



Innovation through Alignment

A clinical integration platform for Academic Medical Centers

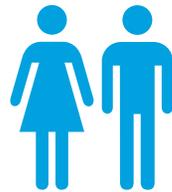
What's at stake?

Academic Medical Centers and community providers must find new ways to work together to remain competitive in the evolving healthcare marketplace.

Hospitals and health systems face unprecedented pressures in today's evolving marketplace. Health reform regulations, a consolidating industry, rapid technological change, and increasingly sophisticated consumers have converged to define a new normal for how health care is and will be selected, delivered, and paid for in the US. Academic Medical Centers (AMCs), as key players in this marketplace, face these pressures along with a unique challenge: they must not only navigate the

increasingly complex industry dynamics, but also manage often misaligned stakeholder groups to advance their core missions in research, education, and care delivery.

45% of health care consumers give the US health care system **an overall grade of D or F** on a typical grade scale. As experience becomes increasingly linked to reimbursement, health care organizations are searching for solutions to access, cost, and quality that **improve the patient experience**



In order to overcome such a challenge, AMCs must integrate their providers of care within a flexible and inclusive platform. More than ever, integration of clinical practices, supporting technologies, and financial incentives will be critical, in order to transform the economics and patient experience of AMC's delivery systems. To achieve such significant transformation, innovation in clinical delivery and workforce integration is needed. Those that cannot transition are likely destined for acquisition or absorption.

As AMCs shift to meet these challenges, several notable trends continue to add pressure to physicians' and hospitals' effort toward clinical integration

Challenges for AMCs

What is clinical integration (CI) exactly? The Federal Trade Commission defines clinical integration as "an active and ongoing program to evaluate and modify practice patterns by the CI network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality". A successful clinical integration requires an organization to have sophisticated measures to manage costs and care, intentional selection and support of participating physicians, and smart investment of capital in meaningful health technologies and resources. In today's environment structural changes such as market consolidation, payment reform, and technological advances are driving the need for significantly stronger partnerships with community physicians.



Instant Insights

Solving your most pressing business challenges starts with knowing the landscape. Instant Insights offers you a digest of vital knowledge and practical steps you can consider now.

However, many AMCs today are not yet positioned to clinically integrate additional physicians outside of the academic model and may struggle to achieve the growth needed to address market challenges. Some have focused on growing their physician base by acquiring independent practices but have been challenged by increasing costs and operational difficulties².

Increasing consolidation and diversification—

Consolidation within the provider industry is increasing competition for referrals and admissions in order to capture patient market share and payer contracts. In 2012, over 100 acute hospital deals represented an 18% increase over 2011 and provider consolidation has come from physician practices transitioning from physician ownership to hospital ownership^{3,4}.

Health system CEOs cite an unprecedented set of changes in the industry, which is creating new challenges for both AMCs and Physicians

Examples of such changes include:

- Decreased reimbursement rates from third-party payers accompanied by increased risk-based contracting
- Accelerating changes in clinical innovation to provide state-of-the-art, evidence-based care
- Increased consumer interest in and use of public scorecards on hospital and physician safety, quality, and satisfaction
- Affordable Care Act (ACA) requirements to deliver services through clinically-integrated, team-based models or face penalties
- Mounting pressures from independent physicians to affiliate with a hospital
- Increased competition from entrepreneurs who capture opportunities in attractive niches and may have the potential to ultimately reduce hospital revenues and margins

Source: 2013 Deloitte Survey of US Physicians

Margin erosion—While consolidation often requires significant investment and employing physicians continues to be costly, payments from both government⁵ and private insurers⁶ are decreasing. AMCs are seeing a decrease in funding for research and education and an erosion in clinical margins. Increasing utilization of Medicare, emergence of health exchanges and ACA reform is projected to decrease weighted average operating margins by as much as 11.5%.⁷

Lack of integration between clinical, research and

missions—AMCs are diversified in both their physician compositions (i.e., private-practice, employed) and enterprise mission (academic/research, functioning hospital), leading to a mix of culture and varying needs. Due to their large, complex nature, AMCs struggle with shedding traditional methods/structures in order to embrace new innovations. The combination of both characteristics leads to silo-ed rather than unified operations and a hindrance in forming a cohesive enterprise strategy that's necessary to tackle the changing industry.

Leading through innovation—AMCs sensitivity to these challenges is driving a need to pioneer industry-leading solutions and reimagine the approach to delivering on their mission by leveraging opportunities to integrate and scale, tapping into broader health alliances and affiliations to enhance education, research and clinical care while simultaneously reducing costs.

In order to address these challenges AMCs are increasingly looking to forge new alliances with non-academic institutions and clinicians to attract more patients, protect their clinical margins, and unlock new sources for growth. A variety of physician partners enable AMCs to extend brand recognition, targeting specific clinical lines to change referral patterns. Culturally, a gradual break down of historical silos among education, research and clinical missions is already beginning to emerge. However, the traditional AMC physician employment model creates additional hurdles that must be overcome to meet the needs of a broad and diverse physician population necessary for population health management and value based care. Removing these hurdles presents significant cultural

% responding very likely/likely that physicians and hospitals will become more integrated in the next 1–3 years



66% of all physicians
Source: Deloitte 2013 Survey of US Physicians

challenges as some entrenched members fear an erosion of the academic mission due to the addition of non-academic physicians and community partners generally aligned to a different set of goals and incentives.

Challenges for Physicians

Physicians today are increasingly more willing to partner with health systems and are actively exploring options. Much like AMCs, private physicians and medical groups are working to overcome their own set of challenges. According to Deloitte's 2013 Physician Survey, physicians are pessimistic about the future of medicine. The majority worry about their ability to address health care reform requirements independently⁸. Most physicians foresee physician-hospital integration. However, many physicians will have multiple opportunities to choose an employer or clinical partner. The most attractive partners will be those systems that create desirable platforms for integration to form mutually beneficial relationships. AMCs can stand out by helping physicians proactively address the following challenges:

Outcomes improvement—Competition for increasingly informed consumers and more demanding payers necessitates the adoption of evidence based medicine, safety protocols, and high functioning EMR technology to measure and improve outcomes and fulfill regulatory HIT requirements. Spreading these costs across large groups of providers is most beneficial and AMCs, which typically have already made significant investments in IT infrastructure, may be well positioned to expand these services to affiliated physicians and assist with outcomes improvement and measurement.

Risk based contracting—The shift from fee for service to a risk based payment model requires scale in patient volume and systematic cost efficiency in addition to outcomes improvement. According to the Deloitte 2014 Survey of US Physicians, physicians report that their compensation 10 years from now will be an even mix between volume-and value-based⁹ Without closer integration, private physicians could be left out of emerging narrow networks and cut off from access to patients. AMCs can leverage a strong brand to attract patients, form networks, and position their affiliated physicians as market leaders.

Non-conventional competition—Increasingly advanced practice providers, retail clinics and even alternative medicine practitioners are emerging as effective and cost efficient alternatives to the traditional doctor model. Many physicians are unprepared to address emerging competition and will need to seek out partnerships to continue competing for patients in a cost effective manner. While successful integration of these providers will lead to joint success, building a model for integration has been challenging.

Our take

An innovative physician model to drive workforce leadership

In order for hospitals and physicians to deliver on these escalating needs they will have to come together by forming highly integrated clinical networks which focus on data sharing to create new models of care delivery, improve patient outcomes and decrease the cost of care. Clinical integration is paramount to transitioning from volume to value and will enable AMCs to achieve the necessary quality and cost improvements that justify joint contracting and mitigate antitrust litigation risk. However, as past experience demonstrates, clinical integration and alignment between physicians and hospitals is wrought with challenges and has had only moderate success in the past¹⁰. In fact, according to

Deloitte's 2013 Survey of US Physicians, the number one "top ten near-term challenges" on the minds of health system CEOs is facilitating physician alignment and integration into leadership roles. Even those organizations that stand out as leaders and have successfully achieved integration have had to undergo a costly transformation lasting over a decade to get there.

Traditionally, AMCs have relied solely on an employment based model for physician retention. In this model physicians are most often dually employed with the hospital, for clinical care, and the medical school for research and education. Most employed physicians are expected to teach, conduct research, and participate in patient care. For some physicians this is an attractive way to work and they are happy to participate in the tripartite responsibilities. Others, however, would rather focus on clinical care alone and have less interest in academics. For these physicians, traditional AMC settings have not always been an inviting place to work or practice. To continue to attract the best physicians and to build a network sufficient for value-based care, AMCs need to evolve new workforce models and methods for attracting top talent. Or as one CEO put it, "We have to develop approaches to partnerships we do not own or control".

In order for these complex organizations to rapidly and seamlessly coordinate the physicians necessary for their ongoing success we suggest developing a platform to allow members with differing priorities and preferences to partner together in order to deliver superior care. Developing a clinically integrated network allows AMCs to offer a competitive alternative to the employment model and can be done rapidly to engage the physician audience ahead of the competition.

This provider network, among other things, would promote selectivity among the physician group and build out the structural and operational elements to significantly increase interaction among participating physicians by improving quality of care delivery and outcomes in the treatment of patients. Assuming AMCs intend to maintain their independence in the near term, clinical integration becomes a market differentiator, enabling the AMC to drive key brand messages of quality, cost and network breadth. The clinically integrated delivery system also enables AMCs to embrace a team-based model and the role as coordinator of clinical information.



The path forward

Five steps to developing a physician integration platform

Physician integration has proven to be a challenge for many health systems and those that have been successful have had to struggle through significant financial challenges and decade long transformation efforts¹¹. By learning from these early moving organizations and rapidly developing the necessary integration capabilities, AMCs can successfully navigate today's healthcare challenges and win the battle for physicians and patients.

To build a sustainable organization and allow for a flexible, inclusive platform AMCs should focus on the following 5 strategic levers:

1. Dedicated focus on care improvement:

Clinically integrated AMCs must sustain dedicated focus on demonstrating high-quality care. Beyond competitive differentiation, clinical integration expands the options for engaging with physicians by satisfying anti-trust requirements and creating the ability to negotiate with payers based on improved outcomes and costs.

Quality reporting and network-wide accountability are key to successful clinical integration and physician alignment. Leading organizations are adopting ongoing quality improvement processes and implementing sophisticated measurement tools to inform and educate providers¹². Quality and cost metrics are measured and reported on a regular basis to members, departments, and leadership to maintain transparency of overall performance. However, rigorous tracking of performance must be coupled with network-wide accountability and dedication to continuously improve based on findings, through comprehensive training and remediation process.

2. Attracting and retaining high-caliber members:

A high value group of members is critical to the network's success. Members must adhere to the network's quality standards, behave as good citizens of the network, and contribute to the financial and brand strength of the network. The culture and caliber of the network will not only serve as an initial differentiator in setting the AMC apart but as a perpetual differentiator, helping the AMC to continuously attract and retain the best providers.

To develop a strong group, the organization must define clear membership criteria—the level of standards required to be accepted into the integrated network. It should be designed with the expectation that the organization will be committed to adhering to the outlined conditions to recruit the best

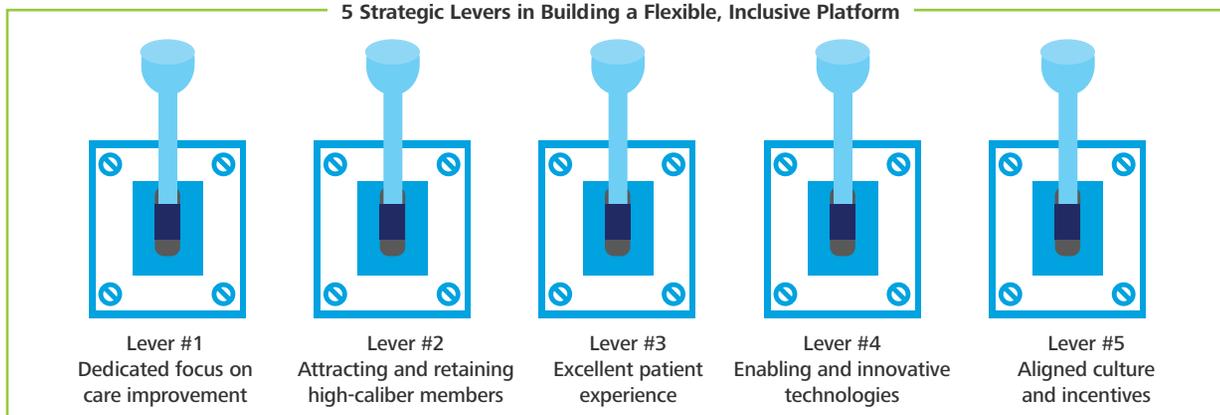
providers. The AMC must also define rules of engagement—what must members do to ensure the high value of the network? These rules should be both strategic and specific, each tying back to overall objectives of the clinically integrated network. They should be supported by protocols and network-wide accountability processes to foster strong membership.

3. Excellent patient experience:

Robust network membership serves as the foundation for successful differentiation by developing a reputation for excellent patient experience. Increasing industry consolidation makes expanding and protecting the patient base both challenging and essential. With a growing attitude of consumerism affecting patients' engagement in their care, patients are now choosing providers based on their care experience¹³. In addition, reimbursement and payer negotiations are increasingly relying on positive patient satisfaction scores to negotiate rates. Once the AMC selects members who put patients first and will collaborate with the network to achieve quality performance targets, they can begin shaping a positive end-to-end patient experience that differentiates them from other providers.

Focus on the consumer experience, though well-defined in sectors such as retail, is a relatively new concept in the provider space. What does an excellent patient experience look like and how can an organization begin thinking about tackling such a universal concept? Excellent patient experience refers to the excellent quality and value in all patient interactions—direct and indirect, clinical and non-clinical—spanning the entire duration of care delivery. AMCs should begin by identifying all of the points of interaction that make up the patient/provider relationship (e.g., scheduling, pre-registration, arrival and entry, rooming, clinical care, and discharge) and the methods of interaction (e.g., point of care, social media, online). Examples of best practices that have been incorporated include a well-defined patient referral and appointment process, an active patient feedback process, and tying patient experience performance to incentives or rewards for providers.

5 Strategic Levers in Building a Flexible, Inclusive Platform



4. Enabling and innovative technologies:

To build and maintain the components defined above, the AMC must be equipped with the right tools. Innovative health information technology (HIT) such as an enterprise-wide EMR, rigorous data analytics, patient-centered information exchanges, and easy-to-use patient/provider interfaces empowers AMCs in their mission to demonstrate excellent quality, build strong membership, and deliver differentiating patient care. The scale of the network can also be leveraged to meet impending HIT regulatory requirements such as ICD-10 or Meaningful Use, allowing participants to pool resources to meet HIT adoption requirements as a larger group.

The integration platform should outline provider-level IT adoption requirements that recognize a diverse composition of providers—e.g., mix of employed and private providers—while ensuring a consolidated strategy at the same time. Best practices for this include tier-based IT participation levels for physicians, with different benefits offered at each level to ultimately encourage the provider to adopt the highest level of HIT participation. Once the macro environment and individual participation have been determined, strategic roadmaps can be developed to orchestrate the investments required and supporting activities needed for the implementation process.

5. Aligned culture & incentives:

The final component of the clinical integration platform will be key to ensuring its sustainability—aligning culture and incentives to gather the buy-in of everyone in the organization. AMCs must recognize the diverse culture and perspectives that are inherent in a clinically integrated network of physicians. An organization composed of academic physicians, employed physicians, community physicians, advance-practice providers, and other members will inevitably have mixed views on clinical integration—on tackling excellent quality performance, what it means to build a strong membership, the most critical point-of-care in patient experience improvement, and which HIT capabilities to invest in. AMCs leadership should orchestrate the existing diversity of thought to discern an aligned integration strategy.

An example of best practice includes the development of a physician compact. A compact outlines the vision and commitment of the broader organization and also lists the expectations that the organization has of every affiliated member of the organization, whether that is dedication to its clinical quality mission, putting patients first, or supporting the academic missions of the AMC. In order to serve as a successful tool for aligning cultures, the compact should be developed by a diverse group of providers from a multitude of settings that reflects the diversity of the network itself—a group composed of academic physicians, community physicians, primary care physicians, and specialists. Once developed by their peers, every member of the network must sign the compact prior to receiving clinical privileges as a gesture of understanding and attesting to the organization's goals. Leadership then leverages the compact as means to ensure accountability across the organization and also to hold themselves accountable in enforcing the vision they have agreed to abide by.

Smart first steps

To embark on this strategic journey towards designing a platform for clinical integration, AMCs can take some smart first steps:

1. **Build a coalition** of formal and informal leaders aligned on the need for a physician integration platform.
2. **Define strategic and operational priorities** based upon internal capabilities and external market conditions.
3. **Engage a broad physician community** in change efforts.
4. **Define and implement specific criteria** for membership, clinical improvement process, and IT capability development.
5. **Embark on a physician integration campaign** to select and invite physicians to participate in the platform



The bottom line

AMCs should be prepared to tackle the road ahead with both patience and discipline by crafting tactical roadmaps with clear owners and milestones. The road to full clinical integration is a long, strategic journey. Developed roadmaps and designated owners—such as a “task force” responsible for designing each component—can bring the necessary determination and drive required for successful integration.

However, organizations that are able to successfully navigate these challenges will be rewarded with a dynamic and committed physician group that maximizes the flexibility of care delivery and is engaged to support the systems’ missions. An integration platform-based physician engagement strategy provides AMCs an alternative to traditional academic employment and creates a structure in which many more physicians will be willing to engage while expanding the care options for patients and payers.

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