A Whole New World: Strategic Partnerships, Alliances and Collaborations with Tertiary Centers

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Objectives

- Review current and future healthcare models (Volume to Value)
- Review strategic motives for collaborations, and how this relates to delivery of care, cost containment and improved quality and safety
- Present personal experiences via case scenarios that demonstrate the complexities involved in forming a collaborations between community and tertiary sites; with focus on motive, alignment and outcome measures.
- Summary and lessons learned from our experiences

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Healthcare Delivery Model: Volume to Value

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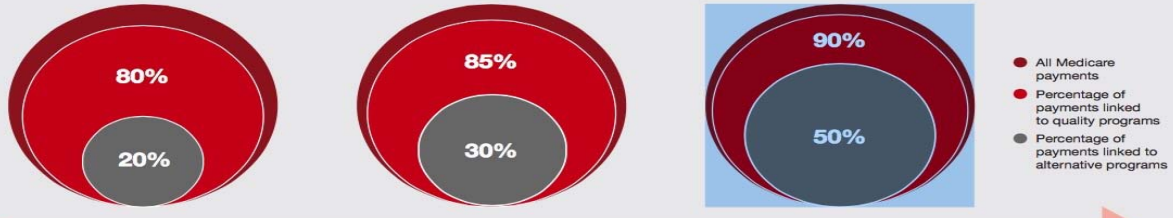
CMS Payment Changes 2015-2018

Medicare's commitment towards quality-based payments grows.



Quality based payment programs

- Hospital Value-Based Purchasing
- Hospital Readmissions Reduction
- Hospital-Acquired Condition Reduction
- End-Stage Renal Disease (ESRD)
- Quality Incentive
- Value-Based Modifier

Alternative payment programs

- Pioneer Accountable Care Organization
- Medicare Shared Savings Program
- Bundled Payments for Care Improvement
- Comprehensive Primary Care Initiative
- Patient Centered Medical Homes
- Comprehensive End Stage Renal Disease
- Oncology Care Model
- Medicare/Medicaid Financial Alignment

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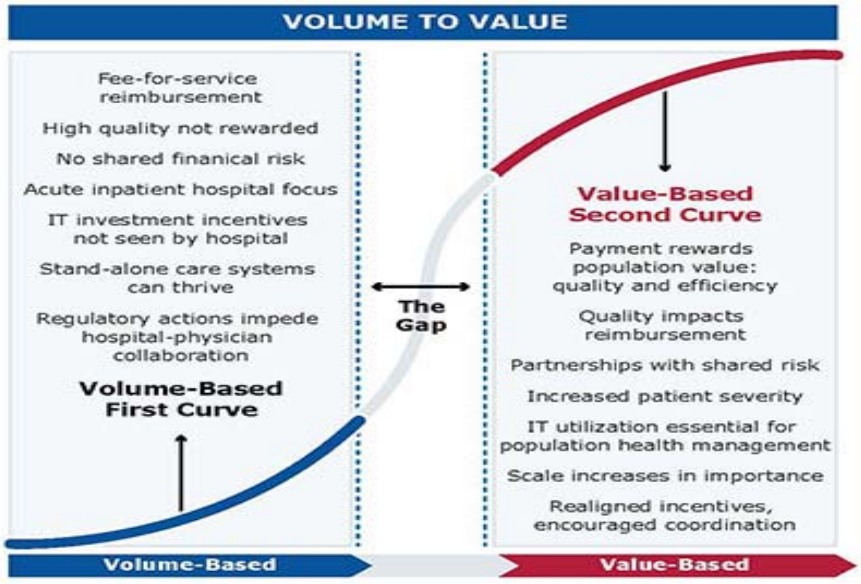

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EXHIBIT 2

Transitioning from Volume to Value

TODAY: Performance Based on Volume

- Revenue driven; margin impacted more by volume and reimbursement per admission and units of work than cost
- Limited incentives to prevent admissions and coordinate care; quality and safety initiatives are process driven
- Organizational focus is on advancing the position of specific providers/points of care delivery; little or moderate integration across the network and across the continuum
- Focus is on managing episodes of illness and disease

Maximizing value is required, but transitioning too quickly may compromise current financial performance

Elements of value can improve performance now by maximizing margins; controlling costs; and enhancing quality, safety and satisfaction

FUTURE: Performance Based on Value

- Cost driven; margin impacted more by managing costs—both variable and fixed
- Positioned to optimize quality, safety and patient satisfaction
- Organizational focus is on advancing the network or system of provider partners; high degree of integration across the network/system and coordination across the continuum
- Focus is on prevention and population health

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Motives for Collaboration/Integration?

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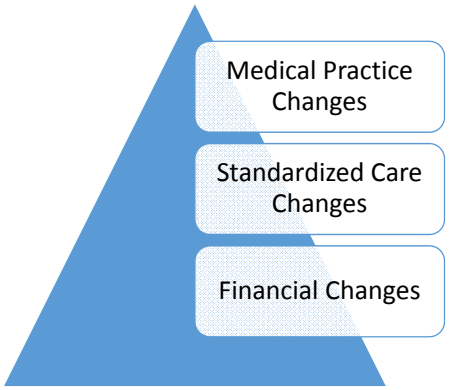

- Cost and Quality of care
- Patient safety and quality
- Access to Care

- Population Health Care Model
- Collaborations/Integrated Care
- Reduce Hospitalizations

- Changing Profit Margin
- Changing Reimbursement and Payment Models

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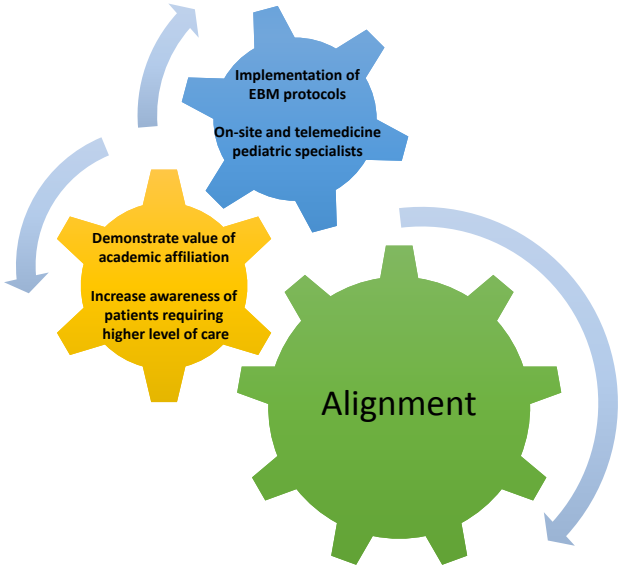
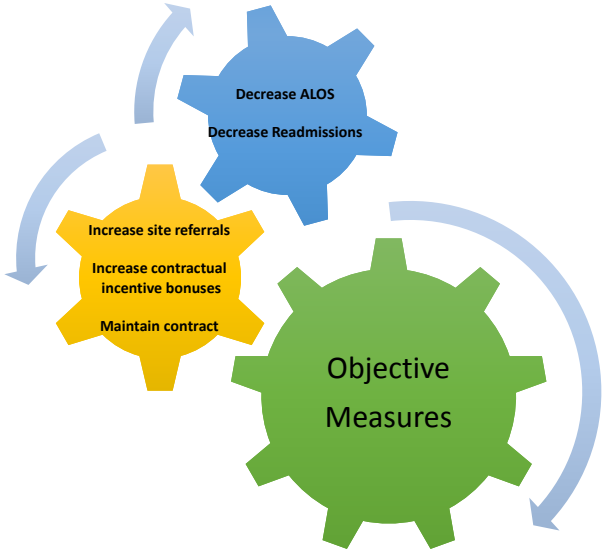
Case Presentations: Our Experiences with Collaboration and Strategic Alliances

Case #1

- Setting
  - Tertiary center in tri-state area with limited local competition
  - Community hospital in state with hospital capitation payment structure
- Situation
  - Community hospital with pediatric and neonatal care needs requiring assistance in developing a hospitalist program and general nursery coverage. Recent state and federal payment adjustments to a hospital "All Payer Model" (i.e. each hospital gets an annual "lump sum" for all adult medical care provided at their site)


Lower cost per patient
Decrease utilization
Acquire and maintain service contract
Increase referrals of high acuity patients
Motivation/ Driver
Community Hospital
Tertiary Center


Implementation of EBM protocols
On-site and telemedicine pediatric specialists
Demonstrate value of academic affiliation
Increase awareness of patients requiring higher level of care
Alignment
Community Hospital
Tertiary Center



Case #2

Setting:

- Community Hospital is geographically located in one of the fastest growing communities of the state with limited Pediatric support for the community
- Tertiary center is constantly at capacity with limited bed availability

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Case #2

Situation:

- Community Site requires Pediatric (general, ED/urgent care support, outpatient support) and Newborn support; there are no systems or process in place to support this goal. They have a SCN with neonatology support that attends high risk deliveries and sees well newborns
- Tertiary site recognizes the need for patient redistribution to regional sites in an effort to improve flow of patients throughout the system
- Leadership teams from both sites understood that collaboration and strategic alliances could help the organization and community best meet its prioritized needs

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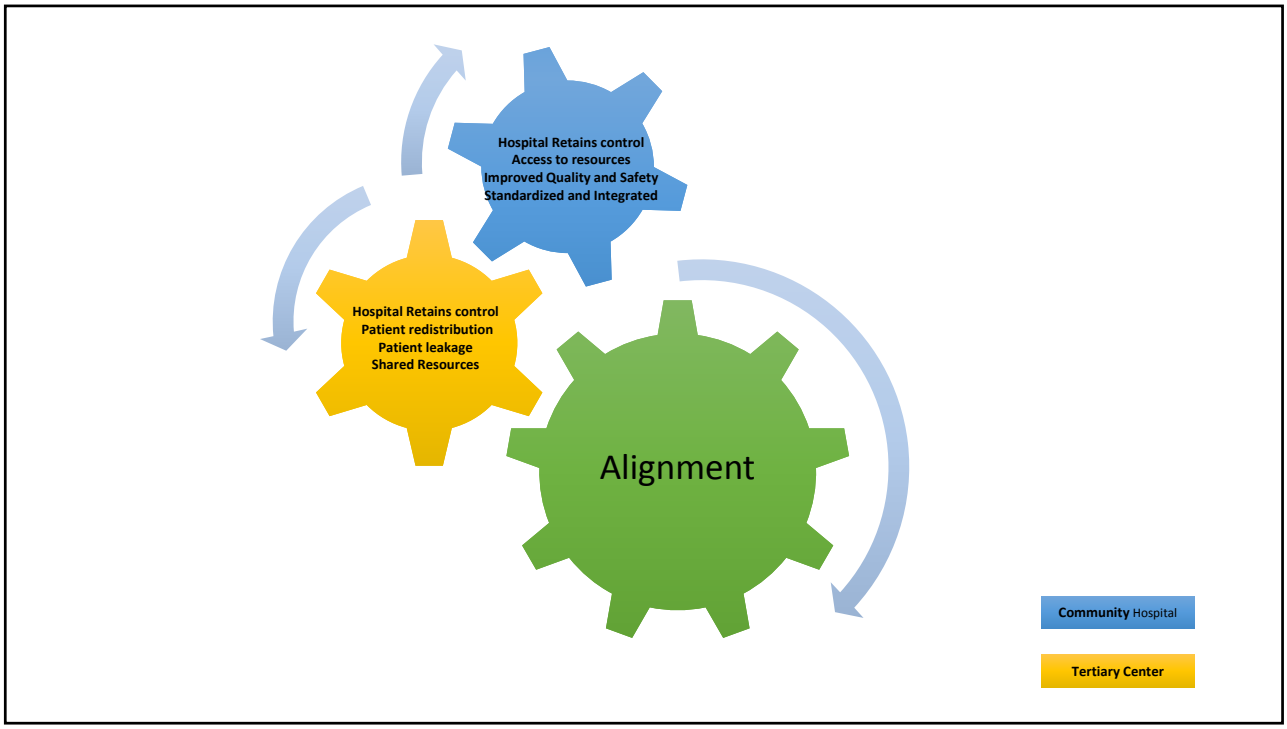
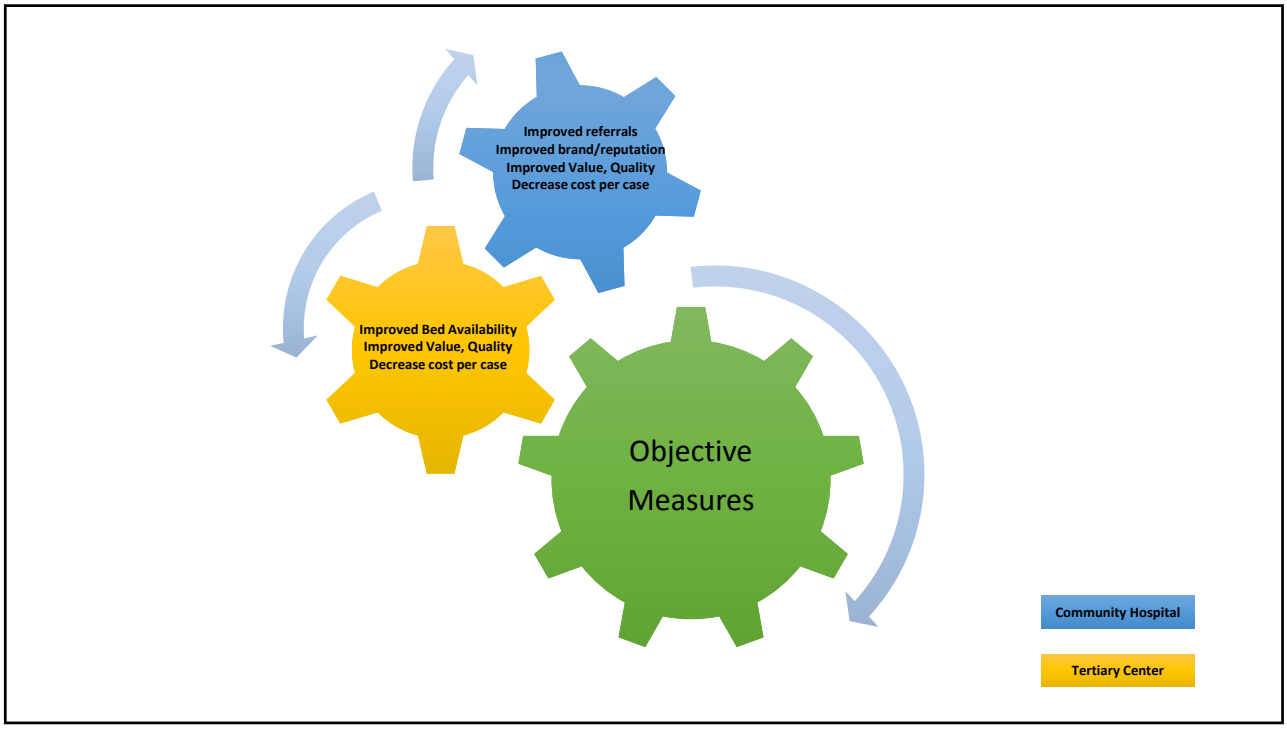
Community Hospital

Tertiary Center


Hospital Retains control
Access to resources
Improved Quality and Safety
Standardized and Integrated
Hospital Retains control
Patient redistribution
Patient leakage
Shared Resources
Alignment
Community Hospital
Tertiary Center


Improved referrals
Improved brand/reputation
Improved Value, Quality
Decrease cost per case
Improved Bed Availability
Improved Value, Quality
Decrease cost per case
Objective
Measures
Community Hospital
Tertiary Center

Case #3

- Setting
  - Community hospital with pediatric floor in suburban city with direct competition
  - Main site with pediatric floor, NICU, ob/nursery unit and specialty availability, North site with pediatric psychiatry unit, South Site with ER, peds floor, ob/nursery unit, and West Site with ER, ob/nursery unit.
  - Four tertiary Children's Hospitals about 180 miles in three different directions
- Situation
  - Community hospital with pediatric and neonatal care needs requiring assistance in pediatric specialty services. Our pediatricians and hospitalists utilize any of the three tertiary centers based on their patient needs. Direct competition with facility in same area that has more pediatric specialty services than our facility. Other facility with collaboration with major cancer center in Memphis, TN.

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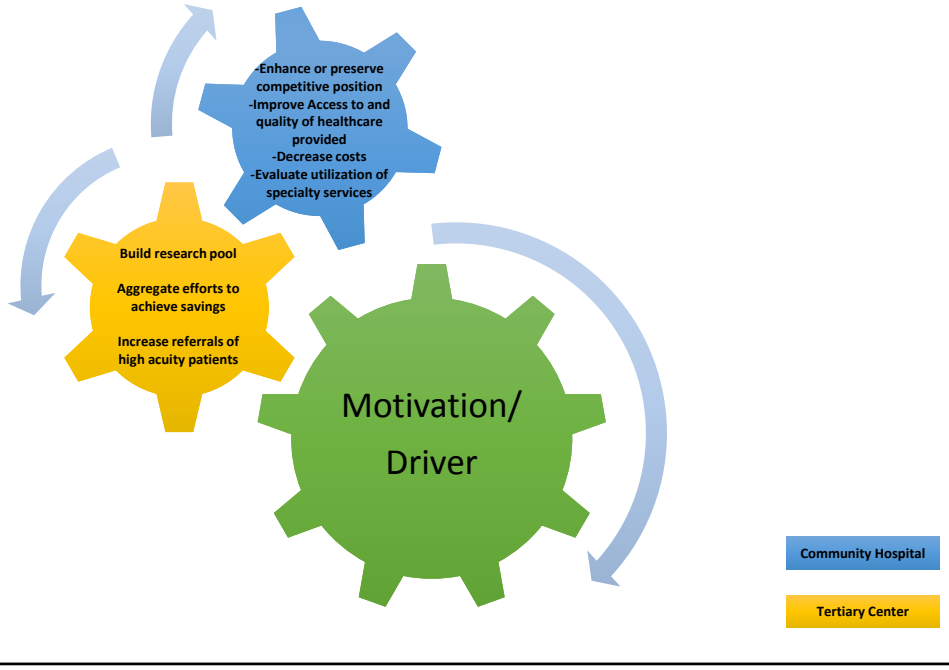
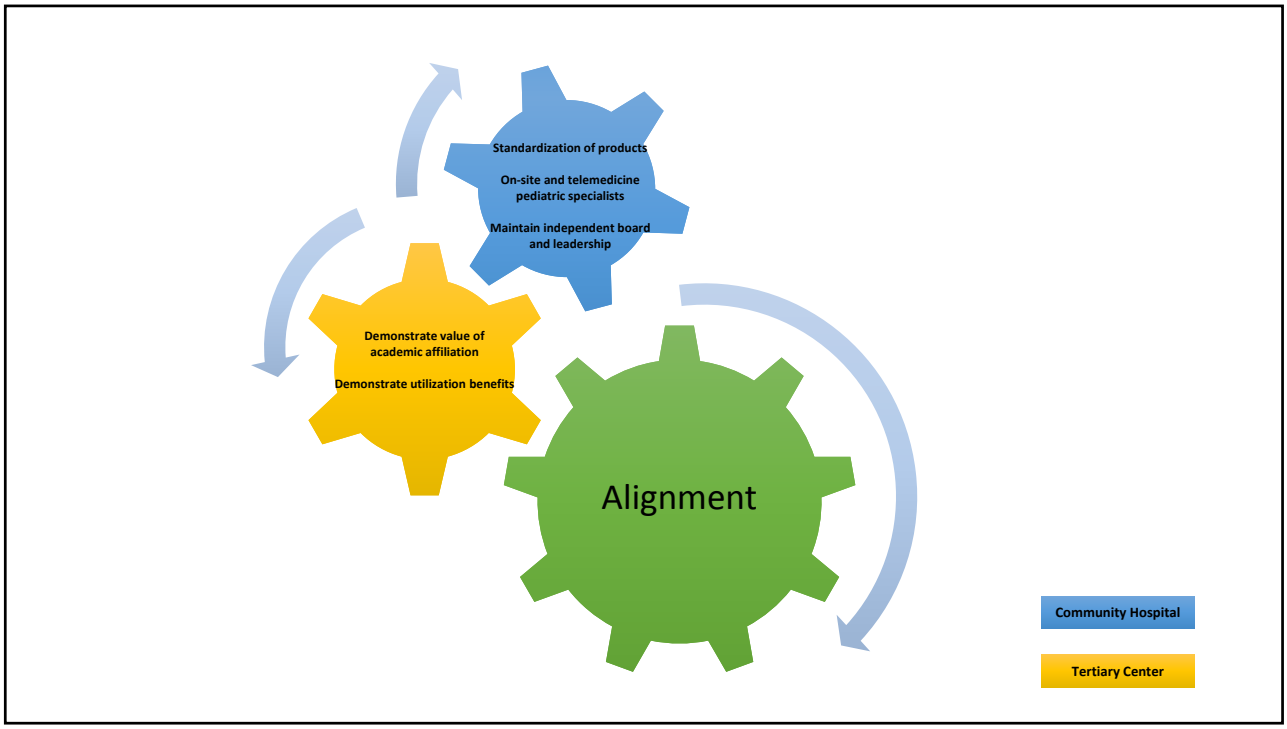
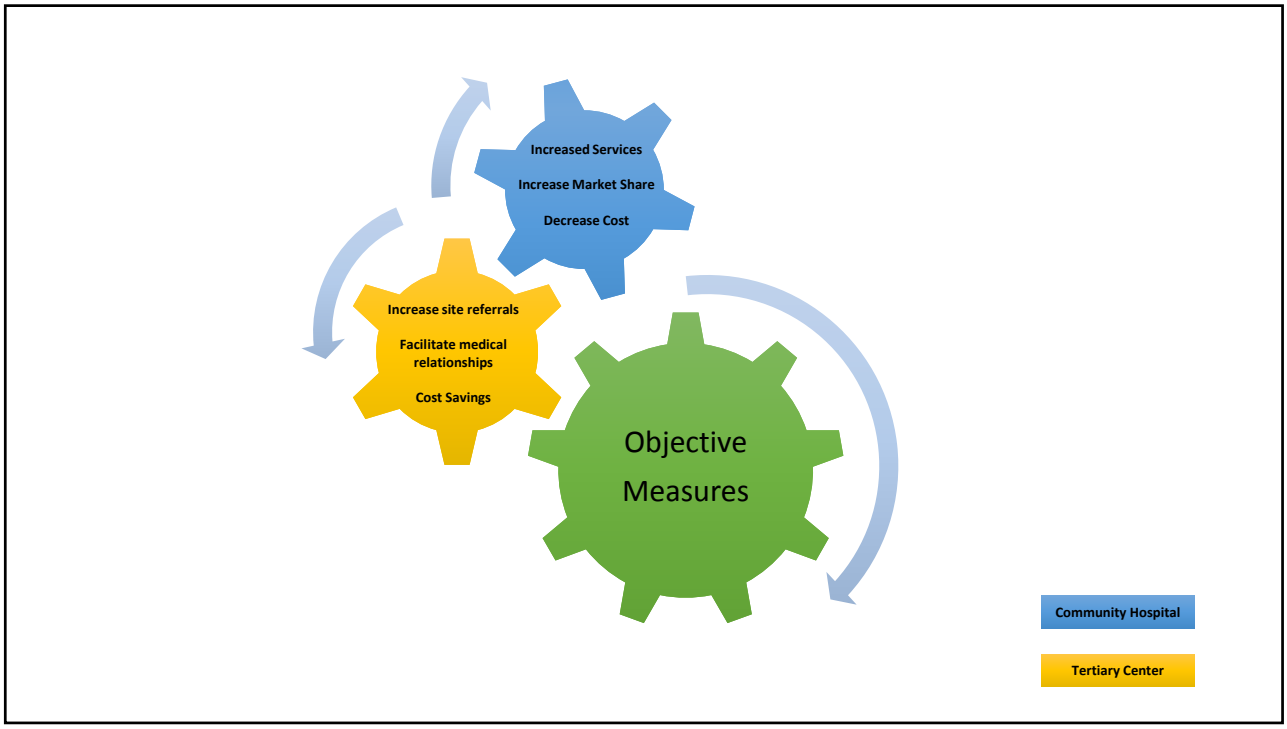



Standardization of products
On-site and telemedicine pediatric specialists
Maintain independent board and leadership
Demonstrate value of academic affiliation
Demonstrate utilization benefits
Alignment
Community Hospital
Tertiary Center


Increased Services
Increase Market Share
Decrease Cost
Increase site referrals
Facilitate medical relationships
Cost Savings
Objective Measures
Community Hospital
Tertiary Center

Approach to Collaboration

Refer to Handouts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Fundamental Ingredients for Collaboration and Integrated Care Principles

1. Professional and organizational alignment around shared goals
2. Supportive (and centrally facilitated) information, communication and technology environment
3. Effective clinical leadership
4. Aligned financial incentives

All of these ingredients may not be essential to the development of integrated care. They may, however, smooth or accelerate the process of integration.


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What Are Your Drivers?

Disclaimer: These are separated for clarity, but all institutions have overlap

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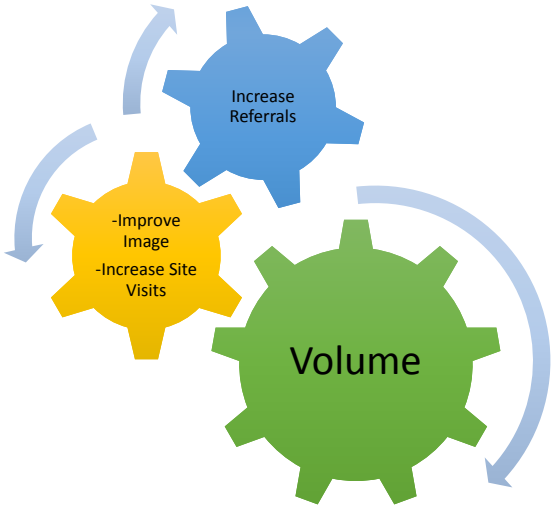
Volume Based



Community Hospital

Tertiary Center

Insurance/Reimbursement Model: Fee for service

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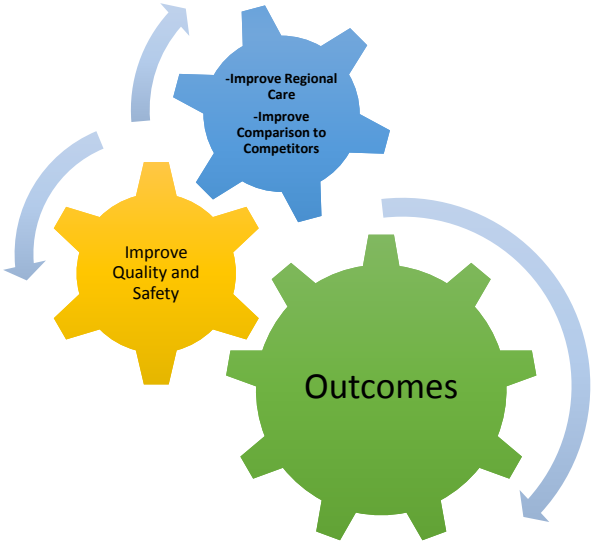
Outcome Based



Community Hospital

Tertiary Center

Insurance/Reimbursement Model:
-Value Based Purchasing
-Private Contracts with Metrics

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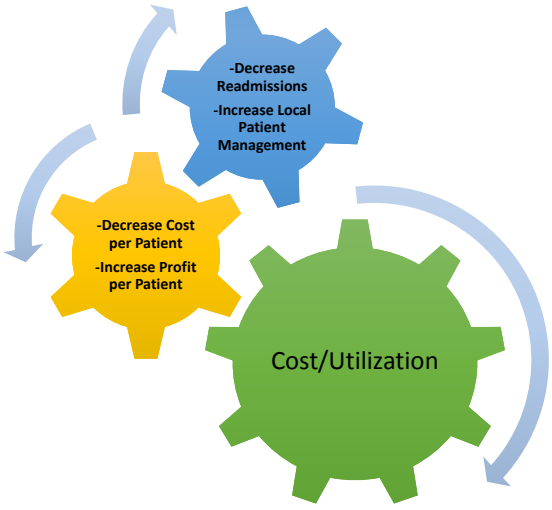
Cost/Utilization Based



Community Hospital

Tertiary Center

Insurance/Reimbursement Model:
-Bundled Payments
-Capitation

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Lessons Learned From Our Experience

1. *Integrated care is a strategy for improving patient care*

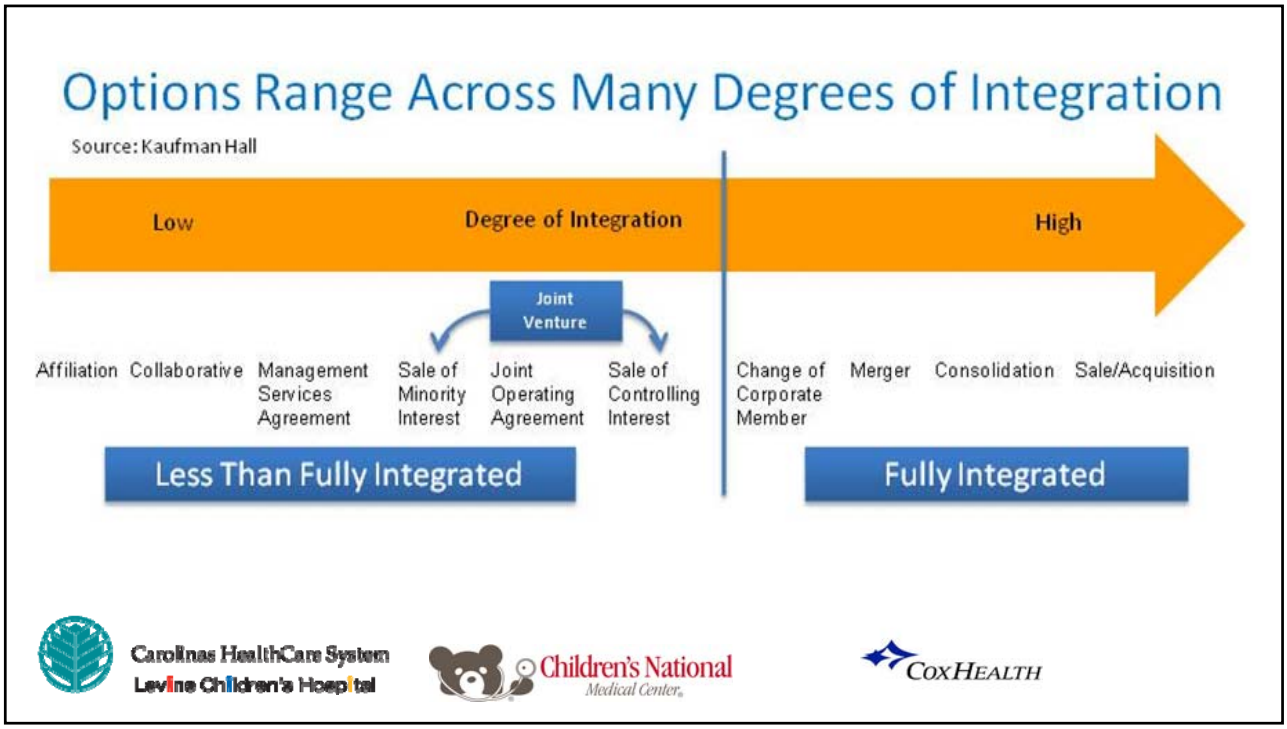
- Improved patient care by better coordination and access to care
- Intensity of integration is essential
- Starting with links across services, coordinating teams or pooling resources

2. Service User is the Organizing Principle

- Analysis of goals of integration is critical
  - Payment/Reimbursement models need to be considered to ensure continued longevity and viability of collaborative/integrative efforts
- Imperative to have a shared vision
  - Shapes how, when and where to integrate services
  - Use "Key Questions to Ask"

3. One model of collaboration does not fit all

- There is no one model of collaboration/integration that is suited to all
  - **Careful analysis is imperative**



4. It is only possible to improve what you measure

- Lack of evidence regarding impact of integration/collaboration
- Current evidence from a limited range of settings and initiatives
  - Focus on structure and process
  - Limited assessment of outcomes or costs
- Need to identify what integrated care initiatives work best

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References

Too Many to List, refer to Handouts

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Key questions to ask When Developing a Collaboration:

Goal

1. What are you seeking to achieve with a collaboration?
2. What is the problem being addressed?
3. Is collaborating the best solution?
4. What is the initial target service user group?
5. How will you ensure that service users remain the organizing principle for integrated care throughout?
6. How will you ensure organizational support for the goals of the project (senior administration, dedicated budget) ?

Context

1. Is the proposed collaboration associated with any other improvement programs/programs?
2. How will this impact local integration? What competing national or local agendas do you need to consider?
3. What service lines are involved and what is their role in relation to collaboration? (Public/Community, Acute Care, Primary Care) What are the potential consequences of integration on other parts of the health/social care economy?
4. How will you identify appropriate leaders from each organization or group to champion the change? How will you ensure open dialogue and consensus across stakeholders and/or organizations about shared objectives of integration and need to reallocate resources?

Type

1. What are the most important integrative process needed for your facility and what will achieve your goal (joint administrative process, aligning financial incentives, coordination of clinical services, developing shared values)?
2. What existing structures, partnerships and processes can you build on? What will you need to create?
3. How will commissioning arrangements support and enhance integration rather than perversely incentivize it?
4. How will you ensure effective data sharing and management of information?

Breadth

1. How will vertical or horizontal integration (i.e. integration across different levels and/or aspects of the care system) contribute to the success of your venture?
2. How will you avoid a possible disconnect (ex. Between horizontally integrated primary/community services and vertically integrated care pathways)
3. How will you address issues of choice, competition and contestability?
4. How will you keep momentum and ensure a sustained focus on integration?
5. How will you identify and align the incentives needed to support integration across professional groups, teams and organizations?

Intensity

1. How does the degree of integration/collaboration (full integration, coordination or linkage) relate to your goals and the local context in which you are working?
2. How will you ensure that collaboration within chosen part of the health economy does not result in appropriate and/or increased fragmentation elsewhere?

Terms and Concepts You Need To Know:

- **Integrated Care**
  - an organizing principle for care delivery
  - aims to improve patient care and experience through improved coordination

- **Integration**
  - combined set of methods, processes and models
  - Aims ***to achieve integrated care***
  - shared vision by all stakeholders (planning, financial, service providers)
  - employ a combination of processes and mechanisms
  - ensure that the **patient's perspective** remains a central **organizing principle** throughout

- **Horizontal Integration** focuses on competing or collaborating organizations, networks or groups in the health economy
  - Ex grouping outpatient clinics within a geographic network of providers

- **Vertical integration** focuses on networks and groups at different stages of care within the health economy (the care pathway)
  - Ex the drawing together of a hospital with local community services.

- **Intensity of Integration**
- Full integration: Formally pooling resources, allowing a new organization to be created alongside development of comprehensive services attuned to the needs of specific patient groups.

- Coordination: Operating through existing organizational units so as to coordinate different health services, share clinical information and manage transition of patients between different units (chains of care, care networks).

- Linkage: Taking place between existing organizational units with a view to referring patients to the right unit at the right time, and facilitating communication between professionals involved in order to promote continuity of care. Responsibilities are clearly aligned to different groups with no cost shifting.

Possible Relationship Types

- **Merger of a not-for-profit (NFP) hospital into a NFP system.** Usually the merger parent board assumes all assets and liabilities of the newly merged organization. In some cases, the local board continues to exist and may have selected responsibilities such as quality, credentialing, or community need.
- **Merger of an NFP hospital into a for-profit (FP) system.** This is typically an acquisition. The acquired NFP is valued, and the value (net of liabilities) often becomes a community foundation.
- **Merger of a NFP hospital into a FP/NFP joint venture.** Some transactions involve less than a 100 percent purchase, with the local entity continuing as a joint venture partner.
- **Merger of a NFP into a FP system plus a "quality partner"** FP systems sometimes link with an academic medical center or other organization known for its quality. The “quality partner” may be a joint venture owner of the acquired hospital.
- **Contractual system.** Not all consolidated systems are merged entities. For example, local boards within the system might retain all fiduciary powers. The top leaders of the local hospital or system are employed by the larger system in order to coordinate strategies; however, the overall arrangement may be a renewable contractual relationship.
- **Collaborative partnerships.** Health systems are increasingly joining, often through contractual joint ventures, to address selected issues together – such as revenue cycle, supply chain, or regional network formation. Examples include the BJC Collaborative, AllSpire Health Partners, and the Integrated Health Network of Wisconsin.
- **"Super" accountable care organization/clinically integrated network (ACO/CIN).** Increasingly, clinically integrated networks recognize the opportunity to achieve economies (e.g., sharing population health infrastructure and expertise) by combining with each other.
- **Health plan/provider partnership.** These "vertical consolidations" take many forms. In some cases, a health plan, physician group(s), and hospital systems enter a joint venture relationship to serve a large employer. In some cases, health plans have acquired physician groups.
- **Employer/provider partnership.** These contractual relationships, usually involving very large employers or a group of large employers, relate directly with provider networks.

Models of Sustainable Integration

Now that you have a better understanding of the elements of successful integration in place, within which model will you integrate your physician practices?

- **Direct Employment:** To be sure, **e**mploying physicians has a lot of advantages and just as many disadvantages. If direct employment is your preferred model, be prepared to spend enough time and allocate enough resources to help previously independent physicians successfully transition to becoming employees.
- **Foundation Models:** Some states have Corporate Practice Acts that preclude direct employment. One vehicle that can be used is the “foundation model”. Popular in California, this model allows hospitals and health systems to contract with physician groups through professional services agreements. The foundation model achieves many

of the same benefits as direct employment while still preserving a measure of independence.

- **Independent Physicians:** It is the wisest of health systems that recognize that they can't employ every doctor in town. Most systems focus so much on employment that they neglect, or even worse, alienate independents. Aligning and engaging independent physicians may need to be as much a part of your integration strategy as employment models.
- **Contracted Physician Services:** Most hospitals have contracted physician services. These might include emergency departments, anesthesia, radiology or clinical laboratory services. It is important to recognize that these physicians need to be integrated as well. Designing contracts with them that reflect the strategic goals of your otherwise integrated system is crucial. It doesn't make a lot of sense to focus your efforts on your employed physicians by building compensation models that reward quality and efficiency while forgetting that your contracted emergency physicians may have completely misaligned incentives.