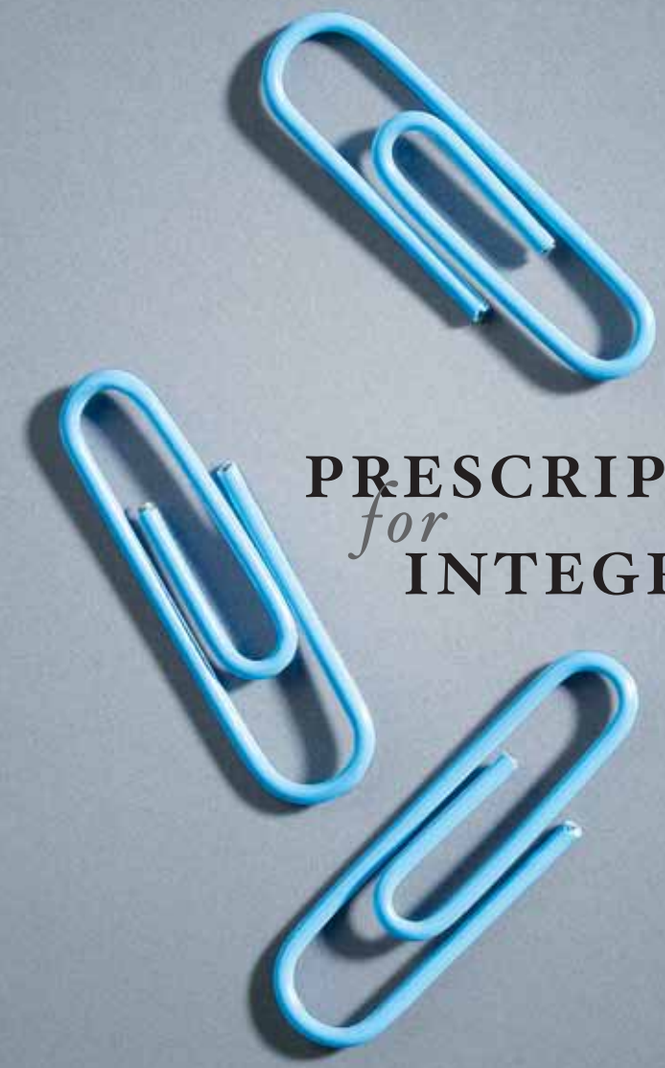

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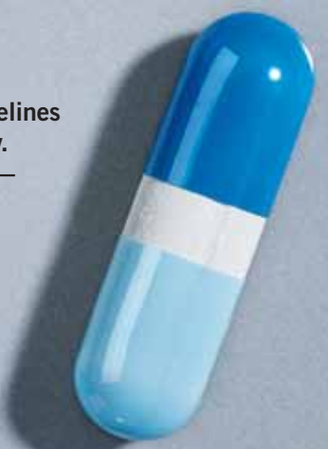

Many U.S. hospitals and physicians are waiting on the sidelines to see if healthcare reform legislation will become a reality. But such hesitancy will put their economic health at risk — regardless of what shape the legislation finally takes.

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PHOTOGRAPHS BY ADAM VOORHES

Understandably upset about the specter of declining revenue, many U.S. hospitals and physicians continue to hold out on healthcare reform, more than a year after the historic legislation was passed. Yet even if the law were to be repealed, America's burgeoning medical bill is not going away. Whatever payment models government and private health insurers establish, such requirements will force healthcare providers to dramatically raise their game: providing better care at more affordable prices. If hospitals and doctors don't play along, they will be at a major competitive disadvantage that will threaten their economic survival.

Premature prognosis? Hardly. The U.S. healthcare system has reached a precarious tipping point, the culmination of decades of spiraling healthcare costs. Despite many attempts during the past 30 years to enact reform and control costs, the financial ecosystem that links up clinicians, hospitals and health systems, and insurers is clearly unsustainable. Past cost-control initiatives have not kept pace with the continued cost increases because of changing demographics, expensive new medical technologies and ever-longer life expectancies.

U.S. healthcare costs now account for more than 17% of GDP, up from 12% in 1990. Annual spending today averages about $7,000 per person. And now baby boomers have officially begun their slow march onto the rolls of Medicare, the government health insurance program covering everyone age 65 and older. These 78 million Americans born between 1946 and 1964 are expected to boost Medicare enrollment from 45 million in 2010 to 64 million by 2020.

That so-called tipping point seems more and more like a breaking point for the U.S. healthcare system.

THE ACCOUNTABILITY CURE

With the nation's healthcare system facing economic crisis, legislators passed a historic healthcare reform act in March 2010 to address the spiraling costs. To bend the cost curve, one measure encourages the creation of accountable care organizations (ACOs). The ACO model ties reimbursements for medical providers to two key components: strict adherence to quality metrics, and reduction in the total cost of care for a defined population of patients.

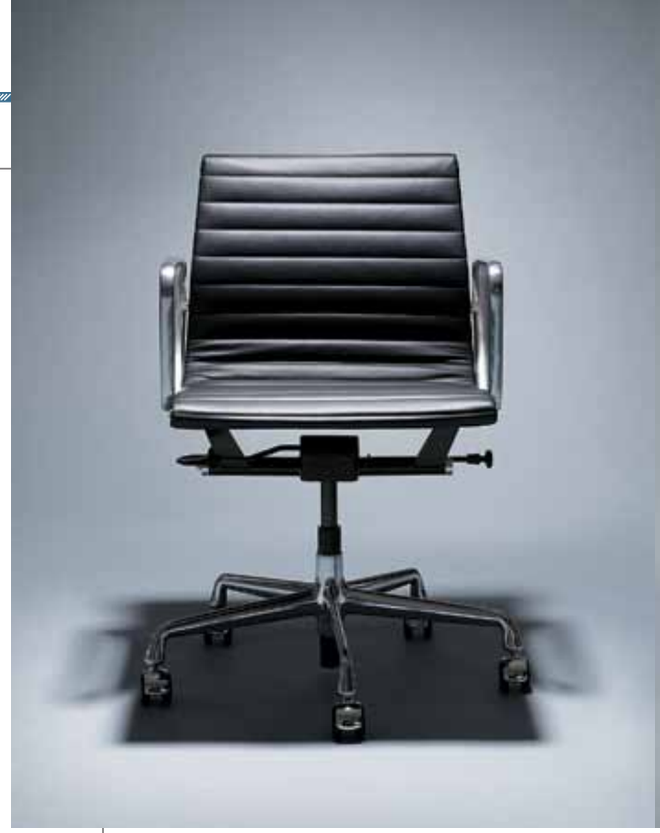
While ACO may be a new term for many, in truth the healthcare industry has been moving away from traditional "fee for service" relationships toward quality-based reimbursements for some time. Pure fee-for-service reimbursement is going away. In some markets the rate of change is faster than in others. But most payers are seeking to base a significant percentage of payments on performance.

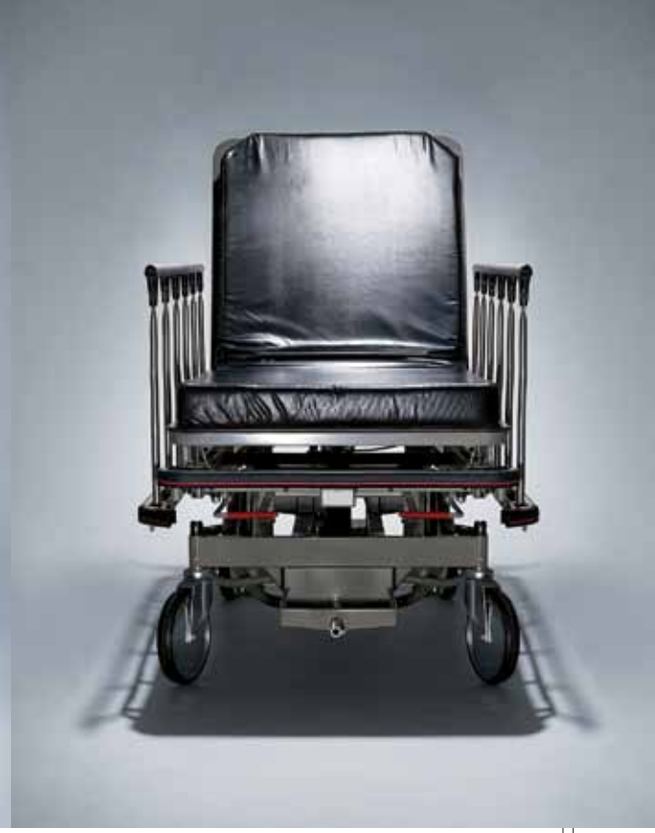
The ACO model is understandably attractive to organizations that pay for healthcare. This is especially true for health insurers, which are squeezed between the demands of large employers to reduce premiums and those of providers concerned about diminishing revenues. But while payers are embracing ACOs' transfer of risk to providers (especially in California, where assumption of clinical risk by providers is still prevalent), most providers are not nearly as enthusiastic, and few have adopted the model.

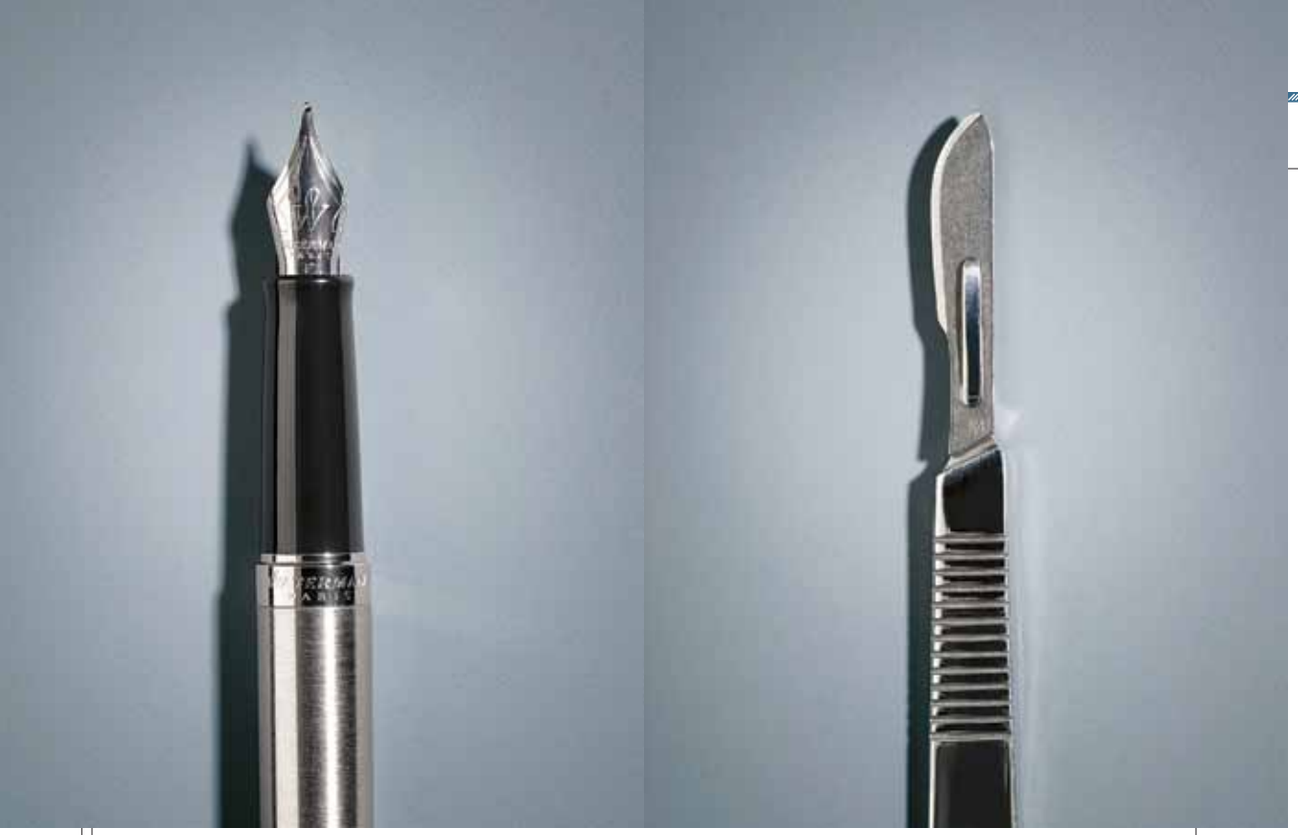
Many healthcare providers argue that the uncertainty around ACOs makes it difficult to buy into the model, which in most cases requires a significant financial investment to ensure success. The cost of implementing technology, reorganizing physician practices and instituting performance measurement systems can be substantial.

In particular, providers make the following arguments:

Many providers argue that the uncertainty around ACOs makes it difficult to buy into the model, which usually requires a significant financial investment to ensure success.







- There is far too much uncertainty in the guidelines on ACOs issued by the Centers for Medicare & Medicaid Services (CMS). Hospitals are being asked to reorganize and invest in a system that is not clearly defined.
- Providers are not proficient with the new regulations because the legislation is new and they haven't fully digested its actual and implied changes.
- The current legislation applies only to Medicare and Medicaid (a joint federal-state health insurance program for the poor) patient reimbursements, a sizable but still limited portion of the entire population.
- It may not make sense to invest in updated systems with the real chance that healthcare legislation may be repealed under a new administration.
- The ACO model may not actually save hospitals money. In part, ACOs reduce costs by lowering demand for unnecessary procedures. Providers worry that lower demand will cut into their bottom lines.

All of these arguments have merit. But they miss the point that the ACO model includes approaches that providers should adopt regardless of the specifics of future payment models. Providers that don't start making these changes soon will find themselves at a competitive disadvantage.

Because of changing demographics, the payer mix is shifting, with a higher proportion of patients qualifying for Medicare and Medicaid. Whether or not ACOs become a model for the health system at large, it seems inevitable that the future reimbursement model for CMS-qualified patients will be based on pay for performance. As a result, providers need to begin standardizing best clinical practices, support disease prevention, reduce overutilization and take responsibility for medical outcomes. Those that do not will likely see declining reimbursements.

Achieving these things requires much closer alignment of physicians and providers than is found in most healthcare systems today. Physicians need to work toward the same objectives that hospitals do: reducing the length of hospital stays, minimizing resource consumption and improving outcomes. What's more, physicians from different specialty areas must work more closely with one another to improve the outcomes for patients who need to be treated by several specialties. These strategies are not incremental changes for physician-provider relations in many healthcare systems but transformative ones in an already embattled industry.

ONE GOAL, MULTIPLE APPROACHES

It is becoming clearer by the day that most healthcare providers must start implementing elements of the ACO model. Early adopters can also gain the favor of consumers and advocacy groups seeking quality and price transparency.

The ACO model holds physicians and hospitals jointly responsible for improving quality and reducing costs. Yet it is up to both groups to determine how best to achieve the goals. For instance, hospitals can lower the cost of treatments by standardizing a "proven" best practice. One group of South Carolina hospitals, for example, embarked on a program of evidence-based care and reduced the rate of mortality from acute myocardial infarction from 12% to less than 5% in the first year.

Providers can reduce costs and improve outcomes by helping patients look after their health. Some providers are educating patients and giving them incentives to do that. For instance, an Alabama program in 2004–2007 to help diabetics manage their condition reduced their emergency room visits by half.

Another way to reduce healthcare costs is to steer patients away from unnecessary hospital visits altogether. That requires establishing the local primary care clinic — not the hospital — as the core of the healthcare delivery

system. Recent studies have shown that a patient-centered medical home model benefits both patients and medical staff, giving patients more one-on-one time with a physician, improving caregiver cooperation and providing more preventive care.

Hospitals can improve efficiency, too, by better managing complex patients — that is, those with more than one condition. Studies have shown that patients in hospitals employing hospitalists — attending physicians for individual patients — tend to have shorter stays, especially in cases requiring close clinical monitoring or complicated discharge planning.

Most of these changes require strong clinical integration: primary care physicians, specialists, nurses and hospitals coordinating their activities to improve outcomes for every patient.

BETTER QUALITY, LOWER COSTS

Baptist Health, a San Antonio, Texas-based five-hospital system with 1,741 licensed beds, was an early participant in a CMS-sponsored Acute Care Episode Demonstration (ACE Demo) project, a Medicare program launched in 2009 that pays participating hospitals a lump sum for hospital and physician services. The goal of ACE Demo is to give hospitals and physicians the right incentives to improve quality and lower the cost of care for 28 cardiac and nine orthopedic diagnosis-related groups of illnesses.

In the first year, Baptist consolidated vendors and reduced the costs of implants by 15%, from $6,000 to $5,000 per case. Baptist tracked 22 CMS quality metrics, of which a subset was used to calculate savings to be split equally between the physicians and the system. By the beginning of 2011, the program had saved Baptist $4 million, and hundreds of thousands of dollars had been paid out to physicians and patients in shared savings.

In addition to savings, Baptist reported dramatic improvements in patient care and quality, including:

- Quality at or approaching 100% for all metrics
- Improved physician alignment
- A shift toward evidence-based practice
- Higher physician satisfaction

Despite many providers' cautiousness about ACOs, Baptist and other health systems are demonstrating real savings and quality improvements by following the precepts of an ACO model. As with Baptist, that means getting the hospital and doctors in formerly segregated clinical disciplines to work closely to produce better outcomes at lower cost for every patient. Such strong collaboration around patient outcomes is referred to in medical shorthand as clinical integration. And clinical integration depends on two factors: better alignment of physicians and the ready availability of clinical data, on both individual patients and populations.

> For most health systems, getting physicians who aren't employed by a hospital system to buy into standardized processes will be a major challenge. Still, it is possible.

PHYSICIANS TAKE THE LEAD

A few health systems, such as Kaiser Permanente and Cleveland Clinic, employ the majority of their physicians. As a result, it is easier for them to get hospitals and physicians working toward the same goals. But for almost everyone else, getting physicians who aren't employed by a hospital system to buy into standardized processes will be a major challenge. Still, it is possible.

Let's look at how one health system is getting its hospitals and independent physicians on the same page.

Consider the success of the Henry Ford Health System (HFHS), which was once a closed system consisting of the Henry Ford Hospital, the 1,300-doctor Henry Ford Medical Group, and a fully owned health insurer, Health Alliance Plan. But in recent years, HFHS has built or acquired four community-based hospitals, creating relationships with many physicians who

U.S. HEALTH EXPENDITURES AS PERCENTAGE OF GDP

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
13.8	14.5	15.4	15.9	16	16	16.1	16.2	16.6	17.6

Source: Centers for Medicare & Medicaid Services

are not part of the medical group. The challenge for HFHS: How can it partner with private-practice physicians and those employed at other hospitals? Many of these physicians want to remain independent and do not want, for example, to participate in the education and teaching requirements of the medical group.

HFHS began looking at how to increase clinical integration back in 2009. The initial motivation was not healthcare reform. Rather, large local employers expressed to Health Alliance Plan their desire to engage with a high-performance network. HFHS leadership realized that if it could integrate physician groups and thereby reduce medical costs and improve quality, it would have something attractive to offer the broader marketplace.

Eighteen months later, the hospital system has the entity in place: the Henry Ford Physicians Network (HFPN). To date, the physician network includes all Henry Ford Medical Group physicians, hospital-employed physicians and almost 200 independents.

Engaging the physicians early in the process and letting them lead it were critical, according to Matt Walsh, HFPN's vice president of operations. The board of HFPN has 15 members, of whom 13 are physicians. Walsh believes that physicians agree quickly to the core tenets of clinical integration — partnership and value creation through improved quality and efficiency — because physicians intrinsically believe in these principles. Payer contracting is another matter, however. The dollars and fee schedules quickly engage the interest and concern of all stakeholders. Careful development of a management structure that builds trust in this area is critical.

Walsh advises health networks moving toward greater clinical integration to communicate to physicians how it benefits them. For the independent physicians in HFPN, those advantages include continuing medical education, performance feedback, and access to best practices and affordable information technology tools and support. All these give physicians opportunities to improve their practices and create access to future contracting opportunities. As more and more physicians realize that fee-for-service reimbursement will fade into the past, such benefits become important incentives.

DATA REVEALS OPPORTUNITIES FOR IMPROVEMENT

The collection and processing of data are also critical to better clinical integration. First, integration of services for each patient is much more effective if there is a patient-centric health record — an electronic health record, or EHR. Second, if healthcare systems are proceeding to a full ACO model, they must report performance metrics to CMS to share the savings benefits beginning in 2012. Most important, it is impossible for hospitals to know where to make improvements without knowing their current performance.

Norton Healthcare is a five-hospital, 500-physician, 100-location Kentucky-based nonprofit healthcare system. Long before the acronym ACO made its way through the halls of Norton Healthcare's Louisville headquarters, the healthcare system was bullish on using data to improve its services. It has long shared performance data with the public. On its Website, it publishes performance metrics for more than 600 quality criteria, each benchmarked to national averages.

Impending healthcare reform was one reason Norton started moving toward greater clinical integration. But it also wanted to leverage its skills in data collection and usage.

As Steven T. Hester, M.D., senior vice president and chief medical officer, explains, "We have much more data than we did 20 years ago, and we can use the data to find opportunities. Everyone always thinks they are doing well, but until you can show them data on how they compare with their peers, internally and externally, they don't know how well, or where the opportunities for improvement might lie."

Given the breadth of data available to Norton physicians, the organization can influence a wide range of quality indicators. As an example, Hester explains how the hospital can focus on reducing the length of stays. "We have specialists who work with hospitalist groups on how they manage care," he says. "We can give them data that compares their indicators with their peers on, for instance, readmissions or length of stays. This information is key to helping them understand how to move patients through the system. Consider a neurosurgery patient. His specialist may

be in the operating room and not be able to discharge him until the end of a busy day. But now the hospitalists see where the bottleneck is and can keep the process moving without having to wait for the specialist to be free."

Comparing practices has been important in just about every industry. Healthcare is no exception. As Hester points out, "Benchmarking data is critical. Clinicians need to see where they sit versus others in the community, both within their own health system and outside."

This cannot be done manually, at least not for any meaningful length of time. Every health system with several hospitals, hundreds of physicians and thousands of patients needs to report dozens of metrics and monitor hundreds more. That requires information technology. Norton has made, and continues to make, significant investments in IT for clinical data collection, processing and reporting.

As Baptist and others have demonstrated, there are financial and quality benefits from organizing as an ACO. Clinical integration brings a range of benefits, including the following:

- Higher quality and efficiency through better-coordinated care
- Improvements against pay-for-performance measures
- A more collaborative relationship with medical staff, leading to higher physician loyalty
- Greater physician support for hospital initiatives

Despite such benefits, healthcare providers trying to migrate toward an ACO model must overcome significant barriers:

- Uncertainty about the future of healthcare reform. No institution relishes investing significant capital in projects without a clear mandate. The possibility of wholesale changes to current reform legislation creates uncomfortable ambiguity for executives.
- The complex task of technology implementation. History is littered with the debris of large healthcare IT projects, and IT challenges in healthcare seem no smaller than they were 20 years ago.
- The challenge of managing change and gaining the trust of physicians. Private-practice doctors are often inherently distrustful of hospitals. It takes time and effort to convince physicians that their needs will be heard during times of reorganization.

The most powerful ways to overcome these barriers are engaging physicians early and giving them leadership roles in which they can shape the future organization. It is especially important to involve physicians who are influential and believe in the change. In addition, identifying very early in the process what data is needed and putting in place the systems to collect and report it is vital.

> Given the inevitable migration from the fee-for-service model toward reimbursement on outcomes, systems should not wait for the future of healthcare reform to arrive definitively.

THE ACO ADVANTAGE

Given the inevitable migration from the fee-for-service model toward reimbursement on outcomes, health systems should not wait for the future of healthcare reform to arrive definitively. Whether or not the current version of reform or of ACOs survives, greater clinical integration will soon define the higher-performing health systems.

The ACO model's core tenet of greater clinical integration is simply good patient care and good business. It reduces costs and improves quality in an industry that badly needs both. What's more, for organizations willing to commit to the hard work of quality measurement and clinician alignment, there is the prospect of first-mover advantage. Patients are acting more and more as healthcare consumers; they, too, are advocating for quality, efficiency and transparency.

For providers, there's really no reason to wait. ■