



# NAVIGANT

## On Healthcare

HEALTHCARE

# CLINICAL INTEGRATION STRATEGIES TO DRIVE VALUE-BASED PERFORMANCE

**Announcer:** Welcome to Navigant On Healthcare. Offering insights for healthcare leaders striving for success in an evolving industry.

**Host:** Welcome everyone to, what we hope to be a very exciting presentation. The topic today is very valid, given where we are with the healthcare and the transition from fee-for-service to fee-for-value. So, having this discussion around clinical integration strategies to drive value-based care, something that's going to be very important for many organizations. Really, the realization that many healthcare systems can't clinically integrate and manage populations on their own, or even with their employee medical group...clinically integrated networks have become really a vehicle of choice to align providers across the continuum -- both employed, as well as independent providers, primary care, as well as specialists -- to drive outcomes.

We can see that significant growth that's happened with clinically integrated networks, ACOs, other entities that are really being brought together to drive Triple Aim performance.

The challenge that we're all aware of, is that, if we look at the data that's out there from MSFT and other reported information, year after year, we only see about a quarter of ACOs reporting a degree of quality and cost improvement that's leading towards shared savings.

So, we're left with the question of asking: "Is it valuable to invest in clinical integration strategies, and other accountable care/population health strategies to drive performance?" While we ask ourselves that question, as providers, we have to realize that the results that are being produced for the government, and for other payers, other purchasers of healthcare, are very meaningful.

Where millions of dollars are being generated for the government and payers, regardless if we hit the minimum threshold for shared savings or not. Furthermore, there's goals that are out there from CMS around advanced payment models, wanting 30% of payments by the end of 2016 to go through some form of alternative payment model. Also, as we looked at fee-for-service reimbursement that are tied to quality, around 85% of that happening through some kind of quality by 2018.

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So, whether we like it or not, we feel it's fair or not, the movement from fee-for-service to fee-for-value will continue. So, the question that we really need to ask as providers is: "What does that mean? And how can clinical integration really serve as a strategy to help us be successful moving forward?"

What we really believe as Navigant, and you'll hear this from our speakers today based on their experience, is that clinical integration cannot be a noun. It's not sufficient, it's not a successful strategy to only create a legally compliant organization and expect for us to deliver the results at the market as looking for.

We believe here at Navigant that clinical integration must be a verb. It must really describe a set of actions that happen across your network that are really geared to demonstrate real results that successfully transition toward value-based care that we can deliver toward the market.

So, Dr. Shields that we welcome and excited to have you today. Look forward to hearing more from you about what foundation truly needs to be in place in order for a clinical integration strategy to be successful.

**Mark Shields, M.D.:** Well, thank you very much, Dennis. It really all starts with culture. It's having physicians across specialties agree that by working together and by driving quality, patient safety, and cost effectiveness, then they can be successful as a business entity.

It's critically important, as we will talk about later on, to partner with a health system. In some places physicians are going alone on this, but there're enormous advantages to partner with a health system. Heading the physician leaders who buy into this culture is the key starting step, but then you need to support those physicians with training and governance.

Just because a physician is effective in the OR, or in the consultation room, does not mean that they can manage a hundred billion dollar a year enterprise. Physicians need to have that support and training. Then, docs need to be supported with infrastructure. You need to give them practical tools that will make a difference in their day-to-day work. In driving quality, patient safety, and cost effectiveness.

You'll be asking doctors to do things in new ways and to do new things. So, they need to be paid for that, and they have the financial support to have their staff engaged with them.

Transparency of results, we know, will drive performance -- even without financial incentive.

So, agreeing across your network that physicians will be able to see how their peers are functioning, and how they rank compared to their peers, will be very important. And then summing the success of the network across all the physicians will be very important to feed back to the physicians, and to feed back to payers and to the market place.

That will help develop the pride and performance, which will drive the culture even further. We need to really make a key: "What's in it for me?" argument for each of the key components of the successful clinically integrated network. Patients need to understand what's in it for them. It's better care, better experience, and lower cost. What's in it for physicians? It's better care, it's more patients, and it's better pay. For hospitals, it's better care and alignment with physicians.

**Host:** Yeah, thanks a lot Mark and completely agree with your comments about culture and also being market responsive, as we're creating relationships with theirs.

Now, we're going to move the conversation back to Dr. Joe, Joseph Vasile. You can see from the screen here Dr. Vasile is President, CEO of Greater Rochester Independent Practice Association (GRIPA) -- as I mentioned, one of the first clinically integrated networks to achieve FTC approval. Dr. Vasile, we appreciate you joining us today and look forward to your comments on how we can really move toward true clinical integration and transformation to drive value for the patients that you all are serving. So, Dr. Vasile, welcome.

**Joseph Vasile, M.D.:** All right, thank you Dennis. It really is a pleasure to be here today. What I think you're going to hear is I'm going to echo much of what Mark discussed. A lot of what we do, or much of what we do, really starts with data. GRIPA has a data repository where we're able to take detailed claims information from the insurers, from those contracted members, and we're able to match that up with clinical data.

That's really the foundation for the reports that we use to run our population help program. Briefly, some of the reports that we have, we have the gaps in care report, so through the claims we will know the name of the patient. We'll know the patient's physician. We'll know what diagnosis they have.

Let's say they have diabetes. At that point, we'll use our data repository and our analytics to look and see if that person has had, that patient has had the appropriate testing. So, we'll make sure they have a hemoglobin A1C. If they don't have the Hemoglobin A1C, those reports, or that will end up on a report that goes to our physician to look into to ensure that they have the appropriate testing.

It's been a very powerful, very simple data-driven report to improve care and to improve quality.

Another place we look are our high risk, high cost patients. There are algorithms to look for those patients, but there's really no mystery to what they are. So, if we have a patient that's aged 65 and older, has 12 ED visits, has had 15 different physicians as part as their care and they're on six medications, and they're high cost over a certain threshold...they will appear on our reports. And that's where we engage our active care management program to try to find out what's going on. It could be that the patient has medications prescribed, but they're not filling them. Could be something as simple as not being able to get to their clinic appointments and our experienced care management team is really to make, is really able to make appropriate interventions.

We have had some significant savings that we have been able to document.

Another part of our program is how we actually engage our physicians. The first bullet I can't over emphasize, is just simple communication. Could be a lot of dinner meetings, could be larger group meetings, could be phone calls, with a very active CMO that visits over 400 physicians in a given year. Much of his job is really getting into a car and going and visiting the physicians in their offices.

Well, we talk about high tech and data; there's really no substitute for one-on-one communication with the physicians. Our incentive methodology, and I'll show an example of that in a moment, is really tied to the performance in the contracts. Like I said, we made a decision that we were going to pay for actually moving the dial. Easy to read and understand meaningful score cards for our physicians has been instrumental. With that is transparency. All of our physicians, our primary care doctors, which is where our program is mainly centered right now, can see their score and the score of their peers on all the quality metrics by name. So, you could see where you end up, and where your peers are by name.

Just that transparency itself has moved the dial. As organizations begin to enter into this world, the quicker you can get to a point where you have transparency, especially around quality reporting, the better off you will be. The other goal that we have is to aggregate all of our physician contracts and then create one, our payer contracts, and create one actionable report for our physicians. We want to make sure that they're not practicing in different ways for different insurers. But they're able to look at their patient population as one and to care for them in the same way. And as we add more contracts, that becomes easier to do.

**Host:** Thanks a lot Joe. I appreciate your comments about how you can align your governance, you can align your analytics reporting, specific initiatives around pharmacy and tying that all together with your intensive model that drives performance. So, I appreciate the comments there. Very excited about Matt Hussmann being on the line with us today. He is the director of population and practice management analytics for Henry Ford Health System. Matt welcome today, and look forward to your comments.

**Matt Hussmann:** Thanks Dennis. This is really what we've been focusing on here at Henry Ford Health System about population health. I'm going to kind of go around the circle starting that corner with Epic...and this is actually even the journey that we took as we were trying to build our data warehouse.

So, starting in that corner, you know we already have access to a lot of information in your EMR. So, we try to take that information and organize it, so that way it's more easily reportable for our physicians. I've heard a lot of people, we're talking about HEDIS, or we're talking about quality scores. There's information that's already in Epic that's great to pull from. So, we worked on really standardizing that information in there, so we can report on it very quick and cleanly.

Then next, we really moved onto building out physician panels. So, this really wasn't even part of, I think, what we're talking about in the population health side. But this is more of that community, where all the patients that our primary care physicians touch. You know, the not insured patients, the Medicaid and Medicare -- you know, a commercial patient.

So, we created panels. That way we know that when we say, are we delivering value for all of our patients, we look to those panels. We also brought in U.S. census data. It's free; it can go out there and just download the U.S. census data. That really helps us drive our risk stratification of our patients about understanding some social economic information about them. We also brought in our Press Ganey; we used them as our patient experience. So, now we also have the ability to report on our physicians through that patient experience lens.

The MiHIN (Michigan Health Information Network) ADT (admission, discharge, transfer) feed, which, that is our, the state of Michigan. Again, that's our HIE (health information exchange). So, we connect to that to know if one of our patients gets discharged from a hospital anywhere in the state. We know the next day and we can follow up with them appropriately.

Then, this last one is where I think a lot of people will always go and try to focus on which is... definitely, a critical spot, but it's your eligibility and claims feeds. So, it's trying to bring in all of those patient files, know who your patients are, and the claims data. That kind of completes the loop about the patients that they go outside your health system.

One thing, just to note on that side too, is if you're starting the journey. I would highly suggest starting with those eligibility files first. Getting that data stored in your warehouse opens up a lot, especially as you connect it back to your EMR.

Some lessons that we've learned, kind of over our decade, or so, of doing this type of work:

So, the first thing is that the core of the work of the data shouldn't be completed by a vendor. It's something that we got in trouble with early on, and quickly found that one out. And I'm not trying to say that you should not be working with an external vendor. I think they can be a great strategic partner in this journey and we have vendors that we use as strategic partners. But if you're going to be a data-driven, or data-focused organization, there's going to be a lot of questions where you just need access to that raw data to be able to pivot it in the--to be able to answer the specific questions that the organization's going to have.

Then, so on that side, I would really say to for our analyst team to really think about how to best structure your data. So, the things I was showing on these slides, we've had this where the file comes into the health system automatically. It's been loaded into our warehouse automatically, and our reports are published from that automatically. That takes a while to get that all set up, but as we set that up, now, we don't have to worry about it. We can set it on a timer; they just run. And now that frees up our team to focus on the issues that are facing us today.

**Host:** Matt, we certainly appreciate your comments. You all at Henry Ford have been at this for a while, and it's been managing risk contracts and associated data sources to manage that risk population for a long time. Also, thank you to Mark and to Joe for the robust conversation and presentation that we've had today.

**Announcer:** That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare podcast series on [Navigant.com/healthcarepodcast](http://Navigant.com/healthcarepodcast). Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at [navigant.com](http://navigant.com).

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