ROUNDTABLE

Construction Ahead: Building the Care Continuum

Hospitals and health systems increasingly must work with providers across the continuum of care to meet the demands of value-based purchasing, reduced reimbursements, new payment structures, and readmissions penalties. But replacing the current fragmented system of care will require nothing less than a business and clinical transformation. Healthcare executives say that care coordination and the care continuum represents their single greatest organizational challenge (*HealthLeaders Media Industry Survey 2013, CEO Report*). Executives and physicians must work closely on patient transitions, including a population approach to patient care, coordinated financial and clinical operations, and healthcare IT expenditures. Alignment—the sought-after state of agreement between hospitals and physicians—has never been more critical or challenging.

PANELIST PROFILES

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Roundtable Highlights

HEALTHLEADERS MEDIA: *Where is each of your organizations in building a continuum of care, and what are the current plans?*

RAND WORTMAN: I find that we're ahead of many of organizations, especially community hospitals, but I see others that are way, way ahead of us. We had begun recruiting and employing physicians years ago, because of our location [in rural Washington]. It became clear we were not going to have a medical staff if we didn't have an employment model, so we've been employing physicians since January of '07 and we have around 100—over 100 if you count the hospital-based physicians. About 80 are community-based physicians, both primary care and specialty. But we're still struggling with how do you put it together, how do you build the culture. We're nowhere near what I would call the Kaiser model, where you ... have put together enough pathways and so forth to actually get significant reductions in cost. We've been very focused on the quality piece. We have a partnership where we own 50% of a home health agency, so we're into ... long-term care, and we have multiple nursing homes in our market where we are providing either the medical director or a full-time nurse practitioner in that facility. ... So we're headed down the road, but it's clear we have a long way to go.

HUMAYUN KHAN: The focus on providing care throughout the continuum of the patient has set in motion a trend of acquisitions and mergers. We have not gone on that path in western Wisconsin. We are looking more at partnerships because all of what you do and your strategy is dependent on the market that you are in. Our market was more favorable for having partnerships with physicians. We have a large independent physician organization. ... We are dealing with essentially two different physician entities. Instead of duplicating our services, we are on the path of forming a clinical integration network. ... I think this strategy is going to [help] us, not only with the care provided within the community, but also when we go into contracts with third parties.

JORDAN ASHER: MissionPoint Health Partners is a fairly new company, started by Saint Thomas Health of Ascension Health, which is focused on a clinically integrated network that is accountable for managing the care of different populations. We look at what we do from four perspectives: How do we improve the healthcare of the community? How do we lower costs for that healthcare? How do we increase patient satisfaction? And how do we increase provider satisfaction? With the latter being big for us from the physician perspective—how do we provide services and models that help the physician care for their patients? We're about 1,400 strong, mostly private physicians, clinically integrated with five inpatient facilities, about 100 ambulatory sites of care, and other pieces of the integrated model, including home health, long-term facilities, hospice, so on and so forth, all working together from a service standpoint, a quality standpoint, and a cost standpoint.

> **"We look at what we do from four perspectives:** How do we improve the healthcare of the community? How do we lower costs for that healthcare? How do we increase patient satisfaction? And how do we increase provider satisfaction?"

Jordan Asher, MD
CMO and CIO
MissionPoint Health Partners

HEALTHLEADERS: *Does MissionPoint own those other pieces?*

ASHER: No. They're pure partnerships and contract relationships.

OLIVER ROGERS: TeamHealth is a little different from everything that everyone else has described in that we're often described as a guest in somebody else's house. TeamHealth started as an ED outsourcing company years ago. ... Today, we're a health solutions company ... not just a staffing company—we provide a comprehensive array of services to hospitals, including emergency medicine, hospital medicine, anesthesia, general surgery, orthopedic surgery, OB-GYN hospitalists, urgent care, and nurse call centers. We own and manage urgent care centers, but always in partnership with hospitals. Everything that we do is very hospital-centric. The reason for that is that in our view, with all the changes that are coming to healthcare, there are going to be

outpatient physicians and inpatient physicians, and hospitals are going to be a relevant part of what goes on. So we've tried to develop the healthcare solutions that our hospital partners need and have requested. ... What we provide to hospitals is an alternative to the employment model. We're the largest physician group in the country. We work with close to 9,000 providers around the country. We have the largest Patient Safety Organization in the country. We invest a lot of time and resources to answer the questions: How do we develop pathways, and how do we develop quality outcomes for our hospital partners? How do we work with members of a private medical staff as they enter into this new world of uncertainty?

HEALTHLEADERS: *When it comes to your strategies and the situations that each of you faces in building the care continuum, what are your big bets and what could blow that up?*

Humayun Khan, MD
Chief Medical Officer
St. Joseph's Hospital and Sacred Heart Hospital

WORTMAN: Physician employment is a big gamble. It costs big dollars to get into that game. ... Since the federal government doesn't reimburse enough to produce enough physicians in the United States, the hospitals are all competing for those physicians as we employ them, and we're driving the compensation up. So in some ways we're our own worst enemy. I don't see that ending anytime soon. By the time we begin producing enough physicians, it's going to be so many years down the road that we're already going to have buried ourselves under a very expensive physician compensation structure. ... The real risk for us has been the physician practices.

ASHER: The new game is a negative-sum dollar game. You're just not moving dollars around; you're saying, "How do you take dollars out of the system?" which then could create winners and losers. So strategically, the question becomes: How do you survive and thrive focused on one's mission when you know there's less money to go around? That is our biggest risk in healthcare today.

KHAN: Whenever you are going into a clinically integrated network, that means partnership. ... Physician groups have typically been quite autonomous. Now, to come into a partnership and try to meet certain goals is suffocating for many physician groups that we are dealing with. Simple stuff like deployment of EHR in their offices—we deal with one EHR company because we wanted to streamline the whole EHR process, but many physicians, for right or wrong reasons, have reservations in using that EHR company. So [the challenges are] buy-in from physicians, and then how do you disperse the shared savings. I agree with Dr. Asher wholeheartedly that there will be winners and losers.

HEALTHLEADERS MEDIA: *We've been talking about physician leadership and alignment between hospitals and physicians, but there's another constituency that I hear a lot of difficulty about: nurses, midlevels, and the multiple cadres of other workers who are particularly important when you're talking about the care continuum.*

ASHER: Yeah, we're having a struggle because one of our main focuses from a service standpoint is what we call our Health Partner model. What we have found is those types of healthcare workers do not exist in sufficient numbers. So we're having to create a whole new workforce from that standpoint. I can't use nurse practitioners or PAs because my financial model doesn't allow that. In this market [in central Tennessee], they're almost as expensive as doctors, so it doesn't really do us any good to do that. ... So that is definitely an area that I think will continue to be a problem. ... How do we train for what we feel the healthcare provider of the future looks like? I think it's going to look very different than the different types of healthcare providers that we have now.

WORTMAN: In Washington state, we're fairly regulated and every role is certified or licensed. One of the barriers we have to overcome as an industry is to change all that. If we want to accomplish A, whatever that is, we can't just go find the person or persons who are most capable of making that change. You have to start by figuring out which certified classification or license does it, which immediately leads to the higher costs, and now you have practice limits as to what they're allowed to do. It's a major problem for our society, for our industry.

KHAN: For any process, you have a finite amount of input and then you try to take care of any variation within that process to get the outcomes that you're looking for. So you have to map the inputs into the system, whatever the process is. The nurses and staff, even the unit secretaries on the front desk, are providers. They are all part of the input, along with physicians. What we have done is that we have defined process flows for specific metrics, core measures, and so on. By doing that, we have assigned responsibilities and we are in the process of defining accountabilities, as well as figuring out how we incentivize people. How do we incentivize your behavior? We can put some pay at stake—say, 10% of nurses' pay, which is not very different for physicians.

ROGERS: You have to figure out not only what's the most cost-effective site for the provision of care, but also what's the appropriate site of care. A hospital bed versus an ER visit versus a home health visit—where's the best place to try to intervene with this patient? And then who can do it? We work extensively with advanced practice clinicians, APCs, and think about how do we best leverage those practitioners in conjunction with our physicians.

ASHER: I'm not necessarily sure there is a physician shortage. I think there's a distribution issue. We are inviting and allowing and incentivizing people to work way below their skill set. Me taking care of a sore throat or a rash or a bug bite—I love doing that because it's easy bread and butter from a dollar perspective, but it's a huge misuse of a resource. When you're using resources in that manner, you create a shortage that I'm not really sure is truly there.

KHAN: This distribution is going to worsen with the health insurance exchanges coming six months from now. I'm not talking about a specific market, I'm talking about the national level, with less primary care providers for a lot more people who will be insured and will be seeking care. So the question becomes: From whom do they seek primary care services? Will there be more allied providers providing the care? Will there be more primary care physicians providing the care?

HEALTHLEADERS MEDIA: *Much of the talk about care coordination concerns back-and-forth readmissions between hospitals and nursing homes, skilled nursing facilities, etc. How big of an issue is that for you?*

ASHER: Postacute care, from a dollar perspective, is our second biggest bucket—and not overly far off from the inpatient amount. Now that's our Medicare data. Obviously different populations are different.

ROGERS: It's a huge issue. If you look at the penalties that were enacted, DRG payments reduced up to 1% in 2013, 2% in 2014, 3% in 2015+. ... For a lot of hospitals, it's the difference between profitability and nonprofitability.

HEALTHLEADERS MEDIA: *When you're setting up agreements with new partners, what are the success factors?*

ASHER: We did a big literature search of what drives appropriate usage and what decreases readmissions from nursing homes, and it turned out to be, interestingly enough, their RN-to-patient ratio as well as their focus on getting DNRs. Those were the two variables that are sort of the starting grounds. So I won't even talk to you unless you have those metrics. And then you have to be able to provide us with an HL7 feed so I know when your patients and my patients are there. You have to have a dedicated account manager for us for the patients. You have to share your satisfaction scores with us. And you have to be willing to create pathways on very specific areas. We're really aiming to work with people who are saying they're willing to work on those things and share that information.

ROGERS: It's an interesting trend that more and more hospitals are starting to work with the SNFs—whether it's done directly at the hospital or they have the hospital medicine physicians or APCs working in the SNFs. Now they have a relationship providing care. There are two reasons for this. One is it's good medicine; it takes care of the patients and there is continuity of care. ... But it's also to stop inappropriate readmissions. ... If a patient fell [at a skilled nursing facility], let me reevaluate that patient right here before we send him over to the hospital because we can probably keep him here.

HEALTHLEADERS MEDIA: *Some of the players in the care continuum might not end up being partners. They might be competitors that eat your lunch.*

WORTMAN: They've already taken all of it, or most of it. The only orthopedics we do is inpatient surgery. Everything else—the MRIs, the physical therapy, the outpatient surgery—that's been gone for years. There's more to go; I'm sure we're going to move more toward the outpatient sector. But the reality is we respond as an industry very well to whatever incentives the payers put out there, and the physicians responded very aggressively to the [incentives] that are lucrative.

Oliver Rogers
President,
Hospital-Based Services
TeamHealth

ROGERS: I think the continuum of care ... is in some ways a euphemism for a series of networks, provider networks, that will come together but will still compete. They will compete to attract lives. ... There will be those people who naturally will align with others because of their historic relationships with one another. But then I think you'll also see a very, very heavy dose of economic credentialing. There will be ... the providers who aren't performing, so they're in my lower quadrant, they don't get the business. They are not of value to the dance. ... I think we'll see more and more people saying, "In this continuum, there are certain providers that I've got to have, and then there are others with whom I have some choices. I have the ability to be selective who I partner with." That will be driven by the value-based purchasing performance of the providers.

WORTMAN: We have multiple payers that are already saying, "We're creating tier 1, 2, and 3, and we've decided that the physicians and nursing homes and hospitals—you name the type of provider—that will be in tier 1 are the ones that have great outcomes, lower cost, they're collaborative, they communicate, and so on." The ones who abuse the system are going to go to level 3 or level 4 and they'll get what's left over in the long run.

ROGERS: Well, look at some of the major … employers, like the Walmarts and the Costcos, and some of the others who have said, "If you want to have X, Y, or Z procedures done, you can have it done, but you're going to go to the Cleveland Clinic or the Mayo Clinic." … I think we'll just see that stratification continue.

Rand Wortman
President & CEO
Kadlec Health System

HEALTHLEADERS MEDIA: *Hospitals are expecting an influx of patients because of health insurance exchanges. What happens to the care continuum?*

KHAN: In general, the impetus for all of this healthcare reform is not consolidation but collaboration. So as the demand for the product goes up, you've got to collaborate much more than what you have in the past. We are going to see exactly how it will all pan out and what's going to happen as the health insurance exchange kicks in. It will be a tough market initially. But the point to remember is that it is already a broken system. So it's not like everything was hunky-dory before and that now we are getting into a tougher situation.

ROGERS: I think a couple things are going to happen. If I understand the exchanges correctly, your multiples of poverty level determines what it costs you. I think there's going to be a huge number of people who are not at the 100% poverty level, and those people will get [coverage]. But the next couple of tiers won't spend the money to get [coverage], and they will remain uncovered. … People think, "Oh, everybody's going to be covered," but I think there's going to be a large percentage that remains uncovered. The big concern I have is not can we accommodate them; our system can accommodate what's probably going to happen. It's that the bottom tier representing the most poverty-stricken has the worst health, and we're going to have this incredible bolus of really sick people who are going to require extensive resources. I'm really concerned that the organizations that get a lowball quote for exchange participation early on are going to take a financial hit because of the severity of all the sick patients that join the system. … There will be an incredible amount of really sick people who have been undiagnosed and untreated for a long time. In theory, you work through that in two or three or four years down the road, and it will level out. But I think when people get into [the exchanges] in a big way, early on they may be in for a real surprise.

ASHER: Well, I'm excited we're going to have this problem. It's good for the population.

HEALTHLEADERS MEDIA: *How do you establish a standard of organizational culture across care continuum partners?*

KHAN: You've got to share the basic beliefs, the assumptions, and the core values at a personal and organizational level. Culture is probably one of the hardest things to change. So this question is a million-dollar question: How do you do it? Culture, as you know, can really make or break any organization or any individual. The makers or breakers, as I see it, are your physician leaders, because there is so much intricate clinical knowledge and information that I think only physician leaders can clearly communicate. I think physicians are really driven by science and data—just like, for example, following evidence-based guidelines.

WORTMAN: You asked about culture, but I think the other piece of it is respect. I'm adamant that my team has to deal with physicians with respect, and frankly not all hospital systems do. Some are better than others. That's important. Part of it is consistency in how the administration behaves or the institution behaves. When you deceive them, they never forget.

ROGERS: I want to comment on the leadership issue because I think that's a big part of it. … It's absolutely critical as we go forward with whatever the alignment strategies are that we enable our physicians to be leaders. We can't just assume that they are natural leaders, because none of us are. … You learn by a lot of trial and error over the years. None of us will ever be perfect, but you get better because you've had a lot of repetition. If you're a physician, between the time you spent in medical school, residency, and everything else, by the time you're just in practice and starting to come into a leadership role, you're in the 45- to 50-year-old age range. How do we jump-start the leadership skills for these physicians, because we don't have time for them to learn by the school of hard knocks? I think that emphasis on formal leadership training is going to be critical to this process of alignment.

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