Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs

Including the Advocate Health Care Example as Presented by Lee B. Sacks, M.D.

James J. Pizzo and Mark E. Grube

Kaufman, Hall & Associates, Inc.  kaufmanhall.com
Introduction

Accountable care organizations (ACOs) have captured industry attention nationwide. Many hospitals and health systems are assessing their current state of readiness for ACOs and their wherewithal for moving from an activity-based payment model to the bundled or risk- and outcomes-based model. No one really has a full understanding of what ACOs will involve at this point, but some organizations are taking early steps toward meeting the Centers for Medicare and Medicaid Services’s (CMS’s) requirements for participating in the Medicare ACO Shared Savings Program, beginning in January 2012.

The CMS program remains a work in progress, but what is known is that its basic objectives are consistent with the new business model that is emerging independent of healthcare reform legislation. The model’s goals are to improve care quality and reduce costs through a value-based payment system that encourages information technology (IT)-enabled care coordination across the continuum of care.

Our work with hospitals and health systems nationwide indicates that few organizations, as described fully later, are ready to function as ACOs. In fact, only a handful of organizations have operational ACO-like programs, and a few dozen more are in the early stages of developing such programs. Early results from a number of emerging programs show that progress is being made in improving quality and outcomes, but that the cost curve is not yet flattening or bending downward, as hoped and expected.

Geared to the majority of the organizations that are concerned about whether and how to prepare and achieve ACO readiness, our central thesis in this white paper is that becoming an ACO should be approached as an evolutionary process, best accomplished through incremental steps built on a “clinical integration” platform. Definitions would be helpful at this point.

Definitions

Like other industry participants, we have witnessed the varied uses of—and confusion surrounding—the terms clinical integration and accountable care organizations, particularly during the months since healthcare legisla-

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efficiency objectives; and 3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies. 3

Clinical integration has the components outlined in the sidebar above.

Accountable Care Organizations

The definitions are numerous and often vague, but the American Hospital Association’s synthesis report on ACOs, published in June 2010, provided needed light. 4

The basics are as follows:

An accountable care organization is a legally structured arrangement between hospitals, primary care and/or specialty physicians, and perhaps other providers (such as post-acute care facilities, inpatient rehab facilities, skilled nursing facility care, home health care, and more) to coordinate and deliver efficient and effective care for a defined patient population for a specified period of time. An ACO assumes accountability for improving healthcare quality and slowing the growth of healthcare costs. “Assuming accountability” may or may not involve the assumption of financial risk for organizational participants.

There are different types of ACO structures and different types of ACO payment models. For example, the Medicare ACO Shared Savings Program, which is to be applied within the current fee-for-service environment, as discussed later, will provide incentives to improve quality and reduce costs through a shared savings program. But, there will be no payment penalties if ACOs do not achieve their savings targets.

In contrast, ACOs that have a fixed price (per covered life, for example) are responsible for financial gain or loss, thus assuming risk for financial gains or losses of providing health management and care to a defined population. 4 Critical to ACO success, as cited by numerous sources, are linkages that facilitate coordination of care delivery across different settings and IT infrastructure to enable the collection and analysis of data on costs and outcomes. Additionally, ACOs “will need to have the organizational capacity to establish an administrative body to manage patient care, ensure high-quality care, receive and distribute payments to the entity, and manage financial risks incurred by the entity,” notes the AHA report. 4

The Interrelationship of the Terms

Yes, these two concepts sound similar and yes, ACOs have the same components as those outlined for clinical integration in the sidebar. But there are two differences:

- ACOs currently are envisioned to meet their quality, health outcomes, and efficiency goals across a larger number of individual care silos than clinical integration programs, which generally are geared to integrate the acute care, specialty care, and primary care silos.
- The CMS program notwithstanding, ACOs generally are envisioned to assume financial risk for the health management and care of the populations they serve; this is not the case, again the word generally, with clinical integration programs, which “generally” use non-risk-based shared-savings incentives.

In this white paper, we hope to help hospital and health system executives understand three facts about the relationship between clinical integration and ACOs:

1. Clinical integration is required for future success in health services delivery, whether or not a hospital participates in an ACO. Independent of what occurs with healthcare reform legislation, the new value-driven business model is here to stay, as defined with quality and cost indicators. The
fee-for-service activity-based (volume-based) business model has proven a failure at containing costs and, in many cases, at improving outcomes. Close collaboration between hospitals and physicians through clinical integration programs will be critical in a value-based payment system. Ultimately, hospitals’ physician strategy must embrace clinical integration to drive both improved quality/outcomes and cost reductions.

2. **Clinical integration is the important first step toward ACO participation for hospitals and health systems.** It will provide vital physician-partnering experience and market, clinical, and financial knowledge needed for success under the new business model and in ACO participation.

3. **ACOs require clinical integration.** There is no way to achieve improved quality and reduced costs without collaboration between hospitals and physicians.

At this time, we advise hospitals and health systems to focus their activities on preparing and planning for ACO readiness through development or enhancement of clinical integration program(s). Having a clear understanding of current capabilities and known ACO end goals will drive this incremental approach, so we return to a fuller description of ACOs.

**ACOs: More on the Concept of “There”**

As currently defined within the context of the Medicare ACO Shared Savings Program, an ACO is “a set of providers, including primary care physicians, specialists, and/or hospitals, who bear responsibility for the cost and quality of care delivered to a subset of traditional Medicare program beneficiaries, who are enrolled in the traditional fee-for-service program. This entity controls traditional Medicare spending by providing financial rewards for good performance based on comprehensive monitoring of quality and spending.”

The goals are what CMS Administrator Donald Berwick, M.D., has named the “Triple Aim”—better care for individuals, better health for populations, and lower per capita costs of care without any harm whatsoever to patients.

In the Medicare ACO Shared Savings Program, an ACO will be responsible for:

- Managing clinical care for a defined population base (a minimum of 5,000 patients) across the care continuum
- Having defined processes to promote evidence-based medicine
- Having the data and systems necessary to monitor and evaluate quality and cost measures
- Being able to receive and distribute payments for provision of patient care

Ultimately, we believe that CMS will likely need to define high-cost, high-acuity “carve outs,” representing specific conditions that ACOs will not be accountable for, such as transplants. However, even with carve outs, it is clear that organizations will need scale in order to manage the financial risk involved in managing the health of patient populations in full risk-bearing ACO models. Some healthcare executives believe that a minimum of 50,000 patients represents the threshold for an ACO’s financial viability.

**Eligible Organizations**

According to CMS, numerous forms of organizations can become an ACO, including:

- Physicians and other professionals in group practices
- Physicians and other professionals in networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians and other professionals
- Hospitals employing physicians and other professionals
- Other forms that the Secretary of Health and Human Services may determine appropriate

As noted by Dr. Berwick, there is “no one-size-fits-all for an ACO.”

There’s considerable current debate about which stakeholder group will take the lead in organizing ACOs—hospitals, physicians, insurers, or independent practice associations (IPAs). Current arguments for one group or the other include the following:
• **Hospitals** have the organizational infrastructure, systems, people, capital, facilities, and provider networks needed to lead ACOs.

• **Physicians** have the intellectual capital related to medicine. Because they deliver or order the bulk of care, physicians are healthcare's economic engine and are most able to drive quality improvements and cost savings. Physicians don’t have capital or organizational expertise and systems, but as noted by one expert, “At the end of the day, clinicians make 80 to 90 percent of the decisions that drive where dollars go.”

• With access to patient and claims information, **insurers** have the data and the IT infrastructure required to manage costs, but not the medical or organizational know-how. Insurers also have significant capital resources.

• With the advantage of having large numbers of covered lives, **primary care-driven IPAs** could essentially use specialists and hospitals as needed, forcing them into a passive “rate-taker” role. Currently, there are only a handful of large, well-established IPAs, most of which are located in southern California.

**Success Requirements**

Whether ACOs in various regions and communities are physician-centric, hospital-centric, insurer-centric, or IPA-centric, two points are clear at this time:

1. ACO success will be dependent on the involvement of physicians

2. In order to lead or participate in an ACO, new competencies and significant resources will be required of hospitals and health systems

Overall, ACOs will be expected to integrate current silos of care that a patient moves through—especially patients with a severe disease or chronic condition—from primary care to specialty care to inpatient hospitalization to skilled nursing and to home healthcare, sometimes with numerous other points along the way (Figure 1). Payment bundling will occur across multiple pieces of the continuum, with acute care bundling the focus of the CMS Medicare ACO Shared Savings Program.

**Management Expertise and Infrastructure Requirements for ACOs**

- Integrated electronic medical records (acute and ambulatory)
- Coordinated utilization management and review systems
- Effective membership services functionality
- Proven care management programs
- High-quality management reporting systems
- Efficient incentive payment systems
- Payor contracting expertise
- Financial and capital planning/management expertise

*Source: Kaufman, Hall & Associates, Inc.*
Technology will assume a more important role than ever in healthcare. Historically, the healthcare industry has undercapitalized technology, spending only one-fourth of what other industries spend, on average. This will need to change rapidly in order to meet the requirements of the new business model. The sidebar highlights specific management expertise and IT-driven or enabled infrastructure requirements.

Hospital and Health System ACO Readiness

In working with not-for-profit hospitals and health systems around the country, four levels of organizational readiness related to these competencies are apparent at this point in time:

1. *Organizations in a high state of preparedness:* Few in number, these organizations are now fine-tuning formal arrangements with specialty and primary care physicians, have the needed IT infrastructure and insurance linkages, and are currently improving the delivery of care through a clinical integration program or similar quality-driven initiatives.

2. *Hospitals and health systems that are “somewhat” prepared:* This bigger, but still proportionately small, group of organizations is hard at work building or strengthening the programs and infrastructure needed to qualify for the CMS program.

3. *Organizations at the lower end of the readiness continuum:* This group, representing the majority of hospitals, is identifying what their first steps should be and has minimal infrastructure in place.

4. *Organizations in the least-prepared state:* This sizeable group, consisting primarily of very small community hospitals, is taking a “watchful waiting” or “denial” strategy. Their leaders hope that the ACO model will evolve to be applicable to their organizations, that their paths forward will emerge, or that health-reform-accelerated programs like ACOs will *not* be the model for care delivery and payment going forward.

As evident from the discussion above, many hospitals and health systems do not currently have the required competencies for ACO participation or for other programs that involve bundled payments and risk. Significant investment is required, particularly for physician alignment, technology infrastructure, care management protocols, and advanced contracting. For many organizations, the gap between current capabilities and future requirements is significant; it would take many years for such organizations to fund and achieve the requirements for success.

Clinical Integration as the Foundation

An organization without such expertise or infrastructure should take an evolutionary approach that can demonstrate early successes with incremental improvements. An appropriate and recommended approach is to start with the development of a clinical integration program in the current fee-for-service payment environment. As mentioned earlier, clinical integration will provide experience in structuring collaboration among the hospital, physicians, and other providers and in building programs that improve the quality and efficiency of care. This will enable hospitals to develop competencies before assuming full risk for a defined patient population.

*If* an organization starts with a limited number of contractual arrangements to reward participating physicians for their quality improvement/cost reduction efforts, large capital investments are typically not needed. Then, when bundled payment or some other form of fixed payment becomes a reality, strong and working contractual relationships centered on effective care management will already be in place clinically and operationally. Clinical integration works with various payment mechanisms and is crucial in aligning behavior to drive costs down.

**Basic Requirements**

Clinical integration programs require the participation and support of a significant portion of an organization’s medical staff. These programs also require the creation of a joint contracting entity that can negotiate fees, set quality targets, and distribute incentive payments. In a discounted-fee-for-service environment, these entities will typically take the form of one of the approved clinical integration programs currently in place.
Although there are many variations, the overall structure and intent of clinical integration programs are fairly consistent:

- A joint contracting entity is established to negotiate fees and set quality thresholds for improvement
- Based on the attainment of these goals, incentives are distributed to participating physicians

**Establishing a Clinical Integration Program**

To create a formal clinical integration program, organizations must have a clear understanding of their market and a financial understanding of the clinical areas that warrant focus. The goal is to identify a set of clinical areas that could achieve the largest improvement in quality without yet having all of the required infrastructure and expertise in place.

Organizations can identify these clinical areas by assessing current market and service capabilities, strategic priorities, and up-to-date utilization and financial forecasts (see Sidebar). This planning process also enables organizations to identify critical expertise and infrastructure gaps that can be filled over time. In the early stages of clinical integration programs, many organizations currently rely upon manual or simple automated data collection efforts. However, to be successful the organization must be committed over the longer term to provide the capital that will support technology and other infrastructure needs across all areas.

Alignment of physician, hospital, and payor economic incentives is critical to achieving and sustaining higher quality and reduced costs. Physicians should be involved throughout the process, particularly during the early development design of the program. Physician collaboration is required to establish the baseline used for current quality measures, utilization statistics, and strategic and financial forecasts of projected future performance. Again, improved quality and efficiency of patient care cannot be achieved without physician leadership and buy-in.

As a model of clinical integration in the current fee-for-service environment, we take a close look now at the Clinical Integration Program established by Advocate Health Care through its joint venture care management and managed care contracting organization, Advocate Physician Partners (APP). Sidebars describe Advocate Health Care (or “Advocate”) and APP more fully.

A special thanks to Lee B. Sacks, M.D., Chief Executive Officer of Advocate Physician Partners and Executive Vice President and Chief Medical Officer of Advocate Health Care, whose keynote presentation at the 2010 Kaufman Hall Financial Leadership Conference provided the content for this example. Dr. Sacks was the leading architect of Advocate’s programs that have aligned hospitals and physicians to create value for patients, physicians, hospitals, and payors.

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**Clinical Integration Planning: Assessing Existing Capabilities and Opportunities**

- Current market and service coverage
  - Geographic coverage, specialty/service line coverage for physicians and hospitals, ambulatory coverage, including imaging, ambulatory surgery centers, dialysis, and others
- Current contracting capabilities
  - IPAs, physician organizations (POs), physician-hospital organizations (PHOs), and physician participation levels within each
- Clinical integration capabilities
  - Collective contracting with physicians, financial incentive program, and a results measurement system
- Structured clinical management capabilities
  - Care management, care coordinators, and mid-level providers, and their role(s)
- Current technology capabilities
  - Hospital electronic medical record (EMR), ambulatory EMR, health information exchange (HIE), physician/patient portals
- Cultural readiness and barriers
  - Physician alignment across the medical staff, physician/hospital alignment, payor alignment
- Current quality programs and results
  - Compared to local competitors, national benchmarks

*Source: Kaufman, Hall & Associates, Inc.*
Clinical Integration in Practice: Advocate Health Care/Advocate Physician Partners

APP's Clinical Integration Program was conceived in 2003 as a program to achieve clinically integrated services provided by hospital-based and community-based physicians. These physicians would be rewarded under pay-for-performance contracts with fee-for-service health plans for improving care quality and reducing care costs.

A high-stakes antitrust arbitration with a large insurer “clouded things” until late 2005 when APP won the arbitration. A Federal Trade Commission investigation resulted in a consent decree in early 2007, allowing the program to proceed. Antitrust laws generally prohibit doctors and hospitals from negotiating jointly with health insurers.1 APP's clinically integrated model has withstood regulatory scrutiny, however, and established the way forward for other organizations to develop similar programs in the fee-for-service arena.

Consistent with ACO goals, the overall objectives of the APP Clinical Integration Program are to improve the quality and efficiency of healthcare through alignment of physician and hospital objectives. Advocate’s 2010 Value Report describes the program as follows:

It joins together what would otherwise be a fragmented group of independently practicing physicians into a comprehensive care management program, comprised of a common set of quality goals and measures across all insurance carriers, with a focus on improved health care outcomes and reducing the long-term cost of care. Unlike other disease management or preventive health programs, the Clinical Integration Program provides extensive infrastructure and support to physicians participating in the program, as well as a pay-for-performance incentive system, to drive outstanding levels of performance.

Advocate Physician Partners’ financial incentive system links hospitals and physicians to increase the level of collaboration and degree of coordination of care. These linkages help overcome the sometimes conflicting incentives that exist in the traditional fee-for-service model of healthcare provider reimbursement.9

Advocate Health Care at a Glance

- A faith-based not-for-profit healthcare system based in Oak Brook, Illinois
- The largest integrated healthcare system in Illinois
- Ten acute care hospitals, 2 integrated children’s hospitals, and more than 250 outpatient sites of care
- Approximately 5,700 physicians on staff, approximately 3,800 of whom are in Advocate Physician Partners
- Serves almost a million patients in the Chicago area through PPO (700,000 lives) and capitated arrangements (230,000 lives)
- The state’s largest physician network of primary care physicians, specialists, and subspecialists
- Three major teaching hospitals with more than 600 residents and fellows

Source: Advocate Health Care, Oak Brook, IL. Used with permission.

Advocate Physician Partners in Brief

Advocate Physician Partners, which commenced in 1995, was conceived as an umbrella organization, loosely affiliating the individual physician hospital organizations and medical groups within the system’s hospitals, mostly for the purpose of capitated HMO contracting. By 2000, APP had standardized and centralized HMO contracting, combining risk pools across the system.

During the early part of this decade, in response to pricing and cost pressures with their HMO product, APP began extensive efforts to increase efficiency and effectiveness of in-network care provision and minimize duplicative, unnecessary care. Through the creation of protocols, the implementation of guidelines, and the capturing and sharing of performance data (particularly with ancillary services), APP was able to significantly reduce per-member-per-month expenses while improving care benchmarks.

Source: Advocate Health Care, Oak Brook, IL. Used with permission.
Dr. Sacks notes that the challenges of organizing independent physicians, accustomed to practicing in solo or small practices, for a collaborative initiative are significant. “We’ve learned through our experience with APP over the years that infrastructure is the ‘secret sauce’ that allows clinicians to be a team that can improve care,” says Sacks. “Infrastructure is required to drive the quality outcomes demonstrated more historically only by multispecialty groups.”

Clinical integration programs require significant physician participation in governance and a major investment in IT infrastructure. Details on how APP built and implemented such infrastructure follow.

Building the Physician Platform

“It starts with strategy,” comments Sacks. Advocate Health Care’s leaders recognized early that its strategic framework must be built on a strong physician platform (Figure 2).

To develop that platform, Advocate Health Care has a wide range of affiliation options for physicians:

1. Independent practice as a solo practitioner or member of a small group practice, while being on Advocate Health Care’s medical staff and referring patients to one or more Advocate hospitals

2. #1 and participation in APP

3. Employment in Advocate Medical Group, which operates with a straight employment model, with participation in APP

4. Employment in the Dreyer Clinic, which requires APP participation. The Clinic is owned and managed by Advocate Health Care; clinic physicians are organized as a separate corporation and are partnered with Advocate through a long-term agreement

Approximately 3,800 of Advocate Health Care’s 5,700 physicians participate in APP. Of the 3,800 APP physicians, approximately 1,100 are primary care physicians and 2,700 are specialists. “We cover every specialty, so it’s possible for patients to receive all of their care within the Advocate system,” comments Sacks. The majority of APP-affiliated physicians (approximately 2,900) are independent practitioners in one-doctor to three-doctor practices across 900 separate practice sites (Figure 3).

The APP board and committee structure reflects its dual, joint-ventured leadership. Two types of directors are on the board:

• System members, who are appointed by the system board of directors; these include senior system executives and a hospital president, who typically rotates every two years

• PHO president members, who are mostly primary care physicians

An outside director also sits on the board. All board members have term limits and formal job descriptions with performance reviews. Physician board members are compensated using a simple formula—a reasonable number of dollars per hour multiplied by the number of hours per meeting, doubled for meeting preparation.
adding another factor for post-meeting communication, and making the assumption that they will attend all of the meetings. “We have virtually 100 percent attendance and everyone comes prepared and engaged,” says Sacks.

A supermajority is required for decision making, and “almost everything has been done by unanimous consent,” says Sacks. “When you present good data, reasonable people have a discussion and come to similar conclusions.”

Figure 4 shows the committee structure. The Contract Finance Committee oversees the performance of the HMO product, both full-risk and contracted. With accountability for the performance of individual PHO entities within APP, this committee reviews and approves the budgets of each entity and monitors each one’s performance on a regular basis. Corrective action plans are required if an individual PHO is over budget, and ultimately the committee can impose changes, such as altering the physician fee schedule, if required. “Physicians do a really good job of minding the Ps and Qs of dollars and cents, especially when some of such funds are theirs through incentive programs,” says Sacks.

The Utilization Management Committee, chaired by the senior medical director, creates guidelines and protocols. The Quality and Clinical Integration Committee oversees both areas of its name and has a subcommittee on measurement. The Credentials Committee develops and manages the APP credentialing process, which is separate from the Advocate Health Care medical staff credentialing process. The APP process requires a higher standard; recredentialing every two years is definitely not a given. “This is a business; physicians are our partners. If they are not doing their job, we ensure the needed conversation to address their performance. If their performance doesn’t change, we have to have the discipline to terminate our partnership or else our organization is going down with the partner,” describes Sacks.

**Design of the Incentive Fund**

A pay-for-performance incentive plan provides the financial foundation for APP’s Clinical Integration Program (Figure 5). Each PHO and medical group has its own incentive fund. “Healthcare is local, so it’s important for the PHOs to be able to shape their own destiny,” says Sacks. Each fund has two branches:

- **Individual incentives**, which comprise 70 percent of the total fund. In small primary care practices, the individual incentives are generally defined to cover the group
- **Group/PHO incentives**, which comprise 30 percent of the total fund

“It takes a team to care for patients, particularly patients with chronic diseases, so practitioners have to be incented as a team,” comments Sacks.

Sacks describes the power of team incentives to change care outcomes, as evidenced during one of the monthly dinners he conducted with rank-and-file PHO doctors who are not in governance or on committees: “I asked the usual question, ‘What don’t you like about APP or what would you change?’ The ophthalmologist who was sitting on my left said, ‘I don’t understand why I have to be measured on smoking cessation counseling to diabetic patients.’ Before I could say anything, the internist on my right says, ‘Joe, when you tell my patient that she’s going to go blind if she keeps smoking, you have a bigger impact than I’ve had for the last 10 years in controlling her diabetes.’ I didn’t have to say a word. Case made.” For the group incentive, everyone who sees a diabetic patient is accountable to all of the diabetes metrics.

APP’s incentive fund distributions to physicians for clinical improvement have been significant, growing from $25 million in 2007 to $38 million in 2009. “It’s real money, which has involved having all of the major payors in our market contribute relatively the same portion of dollars to the program,” describes Sacks. “However, money may have been the original
Performance Improvement and Measurement

APP’s Clinical Integration Program focuses on five broad improvement categories, measuring and monitoring success in each: 1) enhancing clinical outcomes, 2) improving patient safety, 3) adopting clinical technology, 4) improving patient satisfaction, and 5) increasing efficiency.

Managing chronic conditions, including asthma, depression, diabetes, coronary artery disease, and congestive heart failure, is core to the program, as are such improvement objectives as increased generic prescribing. APP provides its physician members with solid protocols and guidelines for wellness and preventive care, as well as disease management. Adoption of evidence-based protocols supports the required implementation of best practices by participating physicians.

The program is data-driven with performance targets established for each of the program’s initiatives. The targets are based on national benchmarks and best practices, research findings, and other credible sources. In 2006, there were 52 measures related to medical and technical infrastructure, clinical effectiveness, efficiency, patient safety, and patient experience for the Clinical Integration Program; by 2010, this had more than doubled to 116 measures.

The process used to develop new clinical improvement measures is thorough, taking a full year (and sometimes more) to complete. The process starts in January to collect suggestions regarding new measures through discussions with physicians, PHO boards, specialty committees, managed care organizations, major businesses in the community, benefits consultants, and others. Early in the year, a work group assesses the new measure’s adequacy, and by year end, measure documentation, administrative processes, and educational plans are in place for approved measures. “For some measures, we might need more than a year to ensure that we can integrate the measure into the electronic health record in time to go live in January,” comments Sacks.

Technology Driven

Performance measurement requires technology. Technology also drives the computerized physician order entry systems, electronic medical record systems, and the online disease management registries that allow physicians to more effectively track the care patients with chronic conditions receive and their compliance along the continuum of care.

Advocate Health Care was and is committed to providing the information technology infrastructure required to meet the goals of the Clinical Integration Program. For participation in the program, physicians are required and incented to adopt new technologies that will help enhance communication of critical information, drive performance, and improve patient outcomes.

Figure 6 indicates the new technologies Advocate introduced between 2004 and 2010—technologies that are now required as APP membership criteria. High-speed internet access in physician offices was the starting point in 2004. By the end of the year, only 100 of the 3,450 APP physicians had not complied, in spite of help being offered to make the installation arrangements, install the line(s), and train the staff. “The board had gone on record saying that high-speed internet access was a membership requirement, so
those 100 physicians were not recredentialed. This was a powerful message,” says Sacks.

Sacks cites patient registries for managing chronic conditions as a very important tool that can have a dramatic impact on care outcomes and cost efficiencies. APP’s registries started as pen-and-paper systems, moved to an Excel spreadsheet version, and are now a web-based system called Clinical Integration Registry and Reporting Information System (CIRRIS). CIRRIS integrates all registries, pharmacy, labs, claims, and performance-reporting data. It also is integrated with the electronic medical record.

Among other means to enhance physician compliance with use of CIRRIS, electronic prescribing, the EMR, and other IT tools, APP provides quarterly training for physicians’ office staff. Sessions aim to help staff with office technology-enabled workflow and processes, especially as related to physician guideline and protocol use. “Staff training has had a big impact on supporting the desired physician protocol use. The professional educational development of staff in the 900 small independent practices has been very well received and probably has helped to stabilize the office workforce,” notes Sacks.

Physician performance is monitored using IT-enabled systems throughout the year and reported formally to each physician on a quarterly basis. “Physician report cards are now available online in real time, so physicians can check where they stand daily and what they need to do to improve performance,” describes Sacks. “There are no surprises at the end of the year when financial incentive rewards are distributed to physicians based on their performance. Next year, we plan to start distributing checks quarterly to improve the connection between the achieved behavior and the financial reward,” says Sacks.

A group of peer physicians reviews physician appeals at the end of the year; Sacks notes that the performance measure/result is upheld in about 75 percent of appeals. The Sidebar outlines 2010 APP membership criteria, most of which is technology related.

### Figure 6. Advancing Technology Requirements

Source: Advocate Health Care, Oak Brook, IL. Used with permission.

<table>
<thead>
<tr>
<th>Year</th>
<th>Requirement</th>
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<tbody>
<tr>
<td>2004</td>
<td>High-speed Internet access in physician offices</td>
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<tr>
<td></td>
<td>Centralized longitudinal registries</td>
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<tr>
<td></td>
<td>Access to hospital, lab, and diagnostic test information through a centralized clinical data repository (CareNet and Care Connection)</td>
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<tr>
<td>2005</td>
<td>Electronic Data Interchange (EDI)</td>
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<tr>
<td>2006</td>
<td>Computerized Physician Order Entry (CPOE)</td>
</tr>
<tr>
<td></td>
<td>Electronic medical record roll out in employed groups</td>
</tr>
<tr>
<td>2007</td>
<td>Electronic Intensive Care Unit (eICU®) use</td>
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<tr>
<td>2008</td>
<td>e-Prescribing</td>
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<tr>
<td>2009</td>
<td>Web-based Point of Care Integrated Registries (CIRRIS)</td>
</tr>
<tr>
<td>2010</td>
<td>e-Learning Physician Continuing Education</td>
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<tr>
<td></td>
<td>Electronic medical record roll out in independent practices</td>
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Impact on Care Quality and Cost

APP’s accomplishments with care quality and cost improvement initiatives through the Clinical Integration Program have been extensive. The 2010 Value Report highlights the significant accomplishments in 2009 (see Sidebar). Dr. Sacks describes a few specific initiatives that warrant further mention.

**eICU.** The eICU® program is, according to Dr. Sacks, an example of a clinical integration best practice. A thorough literature review indicated that ICUs staffed 24/7 exclusively by intensivists (specialists in adult critical care) are associated with a 40 percent reduction in ICU mortality. APP identified use of an “electronic” ICU as a performance-improvement opportunity, created an incentive for physicians to adopt its use, and then, with its continued success, made it a use condition of APP membership.

The eICU® program connects the 18 adult intensive care units across 8 of Advocate’s hospitals to a central command center, staffed by board-certified intensivists who provide clinical oversight to patients around the clock. From the eICU® command center, intensivists can instantly modify the patient’s care plan as the need arises and implement key protocols that improve patient outcomes and reduce complications. Since 2004, APP physician use of the eICU® at the highest levels (3 or 4) increased to nearly 100 percent. In level 3, the intensivist manages according to a treatment plan. At level 4, the intensivist co-manages the patient’s care.

**Turnaround Time for Radiology Reports.** Rapid turnaround of reports is critical to patient satisfaction and, in some cases, to improved patient outcomes. Additionally, bed management, resource utilization, and patient flow each are affected by radiology turnaround times. Advocate Health Care committed to improved turnaround times and achieved a 49 percent decrease in time from 49 hours to 25 hours over a two-year period (2006-2007). “APP physicians thought turnaround times required further improvement because 25 hours still slowed throughput on diagnoses and other processes,” comments Sacks.

In 2008, APP added the radiology report turnaround-time measure to the Clinical Integration Program, bringing attention to the issue and engaging physicians in the goal. From the first quarter of 2008 through the fourth quarter of 2009, the average turnaround time plummeted from 23 hours to 8 hours, a decrease of an additional 65 percent.

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**Significant Accomplishments of APP’s Clinical Integration Program**

- The comprehensive Asthma Outcomes initiative provided additional direct and indirect medical cost savings of $16 million above national averages annually. The initiative resulted in an estimated additional 37,920 days saved annually from absenteeism and lost productivity.
- The Generic Prescribing initiative resulted in prescribing rates 4.6 to 6.4 percentage points higher than two large Chicago-area insurers. The effort resulted in a savings of $14.8 million annually to Chicago-area payors, employers, and patients above community performance.
- Depression screening and subsequent treatment in patients with diabetes or those who had heart failure or a cardiac event resulted in more than an additional $10.8 million in direct and indirect savings above the standard practice per year. In addition, employers saved more than 8,672 lost work days per year.
- The Diabetic Care Outcomes initiative resulted in an additional 12,350 years of life saved, 19,760 years of eyesight preserved, and 14,820 years free from kidney disease. In addition, just one measure, improving poor Hemoglobin A1c levels, resulted in nearly an additional $2 million in savings per year above national averages.
- The cardiac initiative resulted in improvements ranging from 7 to 10 percentage points higher than state and national benchmarks in all three areas of inpatient medication treatment. In addition, calculating for just a single measure for outpatient medication management, savings resulted in an additional $688,000 annually above community averages.
- APP physicians achieved an 82 percent vaccination rate in administering Combination 3 immunizations to children by their second birthday, comparing favorably to the national performance of 58 percent.

Generic Prescribing. “Generic prescribing represents a big opportunity for value creation,” says Sacks. Everybody except the physician saves money on generics, including the health plan, the prescription benefit management firm, the patient, the employer, and typically, the retail pharmacy (because the margin on generics is higher). “But it takes more time for physicians to convince patients to switch to generics, often having to counter the commercials for brand-name drugs,” comments Sacks. APP hired two managed care pharmacists to do “counter detailing” with physicians and improvements started to be made slowly.

“Then, an idea emerged from looking at what pharmaceutical firms do to hook physicians and patients on high-cost branded drugs. They provide samples. I asked our physicians, ‘How many of you sample generics?’ A pregnant pause and chuckles followed because everyone knew that the generic manufacturers don’t use the free-sample strategy,” describes Sacks.

APP decided to fund coupon vouchers for a 30-day supply of a generic drug that people are likely to use for the rest of their lives, such as cholesterol-lowering medicines, anti-hypertensives, and others. APP did a control trial, providing one group of physicians with vouchers and leaving another group without vouchers. The results from the voucher-enabled group showed a statistically significant improvement in generic prescribing. “Now we give vouchers to all of our primary care physicians and cardiologists,” notes Sacks. APP physicians prescribe generics 71 percent of the time, while prescribing rates for physicians affiliated with the two major insurance plans in the Chicago area are a lower 64 to 66 percent.

Increasing the use of generics represents an opportunity to create value that doesn’t impact hospital or physician finances. Sacks comments that the patents for many expensive drugs are expiring in the next year or two, so more generic drugs could be available to generic-prescribing programs.

Creating Value through Specific Factors

The Clinical Integration Program creates value for Advocate’s hospitals, for the physician partners, and for the marketplace (payors and patients), notes Sacks. For the hospitals, the business partnership with key physicians focuses physicians on hospital goals, including patient safety and costs, strengthens their loyalty, and positions the health system for health reform-related initiatives, such as ACOs, bundled payments, and readmission avoidance. “Our liability costs are less than half of what they were five years ago, and certainly the focus on patient safety has been an important part of this,” says Sacks.

The value proposition for physicians is better alignment with the hospital, marketplace recognition (“under the halo of the Advocate brand name,” says Sacks), focus on outcomes, incentives that compensate them for additional work, and the ability to interface with multiple managed care organizations.

For the marketplace, the value proposition includes focus on clinical outcomes, demonstration of efficiencies, ongoing improvement of care delivery, a stable/cohesive network, and leadership from and by physicians.

Factors cited by Sacks as critical to the success of APP’s Clinical Integration Program start with its physician-driven leadership: “The program gets lots of support from Advocate in IT, data, finance, legal, and analytic areas, but the big decisions are all clinical; what’s in our patients’ best interest must come from physicians.” Ensuring the same metrics across all payors is also a critical success factor. “If metrics are not the same in your market, I urge you to come together under the umbrella of the hospital association or a managed care group to develop standard metrics. Without such, no one has enough data to draw any conclusions,” says Sacks.

Data are critical. It took five years before APP starting receiving its claims data reliably from managed care plans. APP required its physicians to submit their PPO claims electronically for all payors and then worked with the two clearinghouses to obtain a shadow copy that goes into the APP database. “We now have more than two years of claims data and that’s a powerful database,” says Sacks.

Other success factors include minimizing additional administrative costs, using additional funds to recognize extra work by physicians and staff, and building and maintaining the infrastructure necessary to support improvement and physician/hospital alignment.
Key Challenges for ACOs

Sacks describes what he sees as the key challenges for ACOs. The dominance of small physician practices in many communities may be a significant stumbling block, he notes. Hospitals will need to organize and support physicians, and such organization is not likely to be successful through the traditional voluntary medical staff.

The dominance of fee-for-service payment will also be challenging. “Fee for service is probably not going to go away, so hospitals have to figure out how to create alignment with physicians under both volume-based and value-based systems. A critical mass will be required. I believe that organizations that are just a Medicare ACO are not going to be able to make it unless Medicare comprises more than 60 percent of their business. This level of mass or scale will be required to invest in the needed infrastructure and care delivery redesign,” says Sacks.

Next Steps for Advocate Health Care

Up to this time, APP has participated in HMO products, which typically have involved capitation arrangements for professional services (physicians and ancillary testing) and per-diem arrangements for hospital care. Even with increased HMO products with Blue Cross Blue Shield and other insurers, hospital incentives would not be aligned to increase efficiency, says Sacks.

Additionally, HMO products represented only 20 percent of Blue Cross Blue Shield’s business with Advocate and even a smaller amount of Advocate’s overall business (less than 10 percent). “We want to be redesigning the way we do things into the future for a much larger proportion of our business,” comments Sacks. “To be fully successful in creating healthcare value, an organization needs to get to a point of having a ‘critical mass’ so that infrastructure and programs can be leveraged across a significant proportion of patients.”

Advocate thus started pursuing innovative arrangements to align incentives related to Blue Cross Blue Shield’s PPO business, which represents 80 percent of the insurer’s business and a $1 billion “spend” with Advocate and its physicians. The challenge is that PPOs offer patients the choice of hospitals and physicians and traditionally have achieved little in the way of effective control over utilization because the interests of patients, providers, and the payor are not aligned. “This is one of the reasons that U.S. healthcare costs are so high and growing rapidly,” says Sacks.

Advocate’s management team is directly addressing this challenge, starting with Blue Cross Blue Shield, which covers two-thirds of Advocate’s commercial business and about one quarter of the organization’s overall business. Effective January 1, 2011, APP established its first commercial ACO-like contract to be accountable for both inpatient and outpatient care. APP will be accountable for population health management for the Blue Cross Blue Shield PPO patients that are “attributable” to Advocate and for the trend in the overall risk-adjusted global cost of care arrangement. This adds approximately 200,000 PPO individuals to the 150,000 HMO patients under Advocate’s care management arrangements.

“We’re still finalizing the definition of ‘attributable to Advocate,’ but similar to definitions with Medicare demonstration projects, attributable patients will be those who have had repeat visits to one of our primary care physicians during a specified time period or who are seeing a specialist for a chronic condition like heart failure or diabetes,” explains Sacks. Because a fair amount of primary care is episodic and a patient might not meet the ongoing definition of “attributable to Advocate,” one of Advocate’s goals will be to create more patient loyalty in order to increase the percentage of attributable individuals, while doing a better job of managing their care. “We have to earn patient loyalty both through performance and creating enough value that patients wouldn’t want to receive care anywhere else than through Advocate physicians and hospitals,” says Sacks.

“We are deliberately establishing this arrangement through APP because the physician-hospital alignment achieved with APP through the years is critical to the arrangement’s success,” says Sacks. “We can build on our solid history and culture, tweaking incentives for more focus on the efficiency that will drive performance under the contract.” Sacks notes that the metric-based incentives tied to readmissions and length of stay, started last year, are moving in the right direction. “At the same time, we will be fully accountable for meeting patient safety, outcomes, and service metrics,” he comments.
Communication and education will be major focuses at the practice level in order to help clinicians and office staffs understand the importance of making changes that “may seem awkward at first.” “If we effectively build relationships and meet patient care needs in the primary care space, patients shouldn’t need to be hospitalized as often,” says Sacks. Although this will reduce hospital revenue, “because we’re an integrated system, at the end of the day, we will figure out how to make that work for the organization as a whole. It’s the right thing to do, regardless of what happens in Washington and how reform plays out in the marketplace. The current system just isn’t affordable or sustainable,” concludes Sacks.

**Take-Home Messages**

Many organizations are not as large or sophisticated as Advocate Health Care and their executives may be wondering how to learn from the Advocate experience and how to address the different challenges their organizations will face. We offer the following take-home points.

*Physician leadership is required for clinical integration programs and ACOs.* This is non-negotiable. Some communities simply do not have the physician “bench strength” that is needed. In these communities, hospitals will need to be proactive in developing physician leadership. Strategies to do so will include compensating physicians for their leadership time and ensuring their meaningful participation in organizational forums for strategic direction-setting and financial/organizational performance goal-setting and measurement. Advocate has more than 100 physicians involved in various roles of governance at the hospital and system level and is working hard to ensure a “next generation” of physician leaders.

*Incremental change over a period of time through a clinical integration program is achievable, independent of organization size.* Most of the implementation of Advocate’s clinical integration program occurred since 2006, but much of the groundwork commenced as early as 1995. Organizations should not be looking to “pull the ACO trigger” at this time. Rather, they should be gaining market, clinical, and financial knowledge and physician-partnering experience through clinical integration initiatives. Clinical integration is instrumental in aligning behavior to improve outcomes and drive costs down. It can be achieved over time in all organizations.

**Technology represents the largest area of required investment to pursue a clinical integration program or to establish an ACO.** However, as demonstrated by Advocate’s experience, this can be deployed over an extended period of time, such as 5 to 10 years, so as to not disrupt current operations or create massive capital requirements in a single year. Significant thought should be given to the issue of how to effectively sequence and deploy future investments in technology.

*A participating physician network can and should be developed over time and clinical and other measures can be implemented gradually.* Advocate Physician Partners continually manages the physicians who participate in the program, treating them as business partners, and carefully credentialing those who don’t perform to the agreed-upon required standards. There are 5,700 physicians on the collective Advocate hospital medical staffs, but only 3,800 physicians are members of APP. Incentive funds can and should be continually modified and updated to reflect market and pricing changes. Advocate started in 2004 with 36 measures of clinical effectiveness, adding to this base each year, and growing to more than 100 by 2010. The approach was to have a group of peers identify the measures so that physician-to-physician agreement could more rapidly be reached on the measures’ validity.

**Planning is critical to future success.** During the past decade or more, Advocate did the required clinical integration program planning to meet market needs in a way that would improve quality and lower costs. To achieve such success, careful competitive/market analysis is required as the first step of all organizations. An organization’s market must be defined and, going forward, it may be different from the current definition. The definition should be based on the market share required to achieve desired care outcomes and to keep delivery costs in line. Starting with a more limited geography makes sense at this point; numerous organizations are discovering that the cost of care for a defined patient population increases as population density decreases.
Many hospitals may find it less expensive to partner with competing or independent entities to provide services that they can’t offer cost-effectively. As markets change, patient referral patterns for tertiary and quaternary services and in-migration and out-migration patterns will change too, so frequent review of and updates to strategic financial plans will be important.

The Sidebar outlines the three stages of planning required to achieve the right clinical and technological infrastructure for clinical integration and ACO pursuit.

Antitrust issues should be considered as organizations move from clinical integration programs to ACOs. Management teams and trustees must be asking the questions, How big is too big? When might market-wide alliances that offer organizations large market shares be viewed by the government as anticompetitive? The answers to these questions will be moving targets and hospitals must be ready to defend their positions and/or adjust their strategies, as needed. A focus on achieving value rather than volume as partnerships are forged will be important.

Scale makes clinical integration programs easier to implement and will be critical with ACOs, but smaller organizations can play a role. Organizational size and scale will be required to manage the total health of a population in many markets. However, smaller organizations can create clinical integration programs with the end target of being part of ACOs. Their ACO participation may involve service offerings where they have a distinct competitive advantage in a particular market, rather than a breadth of offerings that would duplicate available services in the market. Partnerships will be mandatory for many hospitals.

Concluding Comments

To assume full financial responsibility for the provision of patient care to a defined group of patients, as will be required of ACOs, hospitals and health systems must have effective clinical integration programs. But, whether or not ACOs become the means of payment in the future healthcare delivery system, effective clinical integration will be required to achieve higher-quality care and better outcomes at lower costs. This value equation is not dependent on any particular payment system or mechanism, but rather is the core economic principle of the emerging new business model for healthcare delivery.

The functional and new capability requirements for hospitals are significant—better care management, payor contracting expertise, financial and capital planning capabilities, integrated electronic medical records, and coordinated utilization management and review systems, among others. Rigorous fact-based planning and other proven corporate finance-based approaches should guide organizations as they undertake the commitment to build these capabilities for clinical integration programs and ACOs. Both strategic and tactical plans, which have been thoroughly tested under numerous alternate scenarios, will be needed.

The point is that getting ready to compete under different payment mechanisms will be an evolutionary process, not an event. Organizations that are well-prepared at this point may need only another year or two to put in place the infrastructure for population health management; other organizations will need two or three years to develop and implement an effective clinical integration program within the current fee-for-service environment.

Defining and then taking incremental steps to position the organization for success under a value-based care/payment system are critical for all organizations.
Hospitals that sit back and wait for more clarity about federal legislation or government regulations will be left on the sidelines as clinical integration or ACO partnerships are formed with physicians and competitive organizations in their communities. Proactive positioning through the development of clinical integration programs must start now.

James J. Pizzo is Executive Vice President of Kaufman, Hall & Associates Inc., and director of the firm’s Physician Advisory Practice (jpizzo@kaufmanhall.com).

Mark E. Grube, Managing Director of Kaufman, Hall & Associates, Inc., leads the firm’s Integrated Strategic Advisory Practice (mgrube@kaufmanhall.com).

Both can be reached at 847.441.8780.

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