Quality Driven Health Care:
A Medical Staff’s Increasing Role Post Health Care Reform

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Agenda

> What is Driving the Shift to a Focus on Quality?
> The Governing Board Must Make Quality a Priority and Focus on Engaging Physicians
> Redesign of the Medical Staff
> Changing Hospital Approaches to the Medical Staff
> Strategic Implications of the Quality Imperative
Clayton M. Christensen
Professor at Harvard Business School

“The cause of runaway health costs is malpractice, but not the medical kind. **Rather, we’re guilty of business model malpractice on a grand scale.** …Economists are wrong in asserting that competition controls costs. The type of competition that brings prices down is disruptive innovation. Disruption in health care entails moving the simplest procedures now performed in expensive hospitals to outpatient clinics, retail clinics, and patients’ homes. Costs will drop as more of the tasks performed only by doctors shift to nurses and physicians’ assistants.”

(March 15, 2010)

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### Leading Drivers for Quality

- **Employers**
  - More plans are using quality and satisfaction-based incentives than incentives to restrict care

- **Consumers**
  - Reduced errors, increased safety, more efficient and effective care
  - Improved clinical outcomes
  - “Right” thing to do

- **Health Plans**
  - More plans are using quality and satisfaction-based incentives than incentives to restrict care

- **Physicians and Provider Organizations**
  - Signed American Recovery and Reinvestment Act which included $19.2B for HIT/EHRs and PPACA

- **Accreditors**
  - JCAHO adds performance measures and safety measures

- **President Obama**
  - Signed American Recovery and Reinvestment Act which included $19.2B for HIT/EHRs and PPACA

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Medicare Payment Reforms --- Attempting to Encourage Value More than Volume

**Improve Coordination of Care**
- Encourage creation of new delivery organizations including:
  - Medical Homes, particularly for chronic care populations
  - ACOs
- Tie Payments to Broader Units of Services
  - Hospital and Physician Payment Bundles
  - Episode-Based Payment Bundles

**Reduce Cost of Care**
- Stimulate Admin. Efficiencies
  - HIT incentives
- Reduction in Hosp. Payments for Preventable Readmission
- Medicare Value-Based Purchasing
- Limit FFS Payment Updates
  - Medicare captures productivity gains
  - FFS less attractive
- Reduce MA Payments
  - Payments based on FFS

**Alter Content of Care**
- Improving Scientific Basis of Healthcare Decisions
  - Use of information and analytics to optimize resources and improve quality measures
- Payment Tied to Patient Outcomes
  - Based on quality measures

**Value-Based Incentive Payments**
- Present

**Medicare and Medicaid Cost Savings and Cuts**
- Future

Commercial Payor Innovations
Some Markets on Fast Track to Shifting Accountability to Providers

Private Sector-Driven Delivery System Innovation

- Providence Health & Services: $10 M, two-year contract with public employee benefits board
- Blue Shield California: Two ACOs in Northern California
- Anthem Blue Cross: ACO pilot with Sharp HealthCare medical groups
- UnitedHealthcare: ACO with Advocate Health Care
- BCBS MN: Shared savings contract with five providers
- BCBS IL: Shared savings contract with Advocate Health Care
- Humana: ACO pilot with Norton Healthcare
- CHI Health: Medical home contract with Piedmont Physicians Group
- BCBS MA’s Alternative Quality Contract: Annual global budget, quality incentives for participating providers
- Aetna: ACO pilot with Camelion Clinic

Source: Advisory Board interviews and analysis.
Governing Board -
Fiduciary Duties Reminder

Care
The Board must act in good faith with the care an "ordinarily prudent person" would exercise under similar circumstances

Obedience
The Board must ensure that the organization acts consistently with its central purposes as described in its articles of incorporation and the mission

Loyalty
Discharge duties unselfishly, to benefit only the corporate enterprise and not the directors personally

Governing Board

- Fundamental responsibility of governing Board is to supervise quality of care and patient safety
- Required by The Joint Commission and the Centers for Medicare and Medicaid Services
- Hospitals may be liable for negligent credentialing if they fail to supervise the competency of the medical staff
- Overlap between quality and regulatory enforcement
- Quality Initiatives can be platform for response to Health Care Reform
Medical Staff Redesign

**Credentialing / Privileging**
- Determines who can practice at the institution
- Dictates scope of practice based on competencies and standards
- Verifies appropriateness of provider privileges

**Physician Performance / Improvement Infrastructure**
- Sets medical staff quality standards via metrics and evaluations
- Establishes thresholds for performance interventions
- Aligns goals for advancing quality across the medical staff

**Peer Review**
- Evaluates potentially substandard care
- Identifies corrective action to evaluate performance
- Initiates physician removal from the medical staff when appropriate

> Redesign:
  - Effectively use OPPE.
  - Move from a Department Approach to a Service Line Approach.
  - Joint Credentialing / Peer Review Committees.

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Hybrid Service Line Approach

**Adopting a (More) Multidisciplinary Model**
**Migrating from Departments to Service Lines**

**Old Department Structure**
- Medicine
- Surgery
- Cardiology
- Pathology
- Imaging

**Hybrid Service Line Structure**
- Medicine
- Cardiology
- Surgery
- Neuroscience
- Orthopedics
- ICU/ED

**Case in Brief**
- Jewish Hospital
  - 400-bed hospital located in Louisville, Kentucky
  - Medical staff organization adopting a hybrid service line model to improve alignment with hospital care delivery, encourage multidisciplinary collaboration between specialties
Leadership Redesign

Rethinking Executive Representation
No Longer an Automatic Seat at the MEC

Department Structure

Service Line Structure

Medical Staff Redesign-
Maximizing Legal Defenses and Protections

> HCQIA
  - Peer review actions taken in compliance with the notice, hearing, and other HCQIA requirements are immune from federal and state civil liability

> State Confidentiality Statutes
  - State peer review evidentiary protections
  - Caution, certain States statutes only protect peer review when conducted by certain organizations

> Patient Safety Act / Patient Safety Organization
Objectives of Physician Integration

> Support overall hospital/ health system strategy
> Help physicians prepare for continued shifts in practice dynamics
> Provide access and coverage for an expanded population of newly insured patients
> Ensure shared goals related to quality, cost, and outcomes
> Align to drive value for patients, payers, employers, physicians and the health system
> Develop strategies to address the needs of independent, clinically integrated and employed physicians

The Path to Physician Integration Will Require a Pluralistic Physician Model… at Least in the Interim

> Organizations that offer multiple alternatives to integration will be the winners
> Maintaining a hybrid strategy gives hospitals/ health systems time to build capital and adequate practice management capabilities

<table>
<thead>
<tr>
<th>Independent physicians</th>
<th>Clinically integrated physicians</th>
<th>Employed physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Independent physicians will likely continue to practice through a transition period</td>
<td>• Hospital systems will seek to partner with independent physicians in order to drive quality and effectiveness; Clinically focused co-management programs and “clinical integration” strategies will be core to this effort</td>
<td>• Multispecialty groups will be organized around driving highest-quality healthcare</td>
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</table>
### Clinical Integration - Comparatively

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Objective</th>
<th>Mechanism</th>
</tr>
</thead>
</table>
| **Loosely-Affiliated Model** | • Secure referral streams  
• Foster cooperative medical staff relationships  
• Develop depth of physician capabilities and leadership | • Customer service and recruitment support  
• Medical directorships and physician cabinets  
• MSO services  
• Economic joint ventures |
| **Tight Physician Integration** | • Secure market share  
• Directed physician behavior  
• Establishing common compensation and incentive pools | • Direct, subsidiary, or foundational employment  
• Specialty/subspecialty PSAs or joint contracting  
• Integrated clinical systems across ambulatory and acute settings  
• Co-management |
| **Clinical Integration** | • Shared continuous efforts to decrease costs and increase quality while receiving financial benefit for improvements made  
• Information sharing between hospitals and practices | • Effective IT systems to measure cost and quality improvements across ambulatory and acute settings  
• Joint managed care contracting for value/quality  
• Utilization management/review → disease management |
| **ACO (like) Model** | • Acceptance of full risk between independents and institutions to manage population health | • Closed or restricted physician network  
• Membership/risk management competency  
• Actuary competency  
• Partnership development with upstream and downstream providers for services not in the ACO |

#### Different Alignment Models Deliver Different Levels of Value

<table>
<thead>
<tr>
<th>Degree of Provider Integration</th>
<th>Value</th>
<th>Cost/Effort/Risk</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitting Med Staff</td>
<td>MSO</td>
<td>Clinical Integration</td>
<td></td>
<td></td>
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<tr>
<td>Co-Management</td>
<td>PHO</td>
<td>ACO</td>
<td></td>
<td></td>
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<tr>
<td>Joint Venture</td>
<td></td>
<td>Integrated Full-risk Provider</td>
<td></td>
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<tr>
<td>Employment/Foundation</td>
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*Quality Driven Health Care | February 9, 2012*
Laws Implicated by Quality Programs

- Civil Monetary Penalty Provision ("CMP")
- Anti-Kickback Statute
- Stark Law
- Tax-Exemption Rules

CMP and AKS Guidance

- Special Advisory Bulletin
- Numerous favorable OIG advisory opinions
  - Incl. two on P4P
- OIG analysis focuses on:
  - Accountability
  - Quality Controls
  - Protection against payments for referrals
Stark Proposed Exception for Incentive Payment and Shared Savings

> Proposed in the July 7, 2008 Medicare Physician Fee Schedule
> 16 detailed standards with over 40 different requirements
> Very Narrowly tailored and potentially limiting
> Exception eventually withdrawn for further study

Clinical Integration / Accountable Care—The Great Integrator?
California Physician Landscape

Physician Markets Transforming on a Real-Time Basis

Select, Recent Hospital/ Medical Group Mergers, Acquisitions and Partnerships, 2010

Los Angeles
- UCLA purchases Santa Monica Bay Physicians
- Heritage Provider Network purchases Lakeside Healthcare
- IHC acquires Talbert Medical Group

San Bernardino
- Loma Linda partners with EPIC Management
- CHW/SBMC partner with NAMM/PrimeCare for C.I.

Orange
- Wellpoint purchases CareMore (MA HMO plan)

Riverside
- Optum (UnitedHealth Group) buys Monarch HealthCare
- Prospect buys Promed-Alta Healthcare System
- Wellpoint purchases CareMore (MA HMO plan)
The Blurring of the Lines Between Not-for-Profit and For-Profit Healthcare Has Borne a New Pragmatism

The blurring of lines between not-for-profit and for-profit healthcare creates new and more pragmatic competitors

<table>
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<tr>
<th>Joint Venture to Form New System</th>
<th>Joint Venture to Acquire Catholic Hospitals</th>
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<tbody>
<tr>
<td>Duke Medicine</td>
<td>Ascension Health</td>
</tr>
<tr>
<td>LifePoint Hospitals</td>
<td>Walgreens</td>
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<tr>
<td></td>
<td>Walmart</td>
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ACO Formation in California---Where is the Stand Alone?

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<thead>
<tr>
<th>Payer</th>
<th>Health System</th>
<th>Physician</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco</td>
<td>Sutter Health</td>
<td>Brown &amp; Toland Physicians</td>
<td>26,000 lives</td>
</tr>
<tr>
<td>San Francisco</td>
<td>Catholic Healthcare West</td>
<td>Hill Physicians</td>
<td>5,000 lives</td>
</tr>
<tr>
<td>Sacramento</td>
<td>Catholic Healthcare West</td>
<td>Hill Physicians</td>
<td>40,000 CALpers</td>
</tr>
<tr>
<td>Orange County</td>
<td>St. Joseph Heritage Medical Group</td>
<td></td>
<td>30,000 HMO members</td>
</tr>
<tr>
<td>San Diego</td>
<td>TBD</td>
<td>NAMM</td>
<td>500K-750K lives</td>
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Note: Anthem Blue Cross, Sharp Community Medical Group and Sharp Rees-Stealy Medical Centers will pilot an ACO.
Questions?