Becoming the Group of Choice

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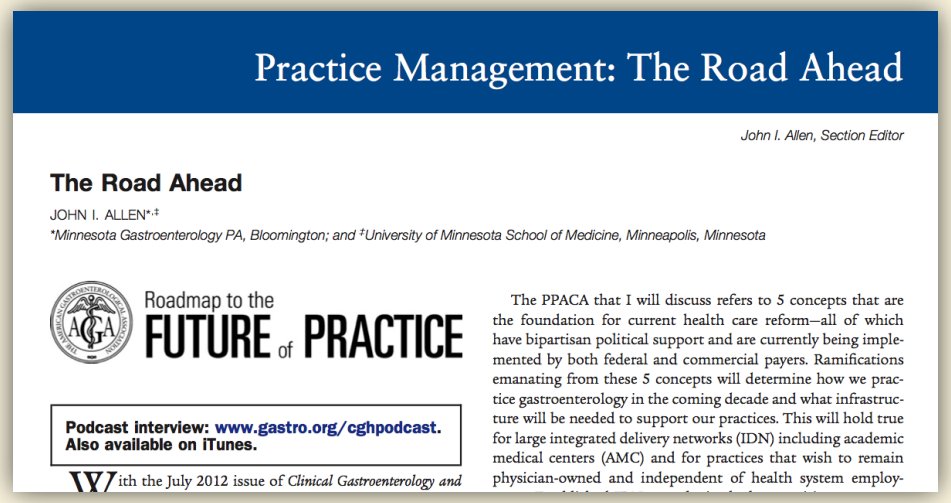
Trends Coming No Matter What



Practice Management: The Road Ahead

John I. Allen, Section Editor

The Road Ahead

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Roadmap to the FUTURE of PRACTICE

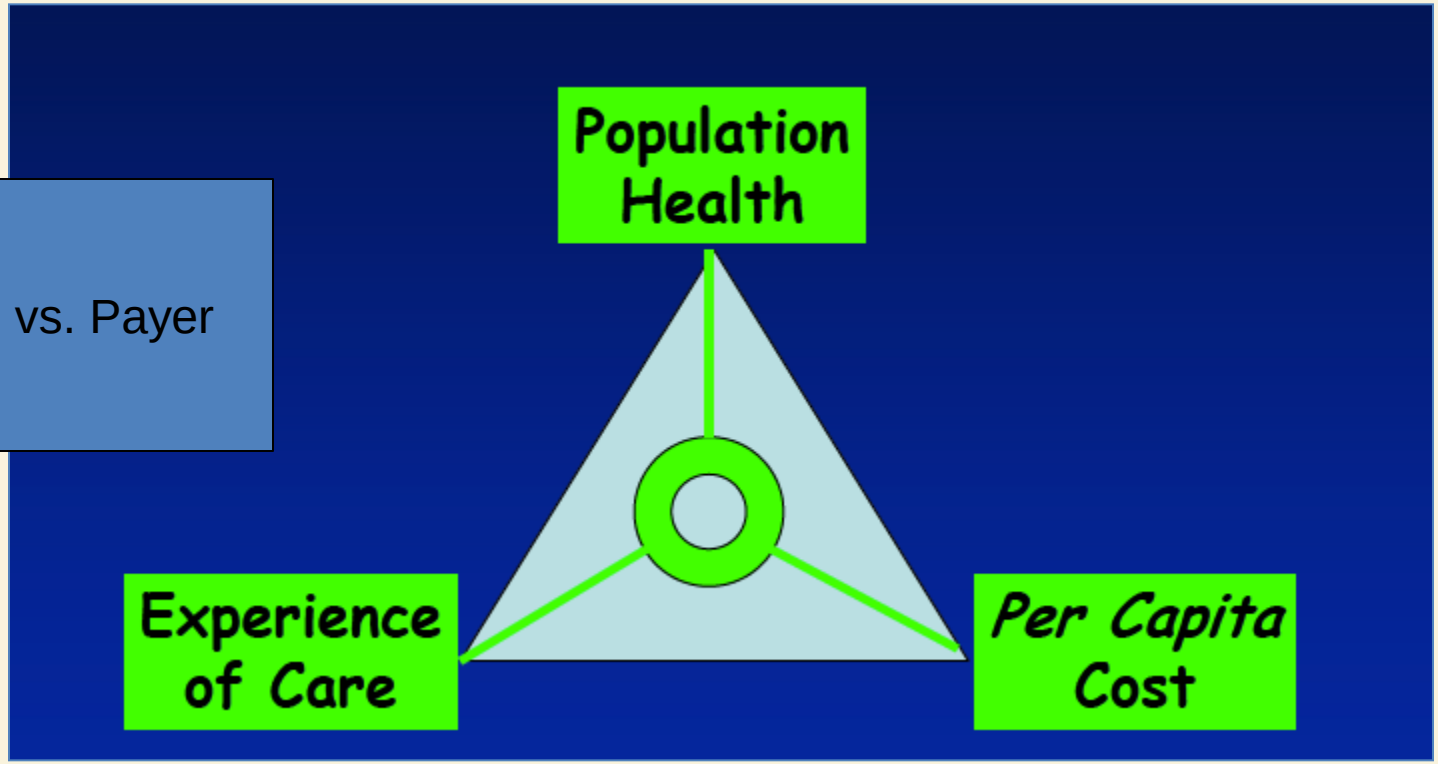
Podcast interview: www.gastro.org/cghpodcast. Also available on iTunes.

With the July 2012 issue of *Clinical Gastroenterology and*

The PPACA that I will discuss refers to 5 concepts that are the foundation for current health care reform—all of which have bipartisan political support and are currently being implemented by both federal and commercial payers. Ramifications emanating from these 5 concepts will determine how we practice gastroenterology in the coming decade and what infrastructure will be needed to support our practices. This will hold true for large integrated delivery networks (IDN) including academic medical centers (AMC) and for practices that wish to remain physician-owned and independent of health system employ-

P	Performance Measurement
P	Population Management
A	Aggregation
C	Cost
A	Accountability

TRIPLE AIM



Hospital vs. Payer

Hospitals as Drivers

- Stanford and UCSF 25 miles apart.
- Both just built new pediatric hospitals or wings.
- Drive 50 miles from S.F. to San Jose.
- Pass 10 hospitals doing cardiovascular surgery.
- 3 do less than 300 cases/year.
- When doing 1 case/day impossible to run cost-effectively.
- Consolidation would raise quality and lower cost.
- No hospital CEO will close the CV service to lower health care cost trajectory.

Individuals in all these hospitals planned for an increased volume, revenue, and profit margin, not a decrease in the health care cost trajectory.

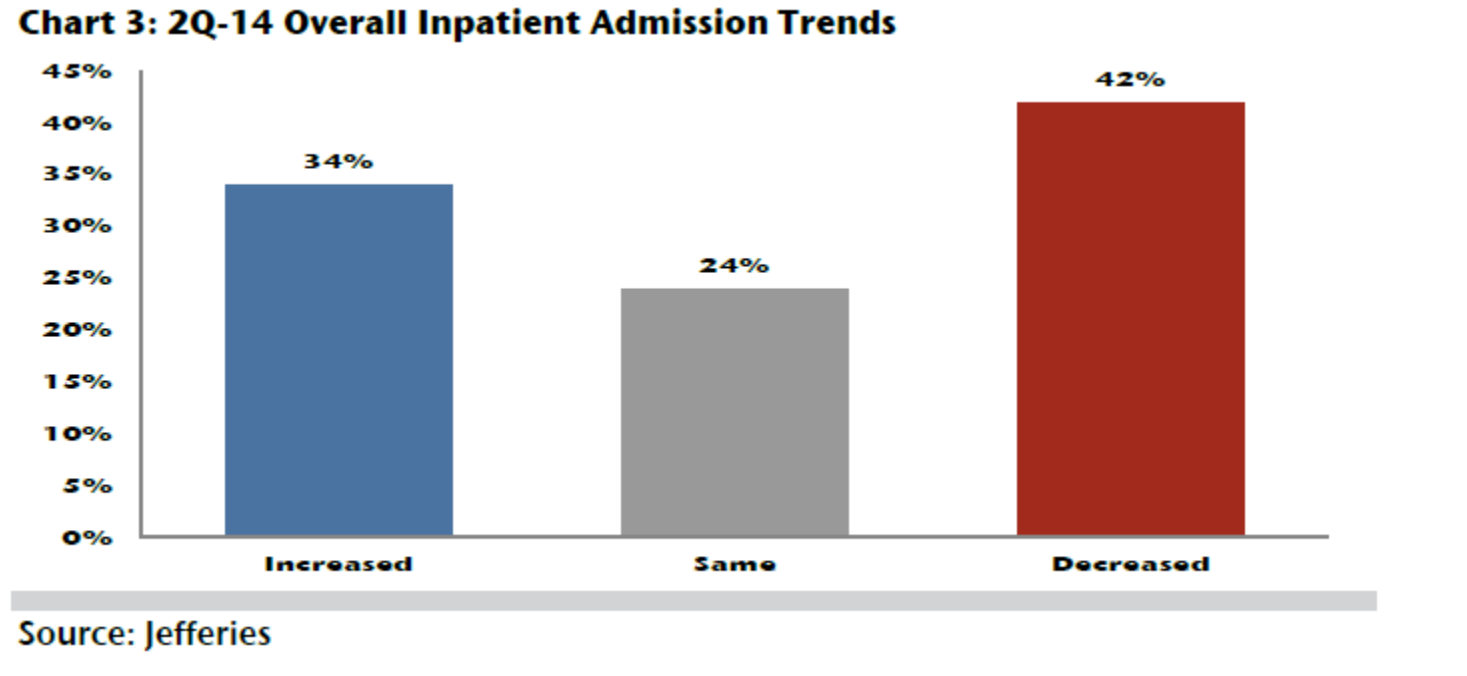
Hospital Motivation to Employ MDs

- Anticipation of ACOs/ CINs/ IDNs.
- Employed MD's subject to pressures to act in compliance with goals of employer rather than interest of patients.
- Less physician autonomy and leverage.

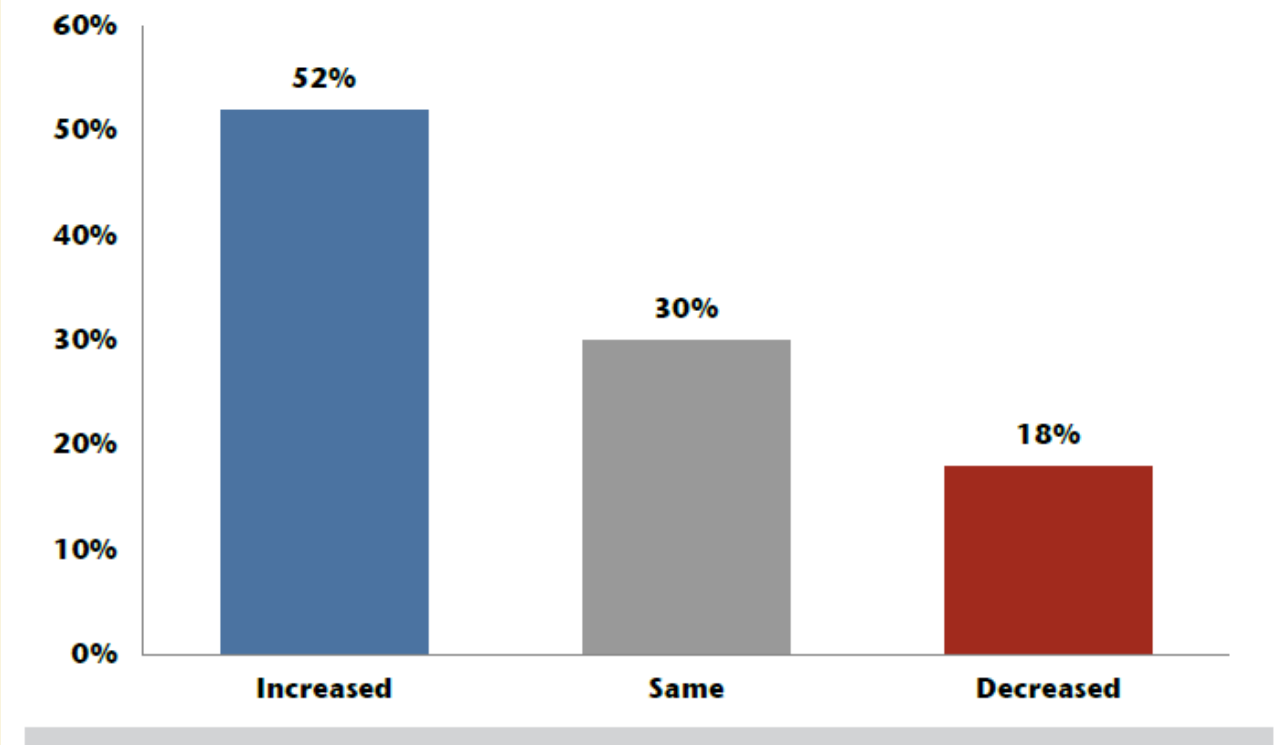
Hospital Motivation to Employ MDs

- Reduce competition from effective MD group aggregation.
- Less competition converts to higher prices.

Hospital Inpatient Volume Trends



Hospital Outpatient Volume Trends



Source: Jefferies

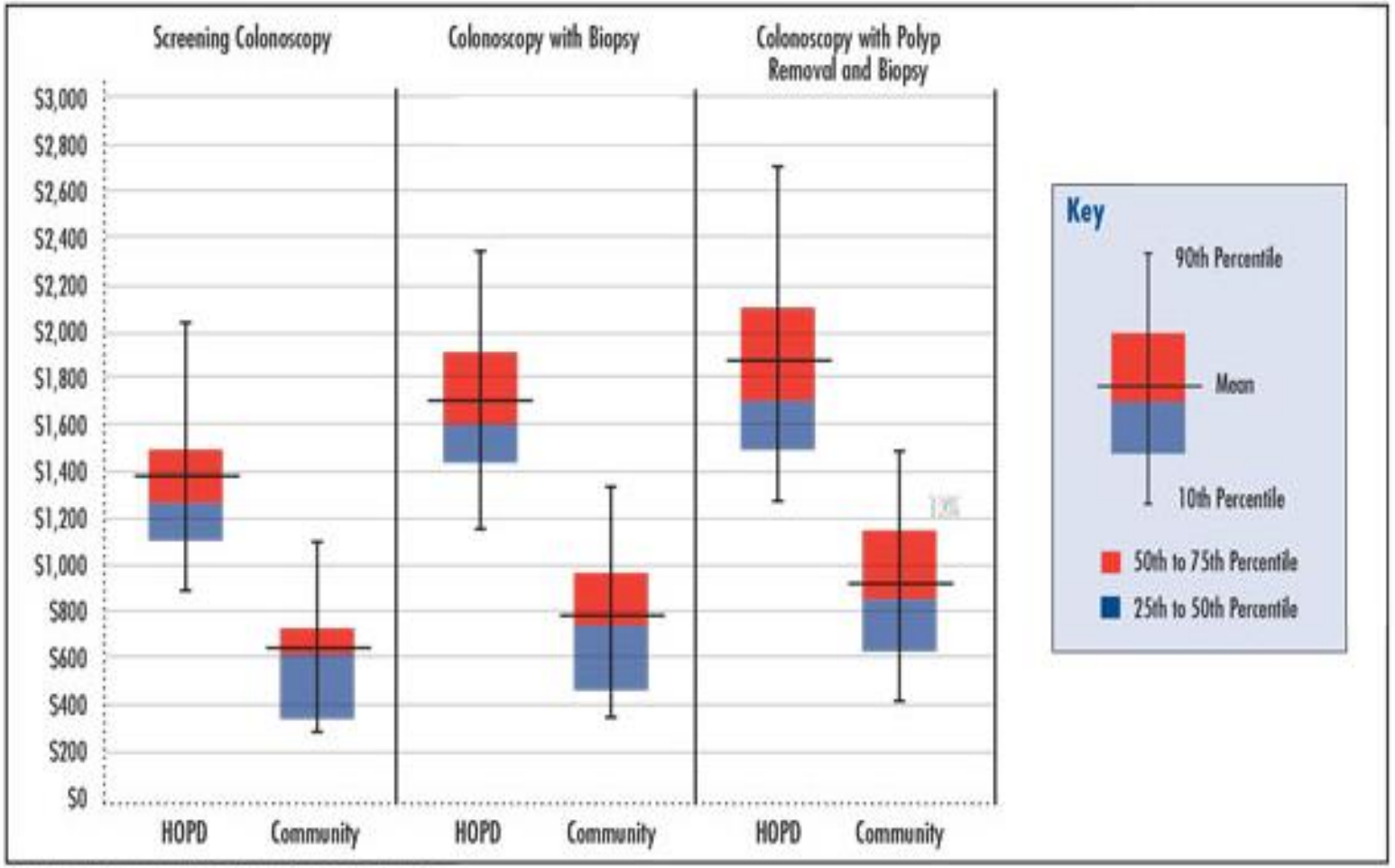
Brian Tanquilut, Equity Analyst, (615) 963-8338, btanquilut@jefferies.com

Employment of physicians and acquisition of physician practices by hospitals, along with hospitals purchasing ambulatory surgical centers and other community-based facilities, are resulting in more and more services being paid at higher hospital outpatient rates.

The payment differentials likely have accelerated the trend of hospital acquisition of physician practices, which is contributing to growing provider market power.

Increased spending on HOPD services is playing a major role in overall spending growth for both publicly and privately insured people because of increases in both prices and quantities.

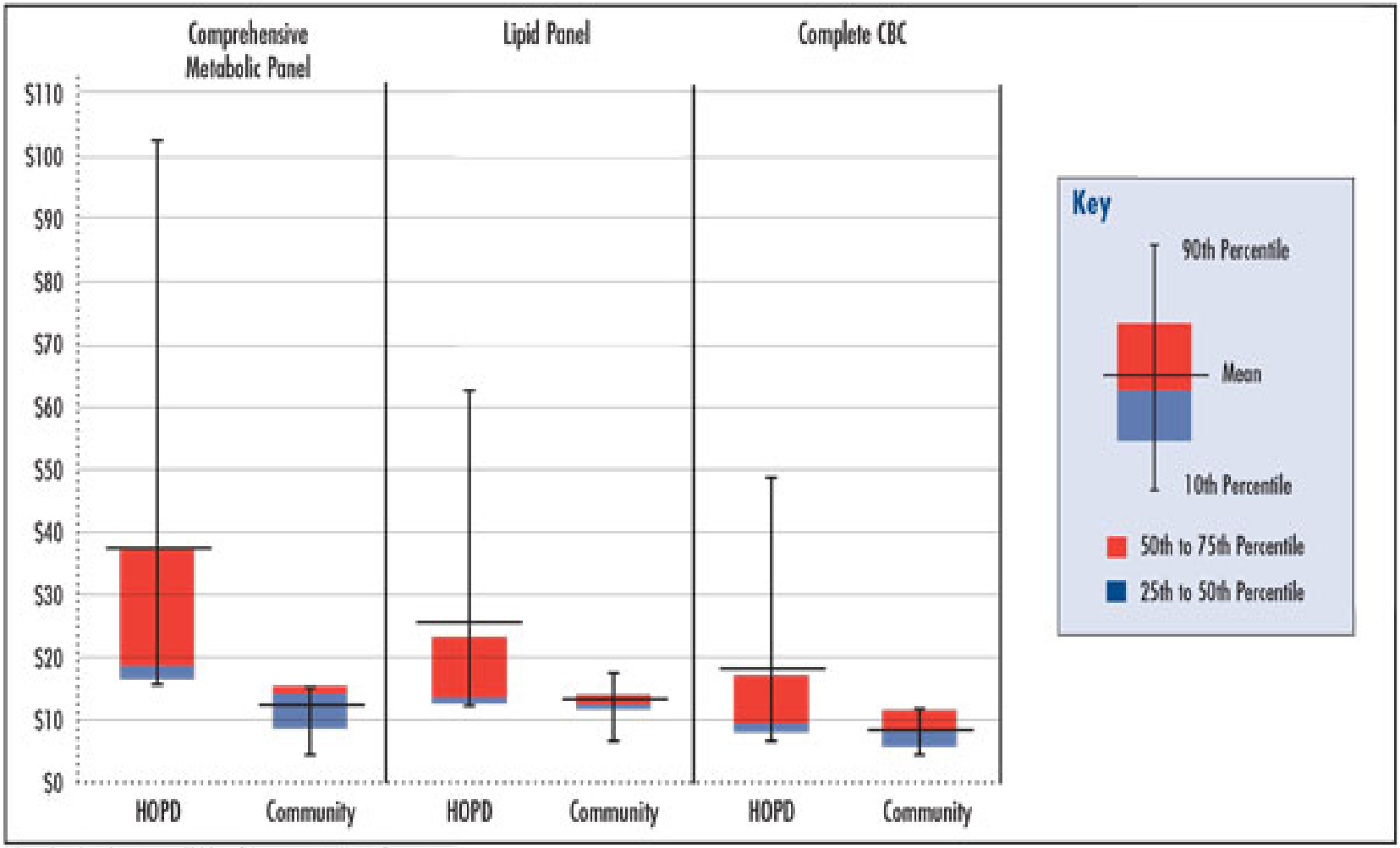
Prices for Colonoscopy Procedures in Hospital Outpatient Departments (HOPD) and Community-Based Settings for Privately Insured Patients



Note: See Supplementary Table 1 for precise pricing information.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents for CPT codes 45378, 45380, 45385 and associated ancillary services

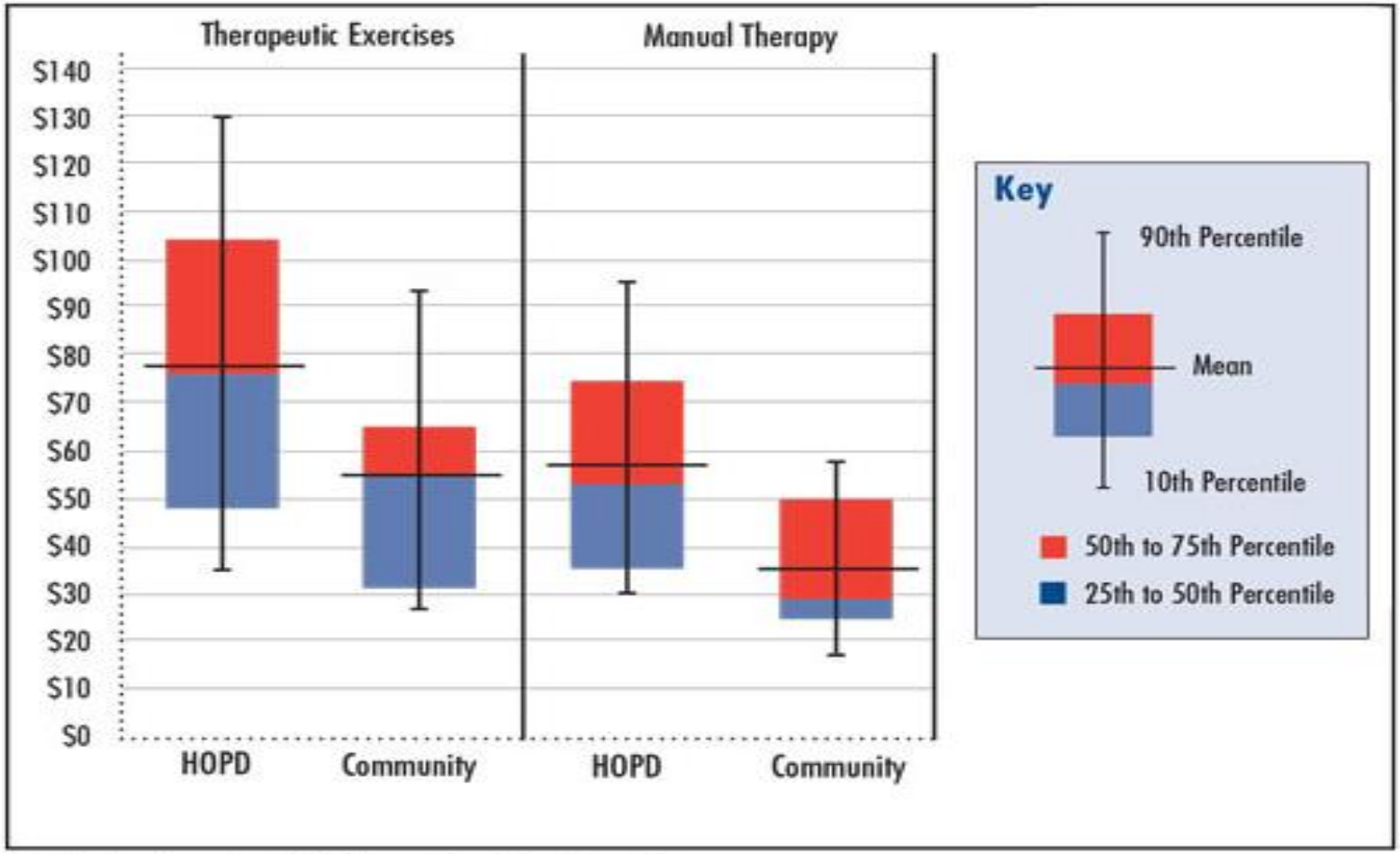
Prices for Common Laboratory Tests in Hospital Outpatient Departments (HOPD) and Community-Based Settings for Privately Insured Patients



Note: See Supplementary Table 1 for precise pricing information.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents for CPT codes 80053, 80061 and 80525

Prices for 15-Minute Units of Physical Therapy in Hospital Outpatient Departments (HOPD) and Community-Based Settings for Privately Insured Patients



Note: See Supplementary Table 1 for precise pricing information.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents for a single unit of CPT codes 97110 and 97140

- MedPAC has questioned whether these site-of-service payment differences are warranted.
- It has recommended that Medicare pay for routine physician visits provided in hospital outpatient departments at the same rate as services provided in community-based physician offices

- Such a move would reduce the cost of an average Medicare HOPD physician visit by 56 percent and would save an estimated $1 billion to $5 billion over five years
- MedPAC recommended reducing or eliminating the differences in Medicare payment rates between outpatient departments and physician offices for 66 specific categories of ambulatory services—a move estimated to reduce patient cost sharing alone by $200 million per year.

Implications for Purchaser Strategies

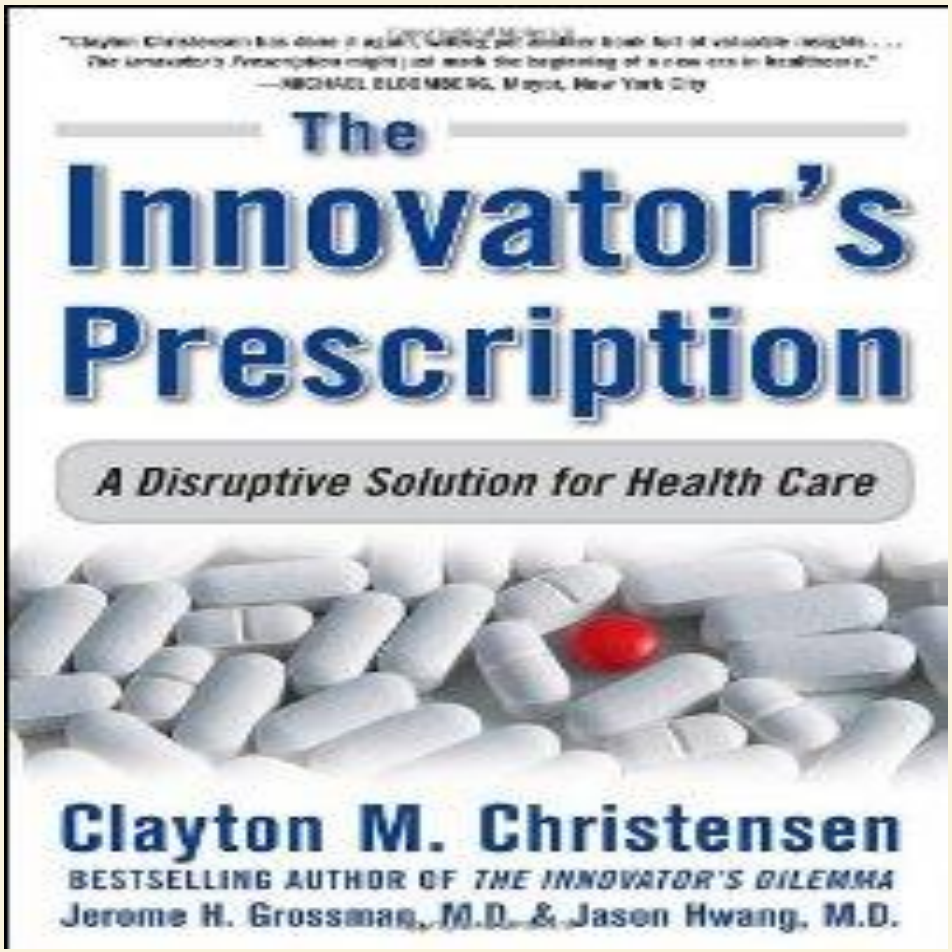
- Large price differences between HOPD and community settings offer an opportunity for purchasers to reduce spending by steering patients to lower-price providers.
- Based on the sample of services examined, substantial savings could be achieved by encouraging the use of lower-price community options, even without downward pressure on HOPD prices.

Purchasers can structure health benefits in several ways to encourage patients to use lower-price providers

- Narrow networks that exclude higher-price providers.
- Tiered networks that require higher patient cost sharing to use higher-price providers.
- Reference pricing that caps allowed payment amounts for certain services for in-network providers.

New Designs

Disruptive Innovation



Trends in Health Care are Accelerating the Emergence of Disruptive Innovations

- The evolution of medical knowledge continues to lead to protocol-based care by nonphysician providers for patients with simpler conditions, while increasing the need for advanced skills in caring for patients with more complex conditions.
- Some health care organizations have been moving away from traditional department structures and focusing more on service lines for specific patient populations.
- Health care organizations are focusing less on revenue generated through service delivery and responding to market forces that emphasize accountability for patient outcomes.

Scenario for Health Care Disruption

- Involves a shift "from an unstructured, experimental, problem-solving process that demands a high level of professional expertise towards a rules-based regime that is less demanding.” (Clayton Christensen)
- The locus of care moves away from tertiary hospitals and general hospitals and toward outpatient clinics, physician offices, and even the community and the patient’s home

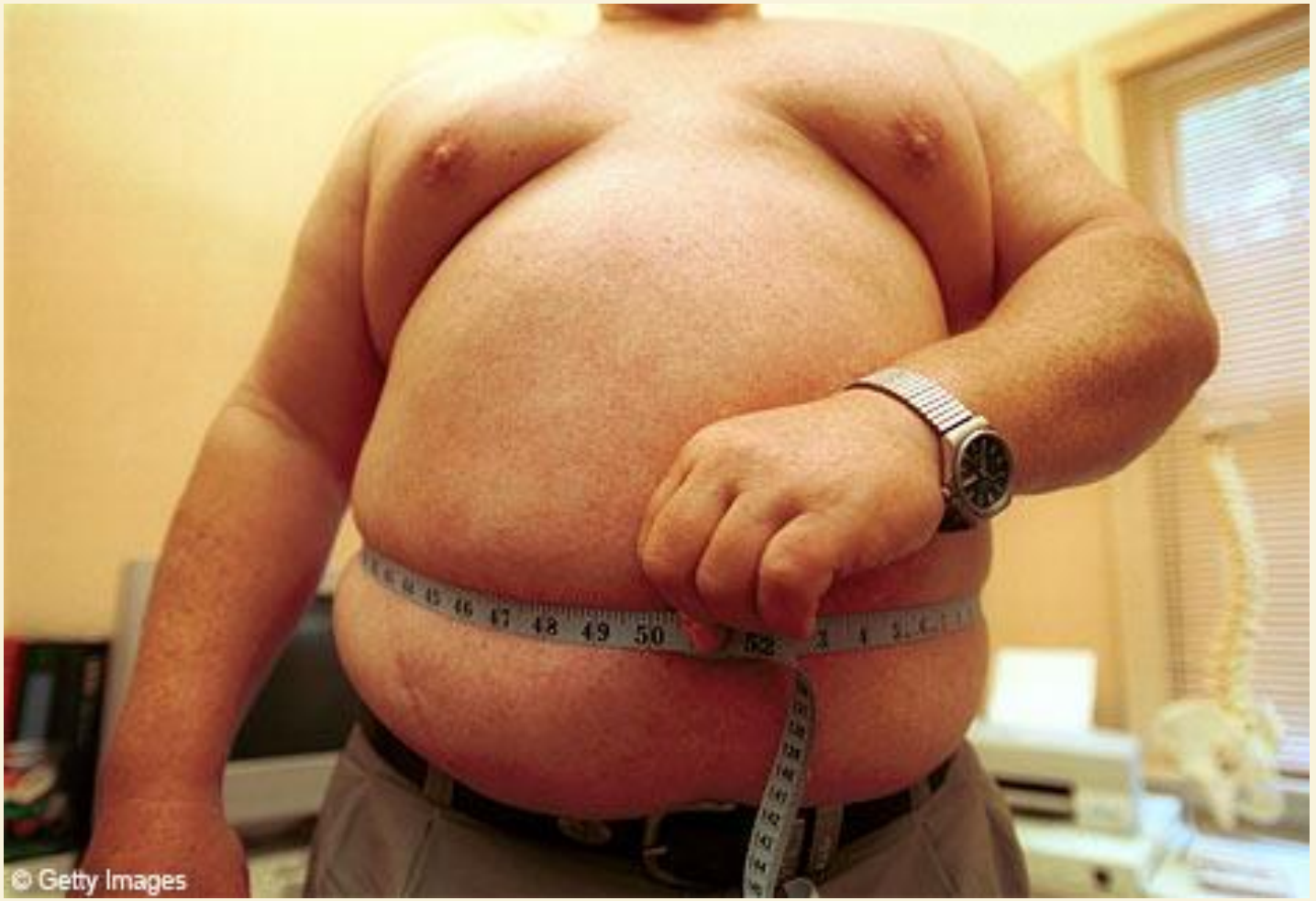
Create new organizations to do the disrupting.

- The health care industry today is trying to preserve outmoded institutions.
- The history of disruptive innovations tells us that those institutions will be replaced with new institutions whose business models are appropriate to the new technologies and markets.

TRIPLE AIM

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations.
- Reducing the per capita cost of health care.

Becoming the Group of Choice (without losing your shirt)


© Getty Images

With hard work and discipline your practice can become lean, muscular, and competitive

With hard work and discipline your practice can become lean, muscular, and competitive.

Driving Forces in Health Care Reform

Transparency

Transparency

Patients will demand it

DEFINING VALUE

Value=Quality/Cost

Patients do not perceive the quality of the care but they do perceive the quality of the experience.

It’s not just what’s the matter with the patient but also what matters to the patient.

Transparency

- Patients will demand it
- Payers will require it

When data = $

It will be mined.

BENCHMARKING

Maturation Process

- Process measures.
- Practice guidelines.
- Clinical decision support.
- Comprehensive health outcomes measurement.

Physician profiling

- Private and public payers use the physician data that they collect to create “profiles” of physicians regarding the quality and cost of the medical care they provide – often using the profile to rank or rate the physicians.

Physician profiling

- Through physician profiling systems, insurers create tiered and narrow networks to control resource use and steer patients towards less costly providers.
- Tiering: Insurers rank physicians and place them into tiers based on cost; patients are encouraged (often through reduced co-pays) to use physicians in the least expensive tier.
- Narrow networks: Insurers require patients to use a small group of lower-cost physicians.

Letter from Cigna

- Beginning 10/21/13 physicians who earn the 2014 Cigna Care designation will be identified in our online directory on Cigna.com by a unique symbol.
- Beginning 1/1/14 your Cigna Care designation status will be effective.
- Beginning 1/1/2014 your 2014 quality and cost efficiency displays will be identified in our online directory by unique symbols for quality and cost efficiency.

Profiling limitations

- The accuracy of insurers' rankings and profiles is compromised by the inherent limitations involved in working with claims data, including the time lag between the delivery of care and the availability of data, difficulties in correctly attributing care, and missing or incomplete information.

Physician profiling

N Engl J Med 2010;362:1014-21

- RESULTS
- Median reliabilities ranged from 0.05 for vascular surgery to 0.79 for gastroenterology and otolaryngology. Overall, 59% of physicians had cost-profile scores with reliabilities of less than 0.70, a commonly used marker of suboptimal reliability.
- Using our reliability results, we estimated that 22% of physicians would be misclassified in a two-tiered system.
- CONCLUSIONS
- Current methods for profiling physicians with respect to costs of services may produce misleading results.

Physician profiling: How to prepare your practice

- Review your contracts.

  -does each contract specify the appeal mechanism or other physician rights with respect to profiling?

Physician profiling: How to prepare your practice

- Develop the necessary infrastructure to capture and evaluate your own data.

Physician profiling: How to prepare your practice

- Train your staff. Careful coding is critical, as profiling systems are based on claims data.
- Ensure that all the relevant ICD-9-CM codes for each patient's diagnosis are reported on each claim, as this information is essential for proper risk adjustment.
- Make sure the Current Procedural Terminology (CPT®) codes that accurately identify the services or procedures performed are reported on each claim.

Physician profiling: How to prepare your practice

- Learn the metrics of the program.

What data will be collected? How will data be collected? What methodology will be used to evaluate the data? In other words, learn exactly how the program works.

Physician profiling: How to prepare your practice

- Request a complete listing of the quality measures that the insurer will use to determine your quality rating based upon your specialty.
- Raise concerns if the quality measures are not appropriate to your specialty.
- Find out which efficiency measurement system the insurer will use.

ETG

(Symmetry's episodic treatment group)

An episode treatment group (ETG) is a patient classification system with groups that are clinically homogenous (similar cause of illness and treatment) and statistically stable. ETG grouper software uses service or segment-level claim data as input data and assigns each service to the appropriate episode. The program identifies concurrent and recurrent episodes, flags records, creates new groupings, shifts groupings for changed conditions, selects the most recent claims, resets windows, makes a determination if the provider is an independent lab and continues to collect information until an absence of treatment is detected.

Physician profiling: How to prepare your practice

- Request a complete copy of your profile, the profiling methodology and the data used.
- Do not accept incomplete information/data from the insurer. You should be given a complete analysis of the data and system used to determine your rating.

Physician profiling: How to prepare your practice

- Review your profile report carefully:
- Compare the data referenced in the report with your actual claims/chart data—is the insurer missing vital information or using another physician's data?
- Are there valid reasons for your practice variation? Examine your data for outlier cases, severity of illness, co-morbidities, unusual demographics and patient compliance problems. If cost efficiency indicators are not properly risk adjusted to control for such differences when they exist, measured physician performance will be inaccurate.

Physician profiling: How to prepare your practice

- Determine whether the profiling methodology is sound:
- What is the margin of error? Pay attention to the number of cases used to determine your rating—small sample sizes are the single biggest cause of inaccurate ratings.

Physician profiling: How to prepare your practice

- Request reconsideration immediately if the data are incorrect or do not belong to you, or if the profiling methodology has been inaccurately applied to your practice.
- Follow up with a certified letter, with return receipt requested, identifying the incorrect data or methodological issue.
- Make sure you file a formal appeal.

Health Care Reform
How Will It Affect our Future

- Coordinated approach to health care delivery
- Reimbursement in the form of:

  -ACO's

  -Patient centered medical homes

  -Pay for performance

  -Risk sharing/gain sharing

  -Bundled payments

  -Value based purchasing

  -Other

Payment Methods Health Plans

Catalyst for Payment Reform

- 11% hospital payments, 6% outpt specialist payments, and 6% of primary care physician payments are “value oriented.”
- 57% involve provider risk such as bundled payment, capitation and shared risk payments.
- 43% provide incentives such as shared savings or pay for performance.

Payment Methods Health Plans

Catalyst for Payment Reform

- 2010 1-3% of provider payments tied to performance.
- 2% of health plan enrollees enrolled in an ACO or a patient centered medical home.

Infrastructure Reform
Accountable Care Organizations

An ACO is a high performing organized system of care and financing that can provide the full continuum of care to an identified population over an event, episode, or a lifetime while assuming accountability and risk for outcomes

ACO'S
2 PERSPECTIVES

- ACO as a destination
- ACO as a compass setting

ACO as a Destination

- Interprets ACO as a noun
- Focused on “care organization”
- Consider it an external market-facing differentiation strategy much like a capitation contract or medical management product.

ACO as a Compass Setting

- Interprets ACO as an adjective
- Focus is on providing accountable care
- Description of internal capabilities and resulting outcomes
- Similar to “VIRTUOSO” describing a musician or “ACCOMPLISHED” an athlete

Driving Forces in Health Care Reform

Consolidation

Strategy to Remain Independent

- Tightly Integrated Practice Governance with internal accountability
- EMR – With Regional Connectivity
  - Quality measures
  - Financial and Production metrics
- Highest Tier Payer Recognition
- Strong Physician Leadership
- Turn-Key Solution for ACO/Payer

Get Bigger - Much Bigger

Five Competencies

- Ability to design, organize, and manage an efficient and effective clinical delivery system.
- Ability to integrate care across time, settings, providers, and geography.
- Ability to innovatively price and cost account for care delivery.

Five Competencies

- Ability to rationally distribute premium and potential dollar savings.
- Ability to live and thrive simultaneously in 2 potentially contradictory models for a significant period of time.

10-STEP ROADMAP TO BECOMING A VALUE-BASED PRACTICE

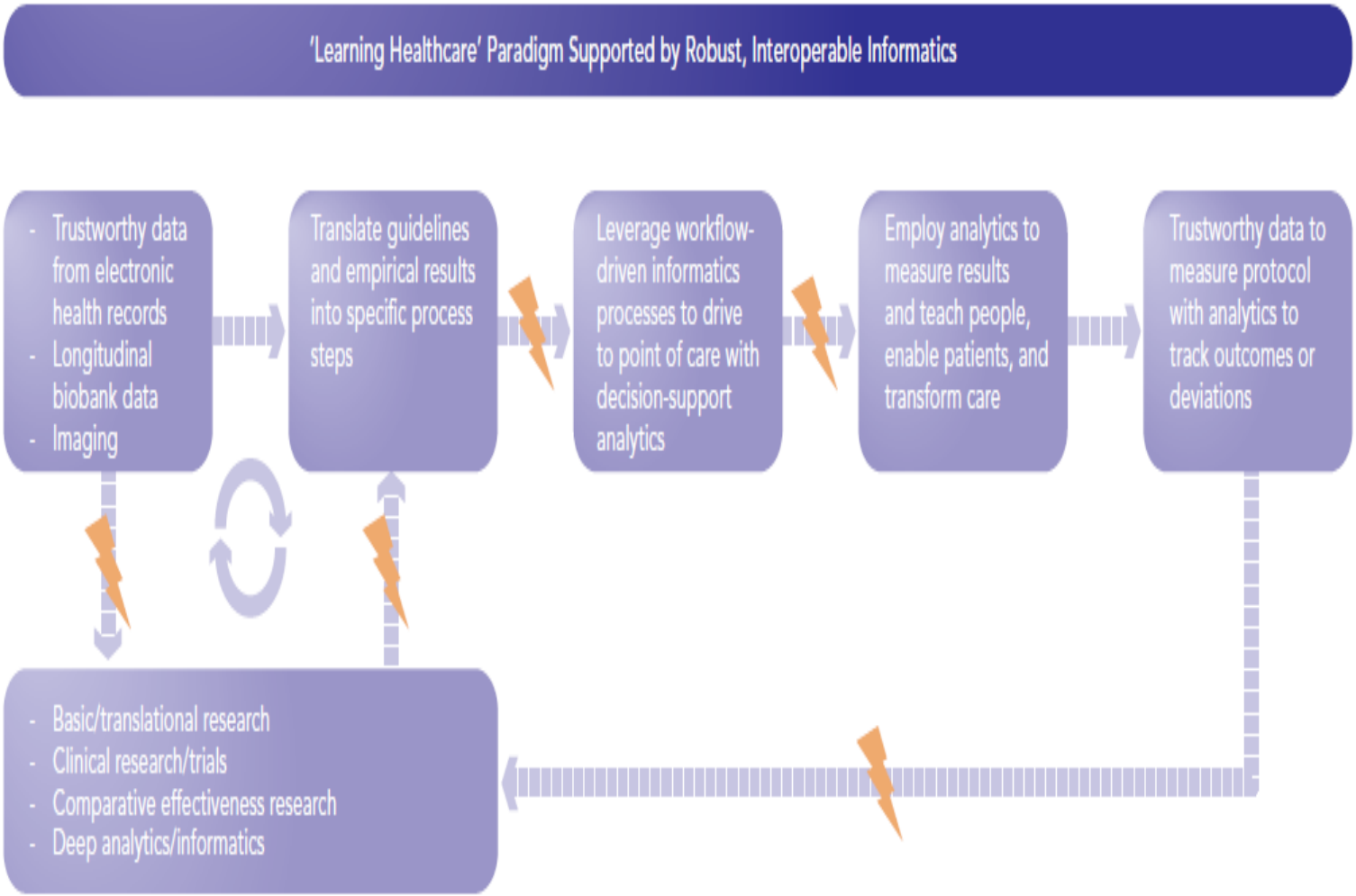
- Get Organized (Big is good) and Clinically Integrated with …
- Strong, Fair, Knowledgeable Governance
- Culture of Quality with Committed (Paid) Leadership
- Business/Comp Structure that = Cooperation and Measurement
- Internal Process Improvement (Standardize)

10-STEP ROADMAP TO BECOMING A VALUE-BASED PRACTICE

- HIT that meets Meaningful Use and Integrates with your Regional Health System's HIE
- Know Federal, State, Commercial and Regional Initiatives
- Learn about Population Management
- Build Capability to Assume Risk (Financial, Performance)
- Total Cost of Care – Shared Risk

Big data

Putting the pieces together



Putting the pieces together

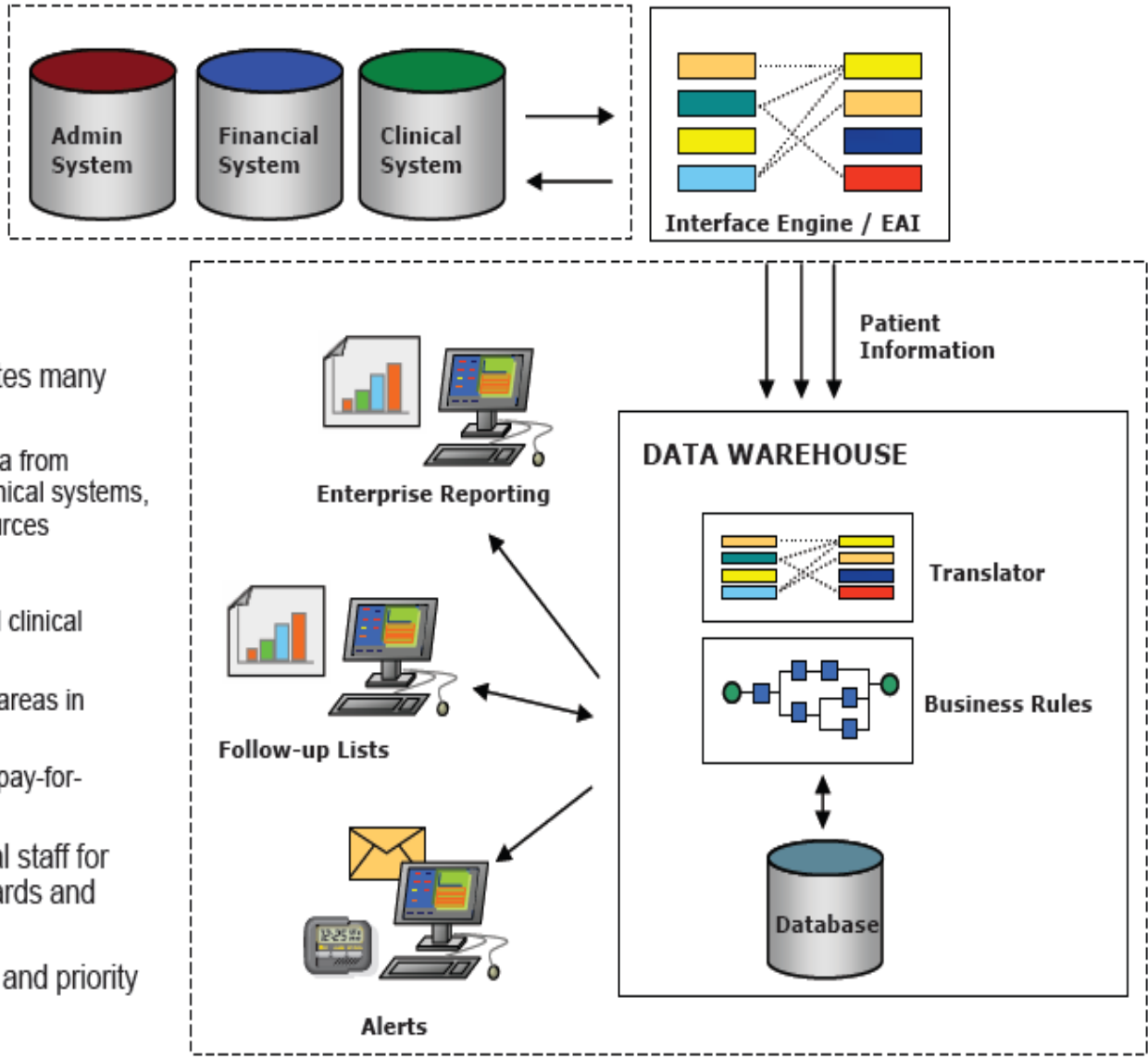
Perform advanced data mining.

Why is it important?

- Simply capturing core data for quality reporting is not enough.
- To be successful in the future, organizations will need to use this data to improve operational efficiency and outcomes.

What can I be doing?

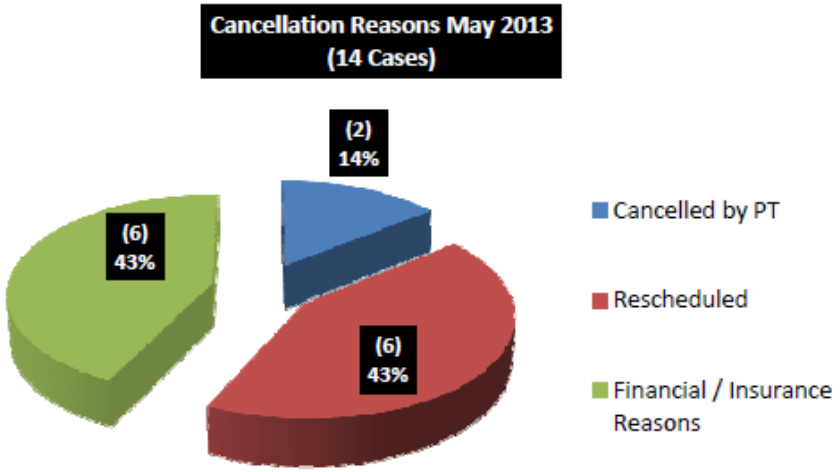
- Building a data warehouse that consolidates many different types of information.
  - Scheduling, billing, and registration data from financial systems, clinical data from clinical systems, as well as information from outside sources
- This repository will provide the tools to:
  - Calculate and benchmark financial and clinical productivity measurements
  - Identify operational efficiency problem areas in hospital and practices
  - Conduct data mining and reporting for pay-for-performance.
- Ensure input from clinical, IT, and financial staff for data normalization and design of dashboards and reports
- Phase in based on availability of systems and priority of needs



Physician Business Scorecard

FY 2012								YTD Total	FY 2013								YTD Total	Variance
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May		
70	48	69	42	40	57	30	57	413	52	33	46	43	46	40	52	58	370	(43)

Non GEC Volume Activity	
Non GEC ASC Volume	60
Hospital Volume	167



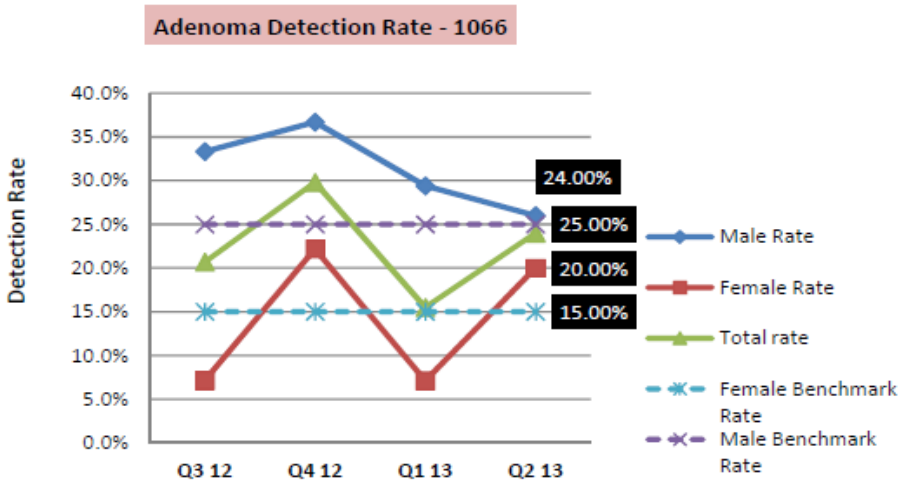
Block Utilization May 2013			
AM Slots Available	AM Slots Used	PM Slots Available	PM Slots Used
82	95%	78	41%

Physician Tardiness May 2013	
Total:	8
> 30 minutes:	-

Physician Clinical Scorecard

Withdrawal Times May 2013 (Minutes)		
Colon Screenings	Average	8
	< 6 Minutes	3
	6 minutes or greater	9
All Colonoscopies	Average	8

Cecal Intubation Colon Screening May 2013			
Total Cases	Cecum Reached	%	Reasons
12	12	100%	N/A



Quality of Prep	
Total Cases	12
Excellent	91.67%
Very Good	0%
Good	0%
Regular	8.33%
Normal	0%
Fair	0%
Sub-Optimal	0%
Poor	0%
Total	100%

Control Your Clinical Service Lines

- CRC
- IBD
- Chronic Liver Disease
- Esophageal Disorders

Escaping the Commodity Trap

- SERVICE EXCELLENCE
- TECHNOLOGY
- METRICS

HIGH TECH

HIGH TOUCH

Channel Management

- Understand the levers for patient referral
  - Changing from PCP to “systems”
- Engage with Governing Boards
  - ACO
  - Health System
  - Payers
- Direct to Consumer (with real value added service)
- Alternative referral sources
  - Minute Clinics
  - Employer-based clinics
  - Social Media

Build Practice Infrastructure

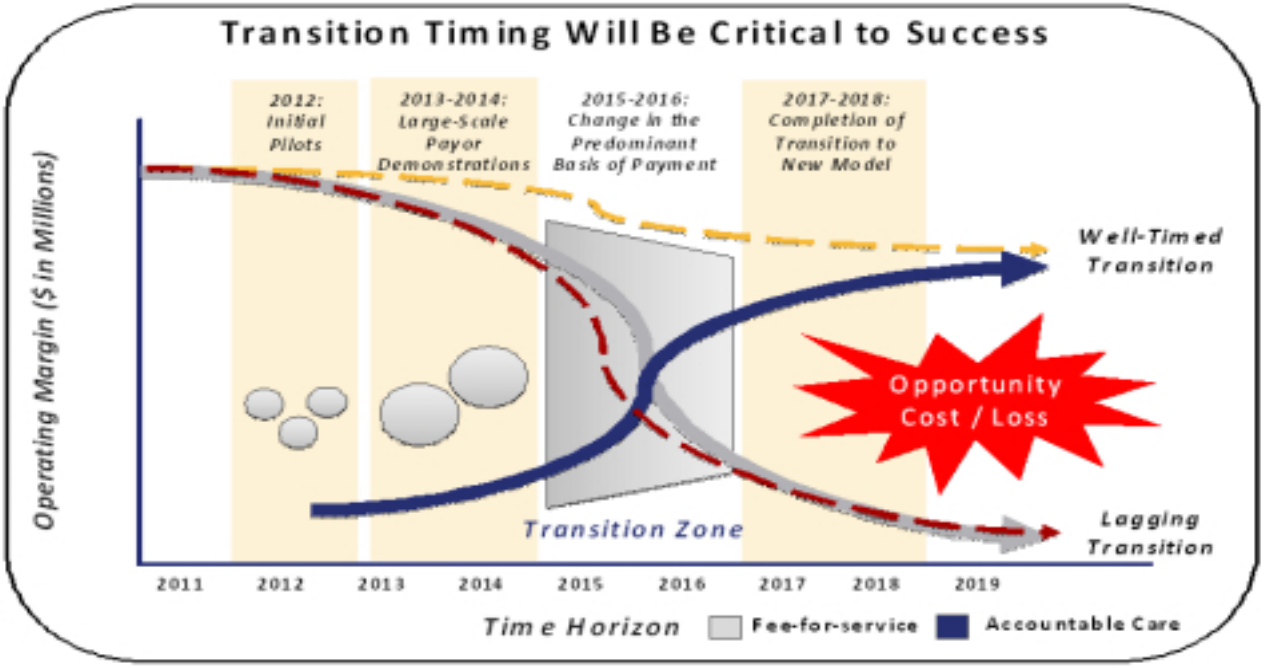
- Clear Mission, Vision, and Strategy
- Strong Governance
  - Physician and Administrative Leadership
    - Fair
    - Understands Health Care Trends
    - Holds partners accountable
      - Peer Review with defined consequences
- Partnership Agreement
  - Commitment to efficiency of the Practice
  - Clear "Gives and Gets"
  - Production and Quality Measurement
  - Compensation system that promotes practice goals

Compensation Plans

- Historically- based on productivity - fee for service reimbursement.
- Future-payers will use quality and efficiency measures to tier MD networks in fee schedule negotiations.
- Quality and efficiency measures will eventually filter down to individual MD compensation.
- Compensation plans will need to incorporate these types of measures.

Managing the Transition is Critical

The greatest challenge will be managing the transition from FFS to value and/or budget-based payments and, in particular, managing the conflicting incentives of each payment system



Build Practice Infrastructure

- Partner commitment to accountability
  - Transparent practice
  - P4P – production + quality
  - Public Reporting of measures
  - Clinical Practice Protocols
    - Consistent management
- Governance
  - Employee by Day – Owner by Night
  - Peer Review Process
    - Learning from errors or poor outcomes

Build Practice Infrastructure

- Electronic Medical Record
  - Practice Management
  - Quality and Production Reports
  - Efficient Scheduling
  - Connectivity
    - Regional systems
    - AGA Registry
- Regional Systems Integration
  - Move beyond the "Consultant" Role to Manager of Digestive Health

Principles to Create High Value System

- Goal is quality not cost.
- Providers to compete on VALUE
- Reorganize delivery of care process
- Volume, scale and experience matter
- Measure outcomes and cost of care
- Pay in way that reinforces value
- Develop information technology platform

Three Truths Shaping the Healthcare Delivery System of the Future

- TRUTH #1- The expectation that care will be as safe as possible.
- TRUTH #2- More patients, fewer providers plus cost pressure will force healthcare organizations to become more efficient.
- TRUTH #3- Cost and quality transparency will be demanded by payers and consumers alike.

HEALTHCARE PREDICTIONS

- HEALTHCARE PREDICTION #1:

  Physician Consolidation

- HEALTHCARE PREDICTION #2:

  Stress on Health Care Systems

.

- The financial stresses that hospitals are suffering today mirror exactly what happened to the dominant players in other disrupted industries.
- They are responding in the same way—by tightening controls on their existing business models.
- They are merging, closing facilities, laying off workers, forming buying groups, delaying payments, adding layers of control-oriented overhead workers, and hiring consultants—while going about their work in a fundamentally unchanged way.

The billions of dollars large general hospitals are spending to build information technology systems and to create integrated feeder systems of physicians' group practices and primary-, secondary-, and tertiary-care hospitals are designed to preserve, rather than displace, the existing institutions.

"It is very likely that the care of disorders that primarily involve one system in the body will migrate to focused institutions whose scope enables them to provide better care with less complexity-driven overhead. If history is any guide, the health care system can be transformed only by creating new institutions that can capably deliver the vast majority of such care, rather than attempting a tortuous transformation of existing institutions that were designed for other purposes."

Clayton Christensen, Richard Bohmer, John Kenagy

Harvard Business Review

HEALTHCARE PREDICTIONS

- HEALTHCARE PREDICTION #1:
  Physician Consolidation
- HEALTHCARE PREDICTION #2:
  Stress on Health Care Systems
- HEALTHCARE PREDICTION #3
  Physician Dominance Restored


We are confronted with insurmountable opportunities
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Dawn of a New Era

“In times of great change you can fight it and die, accept it and live, or lead it and prosper.”

Ray Noorda
CEO Novell

"IT IS NOT THE STRONGEST THAT SURVIVE, OR THE MOST INTELLIGENT, BUT THE MOST RESPONSIVE TO CHANGE".

Charles Darwin

Determinants of Success

- Vision
- Leadership
- People
- Process
- Partnership development


WE HAVE MET THE ENEMY AND HE IS US.
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