

Dorrie Guest
Danna Campbell
Sara Larch
Bob Williams



taking smart steps toward clinical integration

Using the right approach to build a clinically integrated network (CIN) puts hospitals and health systems in a position to capitalize on the benefits of the CIN business model.

In late January, the U.S. Department of Health and Human Services (HHS) took the significant step of establishing a timeline for moving healthcare payments from volume to value. HHS set a goal of tying 30 percent of all Medicare payments to quality and cost performance by the end of 2016, and increasing that proportion to 50 percent by the end of 2018. Commercial payers are following in lock-step, with Aetna saying it expects to make 75 percent of payments through value-based contracts by 2020.^a

a. Millman, J., "The Obama Administration Wants to Dramatically Change How Doctors Are Paid," *Washington Post*, Jan. 26, 2015.

In this environment, it is essential to have the right complement of physicians—in the right locations and with the right level of performance—aligned with the health system around common goals and incentives. Interest in achieving such alignment with physicians prompted aggressive practice acquisition and physician employment cycles among health systems in the past several years. Yet many health systems have found that alignment does not automatically follow employment and that the employment model can bring unsustainable losses and decreased productivity. (See the exhibits on pages 2 and 3)

A clinically integrated network (CIN) offers an increasingly attractive alternative to physician employment for accelerating the shift from volume- to value-based care delivery and payment models. As indicated in the exhibit on page 3, physicians often are more productive when operating in an independent practice than when employed by a health system. In addition, a health system's operating expenses per physician have been shown to be significantly lower when managing a CIN compared with managing employed physicians: The 2014 Medical Group Management Association Cost Survey reports that median operating expenses for a health system in the employed physician model range from

AT A GLANCE

Health systems should take five key steps in the early phases of establishing a clinically integrated network (CIN):

- > Establish the operating model and implementation timeline.
- > Identify who to include.
- > Define what's in it for the physicians.
- > Agree on the tenets that will make the CIN stick.
- > Understand when to say no.

\$320,000 to \$450,000 per physician, depending on specialty, whereas recent Deloitte Consulting experiences indicate operating expenses for a CIN can range from \$30,000 to \$50,000 per physician, depending on the scope of services offered to participants.^b

Moreover, early results from health systems with successful CINs reflect better clinical cost performance in shared-savings arrangements when compared with organizations in which employment is the primary physician engagement strategy. For example, in the Medicare Shared Savings and Pioneer accountable care organization (ACO) programs, ACOs composed of both

health system-employed and independent physicians generated savings per participating physician approximately 17 percent greater than those formed predominantly with health system-employed physicians.^c

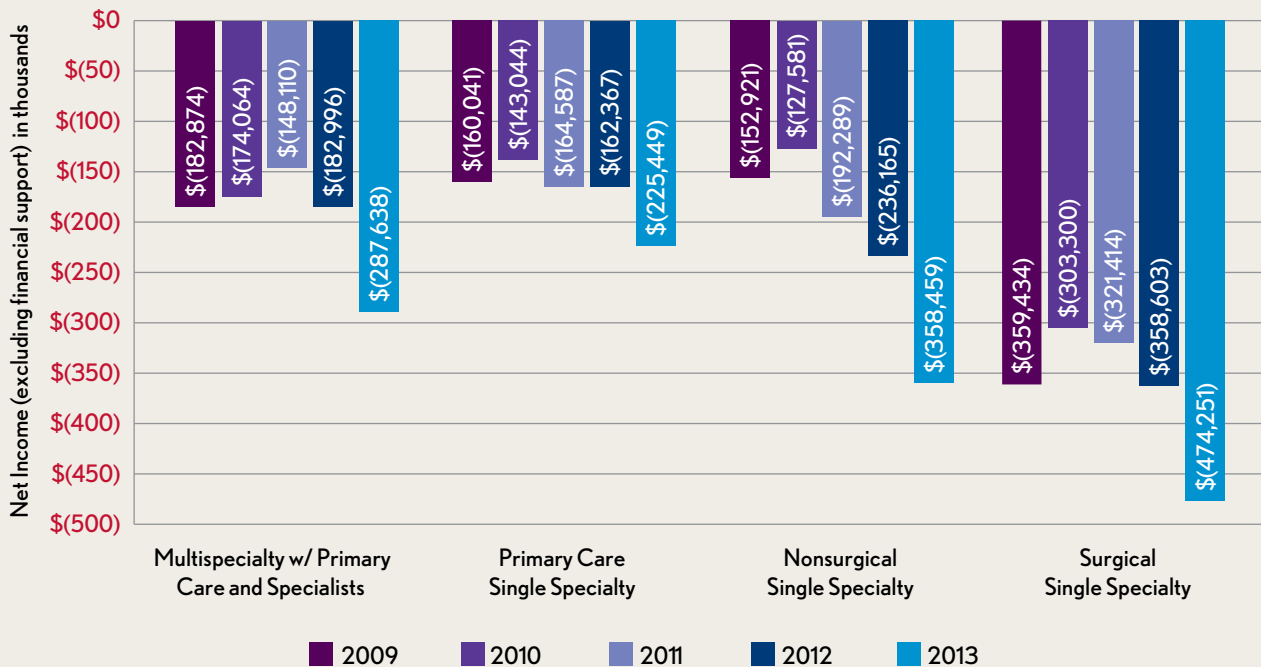
Taken together, findings related to productivity, operating expense, and shared-savings performance suggest health systems that have invested in an employed physician model should consider reevaluating their strategy and—short of unwinding physician employment—explore a broader strategy that includes working with independent physicians through a CIN.

The median loss per physician has been increasing in practices owned by hospitals and integrated delivery systems (IDSs).

b. Medical Group Management Association, "Cost, Revenue, and Staffing" and "Physician Compensation and Production" surveys, 2014.

c. Calculated using data from cms.gov Media Releases and Fact Sheets; Becker's Hospital Review, "ACO Directory: 272 ACOs in America"; and ACO-specific websites.

MEDIAN LOSS PER PHYSICIAN IN HOSPITAL- AND IDS-OWNED PRACTICES, 2009-13



Source: Data were compiled from Medical Group Management Association, "2014 Cost Survey."

Advantages and Characteristics of a CIN

Appreciating the advantages of CINs starts with understanding their key characteristics. A joint report from the Federal Trade Commission (FTC) and the Department of Justice states that clinical integration can be evidenced by “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.”^d The FTC framework for antitrust enforcement, which includes the following four characteristics, is useful for summarizing the

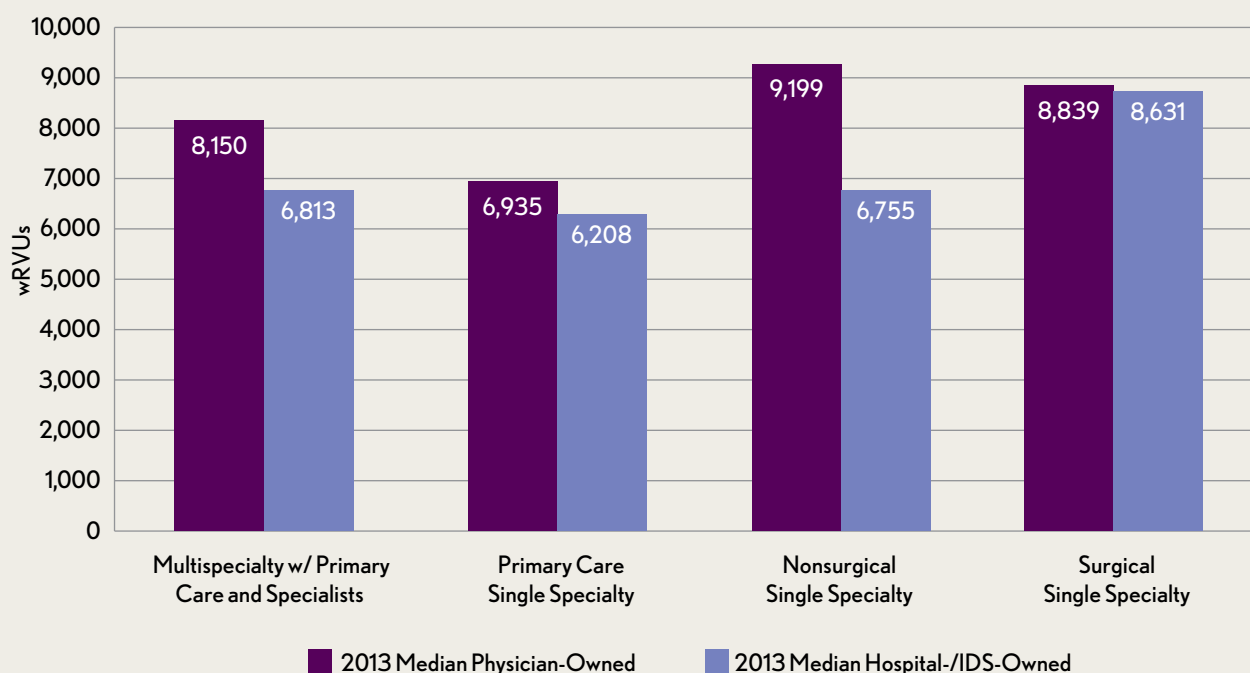
capabilities a CIN might demonstrate to meet the spirit and intent of clinical integration.

The ability to achieve significant clinical and economic efficiencies. In a CIN model, the participating physicians and health system share clinical goals and guidelines and can enter into payer contracts together. Successful networks produce both savings and improved quality, applying strategies to achieve appropriate healthcare service utilization as agreed on by the members. By changing and ultimately improving the way they collectively practice, physicians and hospitals collaborating in a CIN can provide better care at a lower cost—and realize mutually shared financial benefits as a result.

Median work relative value units (wRVUs) are lower for employed physicians than for those in private practice.

d. “Improving Health Care: A Dose of Competition,” U.S. Department of Justice and Federal Trade Commission (Chapter Two), July 2004.

MEDIAN wRVUs FOR PRIVATE-PRACTICE AND EMPLOYED PHYSICIANS, 2013



Source: Data were compiled from Medical Group Management Association, “2014 Cost Survey.”

Broad physician representation and physician investment. Thriving CINs know that success is not simply about signing a good contract. It's about a real partnership, with aligned incentives and meaningful change.

Participation in a CIN requires financial investments by member physicians in the people, processes, and tools necessary to drive real change. These investments can return dividends beyond dollars and cents. Traditionally, having a voice in the development and execution of a patient-centered, quality-focused care delivery model required physicians to either be employed by the health system or have attending privileges, but physicians in a CIN can contribute in that capacity while maintaining their autonomy.

Primary care physicians in a CIN should expect to participate in decisions governing care management programs and to have access to specialists who are committed to a collaborative care delivery model. Specialists can enhance their access by working with primary care physicians to mutually agree on when circumstances dictate care transitions between primary and specialist care. This level of collaboration requires that the CIN include a broad range of physician specialties and that it selectively choose its members.

A well-developed care management program that uses evidence-based guidelines. The clinical focus in health care going forward cannot be hospital-centric. The focus instead should shift to trusting, respecting, and collaborating with physicians to coordinate care for shared populations, one patient at a time.

Evidence-based guidelines are a key tool for CINs. Physicians and other providers, operating as a cohesive team within a CIN, should endorse a set of recommendations involving both published evidence and value judgments about the benefits

and harms of alternative care options. These recommendations should address the care management—including transitions between providers—of all patients with a given condition, all else being equal.

A well-developed care management program, endorsed by CIN participants, helps physician practices and hospitals evaluate and continually improve their evidence-based approaches. Ideally, a patient treated by providers in a CIN receives care from a team that manages the patient's health care using shared information obtained from the patient, hospital, family, and community in a manner that supports the patient's overall health and social status.

Evidence-based protocols should be established, at a minimum, for high-risk patients, who are then followed by the care management team. Services from the resulting comprehensive care plan are delivered by the CIN community of providers in a manner that enhances the continuity and consistency of care—for example, in an effort to reduce unnecessary emergency department visits and inpatient hospital readmissions.

A data management system that enables data collection, information sharing, and utilization review. Enabling technology is vital. An open-source system approach is needed to coordinate care across the continuum and engage directly with patients. Also essential is having the back-end analytics that allow a CIN to continually refine its clinical and financial processes.

Technology provides the backbone of a CIN, allowing disparate data sources to be pooled to create a broad clinical record for shared patients. It also is vital for applying the agreed-upon evidence-based guidelines to consolidated patient data in such a way that noncompliance or gaps in care are readily apparent. Technological

limitations in the past encouraged physician employment models because, practically speaking, all providers needed to be on the same system to create a broad clinical record. However, interoperable technology addresses those data management limitations. Advancements provide the ability to structure, organize, and utilize patient, population, and provider data from various clinical and financial systems to drive efficient and effective care.

Smart First Steps

The following steps can help providers build an effective CIN that complements a health system's employed physicians.

Establish the operating model and implementation timeline. No aspect of setting up a CIN can occur in a vacuum. Health systems should have an appropriately resourced team to manage, monitor, and optimize the CIN, including a core group that can align internal clinical and business leadership on the path forward. The sidebar on the right lists key questions to address with respect to areas that should be engaged early when establishing the operating model and timeline that will govern CIN implementation.

Identify who to include. Health systems should strategically evaluate their existing complement of employed physicians against the projected demands of the population they intend to serve through the CIN to identify variances by specialty (both under-supply and over-supply). Precisely targeting the types of physicians needed to round out the network is critical to curtailing operating expenses and medical spend.

Attention should be paid to determining the specific number of physicians needed by specialty, and to balancing recruitment into the CIN against the health system's overall clinical strategy. The CIN should strive to avoid recruiting

specialists who would exacerbate growth in operating expenses for clinical services where existing supply already outpaces demand. Only high-performing physicians who add value to the network in terms of quality, cost, access, efficiency, health system relationships, and market coverage should be targeted for inclusion.

Define what's in it for the physicians. Certain elements of a well-formed CIN can attract

Establishing a CIN: Key Preliminary Questions

Health systems should ask the following key questions, listed by functional area, when establishing the operating model and timeline for a CIN.

Business Development

How will creating a CIN affect previously planned development initiatives?

Physician Enterprise

What role will the clinical leaders and functions of the employed physician group(s) play?

Finance

Will the capital budget allow for the necessary investments, or will funding approval require a midcycle process?

Legal and Contracting

Can existing payer and vendor contracts be extended to CIN participants in their current format, or will they require renegotiation?

Care, Utilization, and Quality Management

What resources, protocols, and committees could be leveraged by the CIN to avoid conflicting or duplicative efforts?

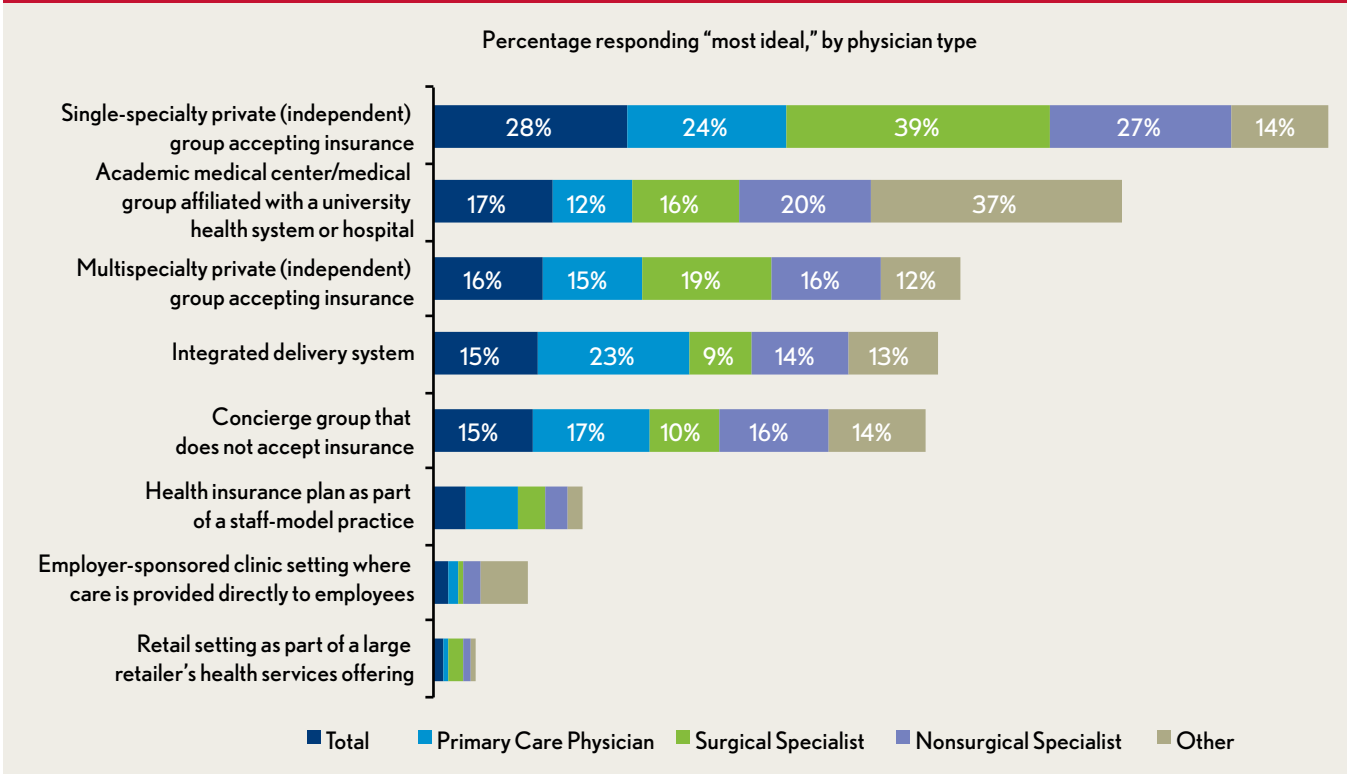
Technology and Decision Support

Does the capacity exist to combine disparate data sources, and will supplemental resources be needed to meet the CIN's reporting and analytics requirements?

Outreach and Marketing

How should communication and recruiting efforts be coordinated to ensure community physicians aren't getting mixed messages about the CIN?

PHYSICIANS REPORT PREFERENCE FOR MORE TRADITIONAL WORK SETTINGS IN WHICH TO PRACTICE VALUE-BASED CARE



Source: Deloitte Consulting, LLP

independent primary care and specialist physicians who may be exploring partnership options with hospitals, health systems, health plans, and nontraditional competitors in their practice areas. These elements include:

- > Preferential access to services of other CIN members for patients, with fewer barriers in care navigation and referral processes, thanks to organized care management
- > Participation in the refinement of quality improvement programs, care management capabilities, robust measurement tools, and workflow-technology enablers, all of which health systems likely have already invested in
- > Contracting processes that enable physicians to collectively negotiate fee-for-service rates, reap

the discounts of the CIN's group purchasing organization, participate in value-based care contracts, and share in the cost savings generated

- > Access to the health system's IT solutions and network scale, which then can be leveraged to allow physicians to meet impending health IT regulatory requirements, such as ICD-10 or accelerated time frames for meaningful use

Agree on the tenets that will make it stick. Moving to a CIN model takes time and commitment, requiring real change in the way care is coordinated and delivered. When payer contracts carry financial risk for the total cost of care, a vague agreement to "improve care" as part of an affiliation is not enough.

The health system and the CIN participants should make a meaningful commitment to core tenets, including a physician-led governance model. In this model, the board of directors, with representation from primary care physicians and specialists, should be accountable for aligning the CIN's culture and incentives across the participating physicians and the health system. Early engagement of physicians in structuring the CIN is essential.

A value-based payer strategy should be another core tenet, with agreements incenting and rewarding the cost and quality efficiencies that justify joint contracting through the CIN.

To establish individual and collective accountability, physicians should be able to gauge their performances against a core set of manageable and understandable metrics. Performance along the way should be transparent to all, and physicians should discuss, peer to peer in a specific and candid manner, what they should stop doing and start doing. When a physician's performance is not meeting expectations and peer-to-peer interactions have not been effective, a set of formal, defined interventions should be deployed.

The CIN also should have structures in place to encourage patient retention within the network. Without clinical integration, the patient experience across the care continuum likely will remain disconnected. When technology and operational processes support data sharing, streamlined care management, effective transitions between providers, and evidence that the care delivered produces better outcomes within the CIN, patients will be less likely to go outside the network (except when clinically necessary).

As a final tenet, CIN participants should embrace collaboration principles and devote the requisite resources to further the clinical integration program, including components such as

evidence-based guidelines, data sharing, patient access standards, and care management protocols.

Understand when to say no. Gone are the days when a health system can simply take all comers into its physician network. The process of continually shaping the composition of the CIN to make it successful requires understanding whom to “say no to” up front. The CIN also should include a mechanism to phase out physicians whom do not meet the agreed-upon tenets, making sure organizational will and business rigor are sufficient to take such action when necessary.

Clinical and business leaders should agree on specific, measurable criteria by which prospects will be vetted, and on a formal, data-driven decision-making process to use before extending affiliation offers. Executing a letter of intent (LOI) with prospective physicians or practices before proceeding with an affiliation agreement will allow time for collecting data and scoring the physicians or practices against defined quality, cost, access, efficiency, relationship, and market-positioning criteria.

The health system should address nine basic questions about the physician or practice during the LOI period:

- > Does the physician or practice fill an identified specialty or geographic need?
- > How does the performance of the physician or practice stack up against the CIN's core quality measures?
- > Will the clinical costs of the physician or practice negatively affect the CIN's shared-savings pools or risk arrangements?
- > Can the clinical and financial systems of the physician or practice meet the CIN's data-sharing and reporting needs?
- > Does the physician or practice have care management resources, or will the physician or practice need to buy into those services?

- > Which evidence-based protocols does the physician or practice follow?
- > What is the existing patient panel size of the physician or practice, and is the physician or practice able to meet access requirements?
- > Which providers does the physician or practice work with when patients need services that the physician or practice can't deliver?
- > Is the physician or practice a good cultural fit with the community of physicians already in the CIN?

A similar assessment should take place when monitoring the performance of CIN participants. Whether vetting a new entrant or evaluating the contributions of existing members, using a documented decision-making process will provide the supporting business intelligence for determining when to say no or consider terminating participation.

Big-Picture Benefits

Strategically developing a CIN can positively affect a health system's financial performance, improve care quality and patient outcomes, and accelerate readiness for value-based payment. The CIN model is an alternative to employment. As illustrated in the exhibit on page 6, findings from Deloitte's 2014 Survey of U.S. Physicians indicate physicians overwhelmingly report a preference for more traditional work settings in which to practice value-based care.^e Health systems, especially those experiencing large losses, may no longer be able to afford to grow their physician complement through acquisition and employment. As noted previously, operating expenses per physician are much lower in a CIN than in an employed-only model,

e. Survey findings based on 561 respondents from among a randomly selected sample of primary care physicians and specialists in the American Medical Association's Physician Masterfile.

and early results indicate that savings generated in terms of medical spend for value-based arrangements track more favorably in a CIN model than in a predominantly employed model.

The clock is ticking toward the 2016-18 ramp-up in value-based payment models. Health systems should be moving quickly to prepare—and affiliating with physicians through a CIN carries a much shorter contracting cycle than does employment or acquisition. Right-sizing the number of employed physicians and complementing that group with a CIN may be a viable way for health systems to strengthen their position in a rapidly changing industry. ■

About the authors



Dorrie Guest, MPH, is director and National Physician Enterprise and Ambulatory Services lead, Deloitte Consulting, LLP, Pittsburgh, and a member of HFMA's Western Pennsylvania Chapter (doguest@deloitte.com).



Danna Campbell, MBA, BSN is specialist leader, Deloitte Consulting, LLP, Houston, and a member of HFMA's Texas Gulf Coast Chapter (dacampbell@deloitte.com).



Sara Larch, MSHA, FACMPE, is specialist leader, Deloitte Consulting, LLP, McLean, Va. (slarch@deloitte.com).



Bob Williams, MD, MS, is director and national medical lead, Deloitte Consulting, LLP, McLean, Va. (rbrwilliams@deloitte.com).