates payer-provider negotiation
- In addition to Carilion and Tucson, Kentucky-based Norton Healthcare, several payers also participating in pilot arrangement

1 Clinical Integration.

Source: Health Care Advisory Board interviews and analysis.

Employing to Build a Closed-Model ACO

Employment Offers Straightforward Levers for Performance Change



Compensation

- Physician income linked to success against strategic goals
- Clinic able to adjust compensation model as priorities evolve

Practice Resources

- All physicians on common platform for information exchange
- IT systems extended to physicians without Stark or anti-kickback concerns

Performance Monitoring

- Clinic access to physician-level data
- Physician access to clinic-level data
- Mandatory performance review process

Cultural Norms

- Expectation of accountability for outcomes, service, efficiency

Case in Brief: Carilion Clinic

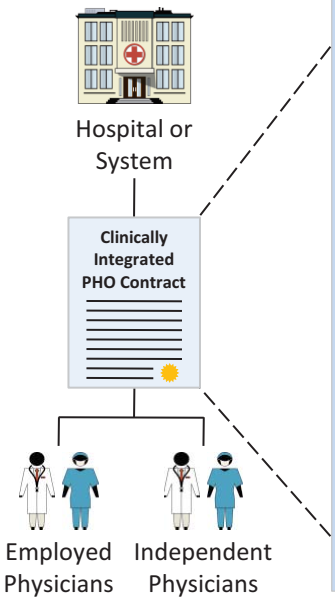
- Seven-hospital health system located in Roanoke, Virginia
- Operates under closed clinic model, with physicians aligned through employment only
- Participation in Brookings/Dartmouth ACO pilot helping accelerate shift among local payers to value-based contract models

Source: Health Care Advisory Board interviews and analysis.

Clinical Integration Uniting Across Contractual Models

CI a Vehicle for Performance Improvement, Joint Contracting

Physician Hospital Organization



Core Components

- **Selective Physician Partnerships**: Network of physicians opting to collaborate with hospitals in delivering evidence-based care and improving quality, efficiency, and coordination of care
- **Comprehensive Improvement Initiatives**: Identified and evolving metrics and targets designed to meaningfully impact the clinical practice of all physicians in the network to improve value across the full continuum of care
- **Performance Improvement Architecture**: Data-based mechanisms and processes to monitor and manage utilization of health care services, designed to control costs and ensure quality of care

Joint Negotiation

Favorable Base Rates, P4P Incentives or Shared Savings

Source: Health Care Advisory Board interviews and analysis.

Viability Contingent on Meeting Regulatory Bar

Joint Contracting Approach Established by the FTC

Statements of Antitrust Enforcement Policy in Health Care

Issued by the
U.S. Department of Justice
and the
Federal Trade Commission

August 1996

"[Clinical Integration is] 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."

- Allows for joint contracting when reasonably necessary and related to achieve goals of the program
- Outlines Clinical Integration (CI) as one approach that may allow for joint contracting (another is financial risk contracts)
- Allows for layering CI-related contracts on top of existing models of economic alignment
- Provides high-level guidance, but limited detail, on CI program structure; more guidance available through FTC Advisory Opinions

Demonstrating Reasonable Necessity

"[In this case] joint contracting…appears to be subordinate and reasonably related to [the] plan to integrate its members' provision of services to deliver coordinated care by a group of providers committed to the program, and reasonably necessary to effectively implement the proposed program and achieve its potential efficiency benefits."

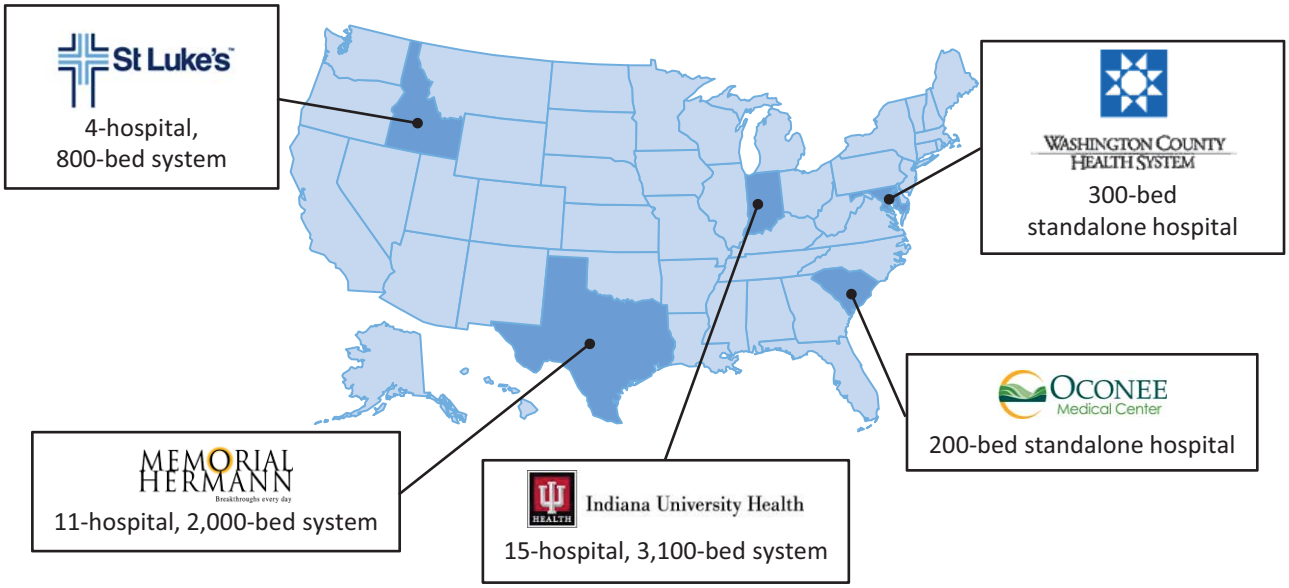
Federal Trade Commission
April 13, 2009

Source: Federal Trade Commission, "Statements of Antitrust Enforcement Policy in Health Care," August 1996; Federal Trade Commission, "TriState Health Partners, Inc. Advisory Opinion," April 13, 2009, available at: http://www.ftc.gov, accessed September 4, 2009; Health Care Advisory Board interviews and analysis.

CI Appealing to Institutions Both Large and Small

Programs Under Construction Represent Variety of Organizations

Examples of Organizations Pursuing Clinical Integration



Source: Select Medical Network, "About Select Medical Network of Idaho, Inc.," available at http://www.selectmednet.org; Memorial Hermann, "Building the Clinical Integration Enterprise," presented at Crimson Initiative Summit, April 14, 2010; Indiana University Health, "Clinical Integration: Frequently Asked Questions," available at http://iuhealth.org; Oconee Medical Center, "Preferred Health Services," available at http://www.oconeemed.org; Washington County Health System, "TriState Health Partners Receives FTC Approval," June 28, 2009; Health Care Advisory Board interviews and analysis.

Putting Clinical Integration Into Practice

Key Program Characteristics

1. Selective, scalable membership
2. Delivery of evidence-based, standardized care
3. Infrastructure for care coordination
4. Performance management system
5. Legal, meaningful incentives
6. Joint commercial contracts

Advocate Physician Partners

- Patient Safety Training
- Diabetic Collaboratives

- Online Physician Portal

- Physician Report Cards

- P4P Bonus Payments

- All Major Plans in Market

Case in Brief: Advocate Health Care

- Nine-hospital system with a large physician network located in northern Illinois
- Advocate Physician Partners (APP) is a platform for risk contracting and CI[1] programs
- APP composed of over 3,200 physicians, about 65 percent of the medical staff
- Approximately 75 percent of participants are independent physicians

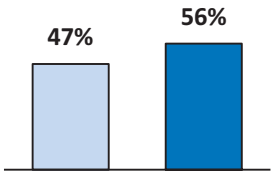
1 Clinical Integration.

Source: Health Care Advisory Board interviews and analysis.

Yielding Impressive Results

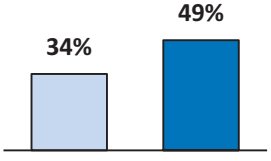
Clinical Performance at Advocate

Generic Drug Usage
Percentage, APP



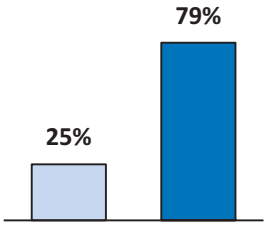
Savings of $25 M per year

Diabetic Care Outcomes
Percentage, HbA1c < 7



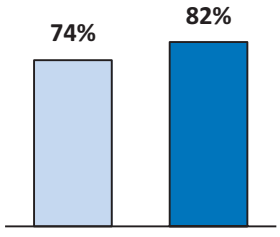
Savings of $700 K per year

Depression Screening Rate
CAD Patients[1]



Savings of $3.2 M

Asthma Management
Percentage with Action Plans, 2008



Savings of $2.1 M per year

Driving Improvement Through Incentives

"In industries other than health care, pay-for-performance is a widely accepted practice by which businesses reward management for performance linked to the strategies and success of the organization. Advocate Physician Partners' pay-for-performance system applies this approach to drive performance improvement in the clinical setting."

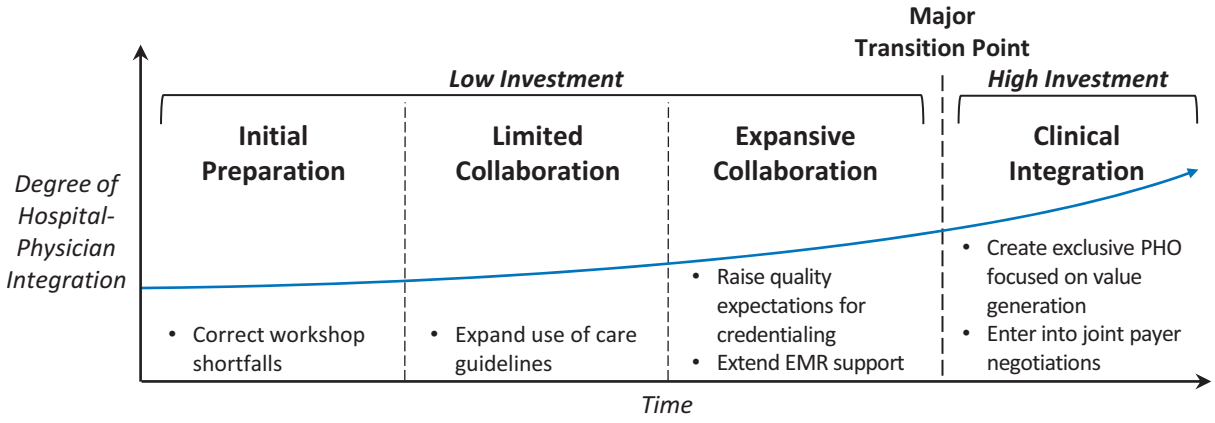
2009 Value Report

1 Coronary artery disease.

Source: Shields M, "Clinical Integration: a Key Tool to Building Strong Relations with the Medical Staff," October 4, 2007; Advocate Physician Partners, "2008 Value Report," available at: http://www.advocatehealth.com, accessed on February 9, 2009; Health Care Advisory Board interviews and analysis.

Program Development an Evolution to Joint Contracting

Incremental CI Program Development Process



Not Always a Bright Line

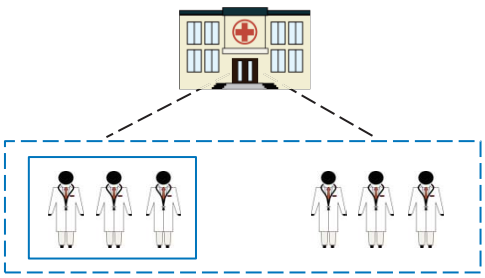
"The ability to contract together with payers is not black and white, but a CI program, properly structured, should help providers to be on the right side of the law. A successful CI program organizes your physicians to act as one for the purpose of providing high-quality, coordinated care. If you have done that, and your payers agree, then, as a practical matter, you should have a reasonable basis on which to proceed."

Douglas Hastings, JD
Epstein Becker & Green, P.C.

Source: Health Care Advisory Board interviews and analysis.

Crafting a Hybrid Approach

Dual Alignment Pursuits



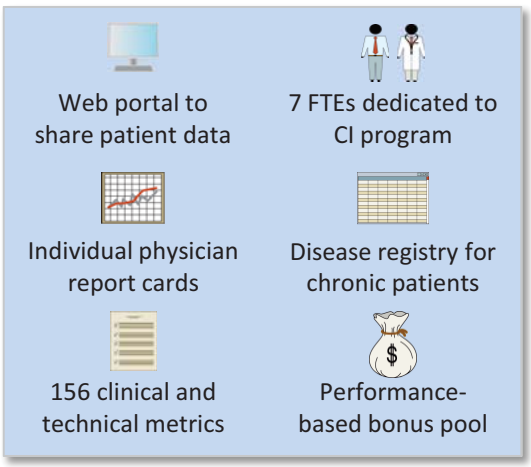
Indiana University Health Physicians

- Merged entity of all employed physicians

Indiana University Health Quality Partners

- Organization created to launch Clinical Integration initiative

Shared Performance Infrastructure



Case in Brief: Indiana University Health

- 15-hospital, 3,100-bed system based in Indianapolis, Indiana
- Simultaneously pursuing employment and Clinical Integration as way to engage physicians resistant to leaving private practice; currently partnering with more than 2,900 physicians
- Infrastructure supports both employed and independent physician performance improvement efforts

Source: Health Care Advisory Board interviews and analysis.

Organizing for Shared Accountability

Takeaway Lessons for Hospital Executives

Lesson #13: Develop strategy-aligned contracts with "ACO Partners"

Understand not all physicians are crucial to the risk-bearing ACO; use separate performance-based arrangements to align non-essential partners in creating an efficient procedural enterprise

Lesson #14: Design joint-contracting capable contractual model with "ACO Principals"

Select between Clinical Integration and extensive employment as the only two vehicles capable of wholly realizing the ideals of a performance-focused physician alignment platform in today's market

Lesson #15: Deploy common performance-focused infrastructure across alignment platforms

Recognize that both paths to ACO creation require similar investment in care management infrastructure, information systems, and performance-based incentives; fully implement this infrastructure to maximize opportunities for success under accountable care economics

Source: Health Care Advisory Board interviews and analysis.

Road Map for Discussion

I Land Grab for Leverage

II Building the Accountable Physician Enterprise

III Enterprise at a Crossroads

Five Conclusions for Senior Executives

1. Rapidly approaching the leadership moment
2. Recognizing a lofty ambition from the outset
3. Managing migration to the market critical to success
4. Securing physician affiliation first step on a long journey
5. Building common culture not an optional step

Source: Health Care Advisory Board interviews and analysis.

Rapidly Approaching the Leadership Moment

Nearing a Fork in the Road

Senior Executives Must Assess Strategic Options

Strategic Alternatives for Hospitals in Emerging Accountable Care Environment

Hospitals Must Cement Relevance in New Value-Based Marketplace

Build the Accountable Physician Enterprise

- Lay the groundwork for stronger hospital-physician integration
- Prioritize alignment with "ACO Principals"
- Begin organizing for shared accountability

Seek Affiliation with Accountable Entity

- Identify partners who can foster transition to the accountable care environment
- Build affiliations with new partner organizations as necessary

Secure Alternative Role in the Market

- Recognize opportunities to become lowest cost or most specialized provider of specific services in the market
- Prioritize alignment with "ACO Partners"
- Invest in desired, specialized service lines; scale back commoditized services

Source: Health Care Advisory Board interviews and analysis.

Assessing Organizational Preparedness

Can We Do This?

Strategic Questions on Institutional Readiness

Physician Network

- Have we aligned primary care providers and specialists toward ACO objectives?
- Do we have the necessary primary care base to manage care and drive growth?
- Are physicians engaged in care redesign efforts?

IT Infrastructure

- Are our IT investments on pace for Meaningful Use?
- Do we share clinical information with partners across the continuum?
- Does our business intelligence and analytics platform support our ACO ambitions?

Clinical Transformation

- Is our ambulatory medical enterprise built around the patient-centered medical home?
- Have we focused on evidence-based standards and care pathways?
- Are we working to activate patients in their own care?

Facility Strategy

- Do patients have sufficient access points beyond the ED?
- Are post-acute care facilities helpful partners in the patient pathway?
- Have our capital investment plans been evaluated through an accountable care lens?

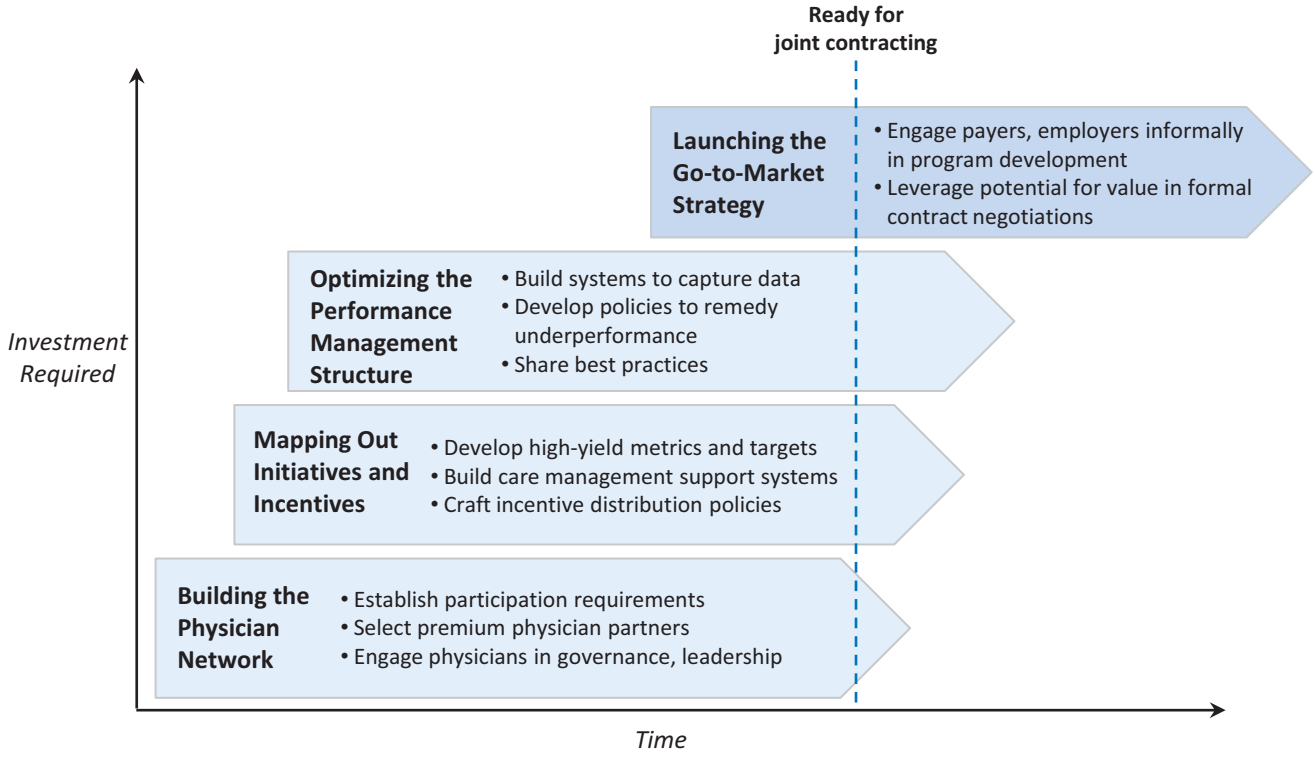
Advisory Board Tool: Accountable Care Readiness Diagnostic

- Assesses internal institutional readiness through a series of diagnostic questions addressing physician, IT, facility, financial, and clinical assets and capabilities
- Provides customized suggestions of additional Advisory Board tools and resources to support accountable care transition efforts
- Available at Advisory.com

Source: Health Care Advisory Board interviews and analysis.

Staging the ACO Ambition

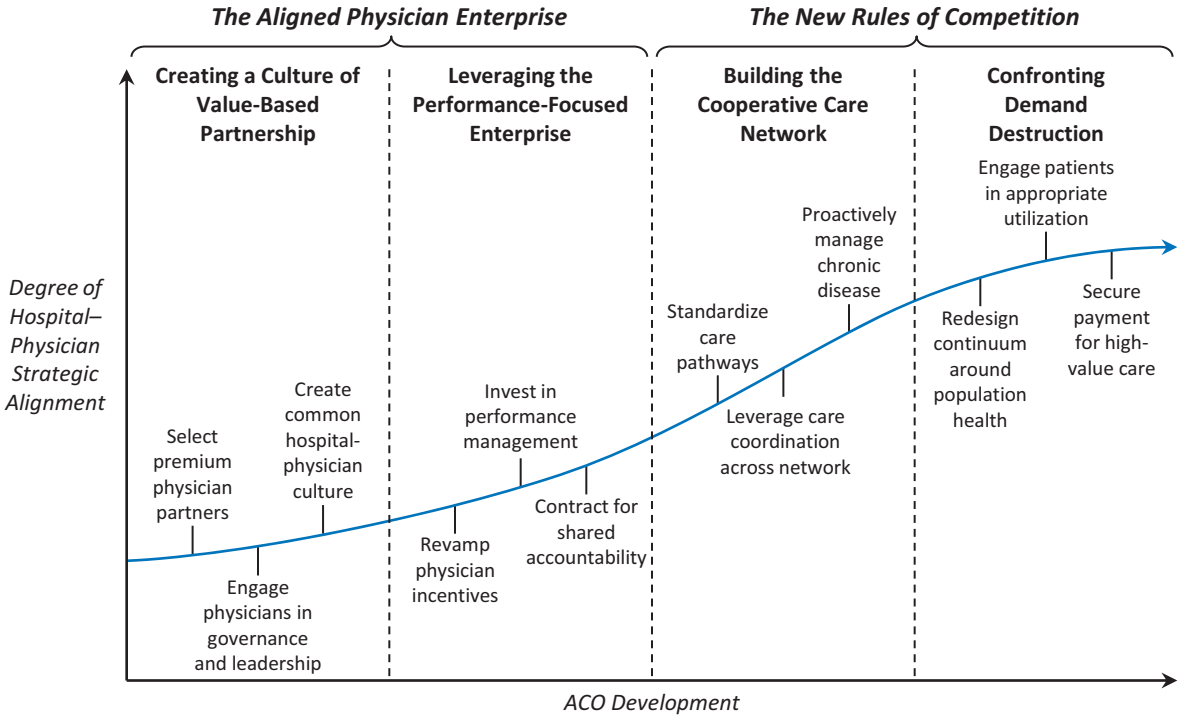
ACO Rollout Process



Source: Health Care Advisory Board interviews and analysis.

Winning the Battle for Affiliation Is Just the Beginning

Hospital Migration Toward Accountable Care



Source: Health Care Advisory Board interviews and analysis.

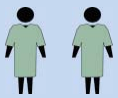
Creating a Patient-Centered Culture

Successful Migration Requires Revamping Organizational Culture

Hospital Culture

- Bureaucratic and deliberative
- Siloed mentality
- Seeks alignment
- Focus on high-margin acute care
- Responsible to community at large

Patient-Centered Culture



- Principled and responsive
- Collaborative and interdependent
- Commitment to evidence-based care
- Delivery of high-quality, low-cost care
- Responsible to patients

Physician Culture

- Agile and reactive
- Siloed mentality
- Cherishes autonomy
- Focus on individual productivity
- Responsible to physician partners

Putting the Patients in the Forefront

"Virtually all physicians and hospitals throughout the world say 'Patients come first'—but relatively few are ready to act on the implications of this slogan, which include 'Physicians come second.'"

Thomas Lee, MD
James Mongan, MD
Partners HealthCare

Source: Lee T and Mongan J. *Chaos and Organization in Health Care*. Cambridge: The MIT Press, 2009; Health Care Advisory Board interviews and analysis.

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