Partners in Health: How Physicians and Hospitals Can Be Accountable Together

Speakers:
Stephen M. Shortell, PhD, Stuart Guterman, and Francis J. Crosson, MD

Moderator:
Laura A. Tollen

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the Kaiser Permanente Institute for Health Policy
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Partners in Health: 
How Physicians and Hospitals Can Be Accountable Together

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The Web Forum recording and slides will be available at www.Dialogue4Health.com
Matthew Marsom  
Director of Public Policy  
Public Health Institute (PHI)

As Director of Public Health Policy and Advocacy for the Public Health Institute (PHI), Matthew is responsible for designing and implementing PHI strategy for monitoring and influencing public policy, legislation and regulations affecting PHI projects and public health policy relevant to PHI interests.

Matthew was previously Chief of the Policy, Partnerships and Planning Unit within the Cancer Prevention and Nutrition Section of the California Department of Public Health, where he provided support for policy development, legislative analysis and government relations, and oversaw the policy and partnership activities of the Network for a Healthy California. Website: www.phi.org
Laura A. Tollen

Laura Tollen is Senior Policy Consultant with the Kaiser Permanente Institute for Health Policy. Her recent work has focused on the potential of organized delivery systems – particularly those in which physicians and hospitals collaborate effectively – to mitigate health care cost increases and improve the quality, safety, and accountability of care.

Other projects have examined trends in benefit design and the implications of increased consumer cost-sharing. She is the author of numerous journal articles and policy briefs and co-editor of two books, *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice* (San Francisco, Jossey Bass: 2004), and *Partners in Health: How Physicians and Hospitals can be Accountable Together* (San Francisco, Jossey Bass: 2010).

Prior to joining the Institute, Laura was Senior Analyst and Project Director at the Institute for Health Policy Solutions, a DC-based think tank. Laura’s other experience includes work as a Policy Analyst in the Colorado Department of Health Care Policy and Financing.

Laura received a bachelor's degree in anthropology from the University of California, Berkeley and a masters of public health with an emphasis in health policy, also from UC Berkeley.
Today’s Agenda

Mary Pittman, DrPH, President and CEO, Public Health Institute
Welcome

Laura Tollen, Senior Policy Consultant, KP Institute for Health Policy
Setting the Stage: Why is Physician/Hospital Collaboration Important?

Stephen M Shortell, PhD, Dean, UC Berkeley School of Public Health
Organizational and Structural Change to Support Physician/Hospital Collaboration

Stuart Guterman, Vice President, The Commonwealth Fund
Payment Reform to Support Physician-Hospital Collaboration

Francis J. Crosson, MD, Senior Fellow, KP Institute for Health Policy
Stakeholder Action Steps to Support Physician-Hospital Collaboration
The New Delivery System Reform Opportunities

• Accountable Care Organizations in Medicare
  ✓ An ACO is an “organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries in traditional Medicare.”
  ✓ Shared savings payment model
  ✓ Effective January 1, 2012; CMS regulations due in Fall

• CMS Innovation Center
  ✓ Charged with developing payment models that can both improve quality of care and slow cost growth
  ✓ $10 billion in funding for pilot programs, 2011-2019
  ✓ Focus on Medicare and Medicaid
According to Law, a Medicare ACO is:

- A group practice
- A network of individual practices
- A partnership or joint venture
- A hospital employing professionals, or
- “Other entity determined by the Secretary”
  - Why not a public health department, community clinic, public hospital, etc?
Polling Questions
A Chicken and Egg Conundrum

• Changes to both the structure of and methods of payment to health care providers will be necessary to produce significant changes in the trajectory of health care costs, but which comes first?
  - If you pay for it, it will come into being, or….
  - You can’t pay for it until it exists!

• The payment model should challenge the existing delivery system to be better without setting the bar so high that it’s out of reach
Moving Away from FFS Puts Care Coordination in the Spotlight

- FFS pays providers more for doing more….so (most) chronic illnesses are profitable!
- A changing payment paradigm creates financial pressure to provide better value in chronic disease care.
- There will be an need for better coordination across the entire continuum of care – including the public safety net system.
Stephen M. Shortell, PhD

Stephen M. Shortell, Ph.D., is the Blue Cross of California Distinguished Professor of Health Policy and Management and Professor of Organization Behavior at the School of Public Health and Haas School of Business at the University of California-Berkeley. He is also the Dean of the School of Public Health at Berkeley. Dr. Shortell also holds appointments in the Department of Sociology at UC-Berkeley and at the Institute for Health Policy Research, UC-San Francisco.

A leading health care scholar, Dr. Shortell, has been the recipient of many awards including the distinguished Baxter-Allegiance Prize for his contributions to health services research. He is an elected member of the Institute of Medicine of the National Academy of Sciences.

He is currently conducting research on the evaluation of quality improvement initiatives and on the implementation of evidence-based medicine practices in physician organizations.
Stuart Guterman is vice president for Payment and System Reform at the Commonwealth Fund, based in Washington, D.C. He is responsible for the Fund’s research agenda on the use of payment incentives to elicit changes in health care delivery that can achieve high performance; the development, management, and review of grants to be funded under the program; and analyses related to the current performance and future improvements in the payment system and the health system overall.

Mr. Guterman was director of the Office of Research, Development, and Information at the Centers for Medicare and Medicaid Services from 2002 to 2005. Prior to that, he was a senior analyst at the Congressional Budget Office, a principal research associate in the health policy center at the Urban Institute, and deputy director of the Medicare Payment Advisory Commission (and its predecessor, the Prospective Payment Assessment Commission) from 1988 through 1999.

Previously, Mr. Guterman was chief of institutional studies in the Health Care Financing Administration’s Office of Research, where he directed the evaluation of the Medicare Prospective Payment System for inpatient hospital services and other intramural and extramural research on hospital payment. He holds an A.B. in Economics from Rutgers College and an M.A. in Economics from Brown University, and did further work toward the Ph.D. in Economics at the State University of New York at Stony Brook.
Francis J. Crosson, MD

Dr. Crosson is a Senior Fellow in the Kaiser Permanente Institute for Health Policy. He was the founding Executive Director of The Permanente Federation. From 1997 to 2007 Dr. Crosson served as the Executive Director of the Federation and co-chair, with Mr. George Halvorson, CEO of Kaiser Foundation Health Plan and Hospitals, of the Kaiser Permanente Partnership Group (KPPG). Dr. Crosson also served as the CEO and President of The Permanente Company. He also currently serves as a consulting senior executive of the Permanente Medical Group.

In 2002, Dr. Crosson founded and now chairs the Council of Accountable Physician Practices (CAPP), an affiliate of the American Medical Group Association. CAPP is an alliance of 34 of the nation’s largest multi-specialty group practices which promotes delivery system improvement in the United States.

Dr. Crosson is Past Chair of the Governing Board of the American Medical Group Association and also served on the California Medical Association Board of Trustees. Dr. Crosson just completed six years on the congressional Medicare Payment Advisory Commission (MedPAC), where he served as Vice-Chairman from 2009-2010.
Send in your comments and questions using the Q&A feature.
Stephen M. Shortell, PhD
## The Institute of Medicine’s Redesign Challenges and the Transactional-Relational Continuum

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<tr>
<th>Redesign Challenges</th>
<th>Transactional</th>
<th>Relational</th>
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<tr>
<td>Redesign Care Processes</td>
<td>Separation of Office Practice From Hospital Practices; Ad-hoc Committee Work on Quality Improvement Processes</td>
<td>Protocols and Pathways Established for Entire Episode of Care Embracing both Inpatient and Ambulatory Care Disease Management Teams Work Seamlessly with Primary Care Physicians and Hospital Staff</td>
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<td>Effective Use of Information Technology (Electronic Health Records, etc)</td>
<td>Hospitals and Physician Make Independent Decisions; Independent Vendors</td>
<td>Coordinated IT Strategy Established after Redesigning Patient Care Workflow (See Above). Work with Common Vendor</td>
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<td>Knowledge and Skills Management</td>
<td>Occurs Largely in Isolation and by Chance; Traditional Clinical Education Programs</td>
<td>Use IT Capability (See Above) to Generate Real Time Data for Knowledge and Upgrading of Skills; Custom-Designed Problem-Focused Learning</td>
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<td>Develop Effective Teams</td>
<td>Separation between Hospital Teams and Private Practice Teams; Separate Team Development Programs</td>
<td>Continuum of Care Based Team Development; Disease Management Team Training Includes Inpatient, Outpatient and At-Home Care</td>
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<td>Coordination of Care Across Patient Conditions, Providers, and Settings Over Time</td>
<td>Accomplished Through Integrating Referral Arrangements and Contracts; Little Monitoring or Feedback</td>
<td>Designed into One Care Plan across Settings and Providers. Common EHR (See Above) Helps with Flow of Information and Feedback</td>
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<td>Performance and Outcome Measurement</td>
<td>Largely Ad-Hoc, Accreditation Oriented, Separation of Hospital Indicators from Ambulatory Indicators</td>
<td>Integrative Scorecard Set of Indicators Used for Quality Improvement and External Reporting</td>
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## Key Factors for Achieving Hospital/Physician Integration

### Outcomes

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<th>Quality of Care</th>
<th>Cost</th>
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<td>• Clinical Outcomes</td>
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<td>• Functional Health Status</td>
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<td>• Patient Experience</td>
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### Robust Properties

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<th>Aligned Incentives</th>
<th>Care management practices</th>
<th>Clinical information technology</th>
<th>Continuous quality improvement</th>
<th>Population-based health care delivery models</th>
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### Foundation Properties

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<th>Leadership and empowerment</th>
<th>Governance and management</th>
<th>Capital</th>
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Supportive Framework for Creating Accountable Care Organizations (ACOS)

- Financial Incentives and Regulatory Flexibility (for example, Bundled Payments, Shared Savings)
- Internal Capabilities (for example, Electronic Health Records, Governance and Administrative Leadership)

Transparent Accountability
(Performance Measurement and Public Accountability)
Payment Innovation in Health Reform Legislation

- Medical home: Expansion of current Medicare demonstration, new Medicare pilots, Medicaid initiatives
- ACO: Broad responsibility for quality and cost of patient care, rewards for quality, shared savings
- Bundled payments: Medicare pilots for hospital and post-acute care, Medicaid initiatives
- Medicare Advantage: Rates based on plan performance
- Center for Medicare and Medicaid Innovation
A Flexible Payment Approach

Continuum of Payment Bundling
- Global Payment
- Global Case Rates
- Blended FFS/ Care Mgmt. Fee
- Fee-for-Service

Continuum of Organization
- Small practices; unrelated hospitals
- Independent Practice Associations; Physician Hospital Organizations
- Fully integrated delivery system

Feasible Payment Options
- Outcome measures; large % of total payment
- Care coordination and intermediate outcome measures; moderate % of total payment
- Simple process and structure measures; small % of total payment

Using the Payment System to Move Toward More Integrated Care

• Provide an array of bundled payment options
• Offer positive incentives for providers who take broader responsibility for quality, outcomes, and efficiency of care for their patients
  --Larger payment updates for providers in accountable care organizations
  --Larger rewards for high performance providers
  --Shared savings for provider organizations that reduce cost growth (tied to high performance?)
• Make fee-for-service payment less attractive to providers
  --Smaller updates for providers in fee-for-service
  --Smaller updates for providers in high-cost areas (except those who participate in bundled payment mechanisms)
• Establish an infrastructure for improved care
  --System reforms (e.g., comparative effectiveness mechanism, health information exchange, public health)
  --Shared resources (e.g., night/weekend care, chronic care management)
Francis J. Crosson, MD
“Regardless of the outcome of the current debate, and even if no legislative changes occur in access or delivery, health care must and will be fundamentally redesigned...

This book begins to elucidate where we have been, where we are now, and a bit of where we should go to create structures that might unleash provider driven, patient focused, value based care redesign.”

- Dr. Glenn Steele, CEO, Geisinger Health System

Francis J. Crosson, MD

Laura A. Tollen, MPH
Stakeholder Action Steps to Support Physician-Hospital Collaboration

**Hospitals**
- View physicians as partners, not competitors or employees
- Support the development and success of legitimate physician leaders
- Build a business case for success with new payment models
- Support the formation of multispecialty group practices

**Physicians**
- Create or join a multispecialty group practice
- Adapt to new payment methodologies
- Newly engage with hospital governance and management
- Understand the utility of care and patient safety pathways
- Manage the new reality of transparency
- Learn to lead and follow

**Policy**
- Mitigate legal and regulatory obstacles to integration
- Prevent delivery system monopolistic pricing
- Support payment reforms that move away from fee-for-service
- Experiment with risk sharing rather than risk transfer
- Accept reasonable delivery system consolidation

Kaiser Permanente Institute for Health Policy
Discussion and Q&A
Thank you for your participation!

If you have further questions, please contact Laura Tollen: laura.a.tollen@kp.org