Clinical Integration Strategy Deployment at Salem Health

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Director of Strategic Programs & Clinical Integration
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Agenda

What is Clinical Integration?
Salem Health’s Approach
Will it work?
Q&A
The focus on value is driving new reimbursement models and health care models and partnership strategies.

Navigating current and future health care reforms and the inherent challenges requires cooperation.
Medicare Announcement on January 26, 2015

Evolving Payment Models

Evolving APP Value-Based Contract Structures

- Global risk
- Shared savings with downside risk
- Shared savings/global budgets
- Primary care management fees
- Bundled payment for episodes of care
- Bundled payment for acute care (inpatient only)
- P4P/value-based purchasing
- Inpatient case rates (eg, DRGs)
- Fee for service

Scope of Risk

Clinical Integration Care Model

ACO Care Model

Population Health Care Model

© Advocate Physician Partners

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Clinical Integration Definition

Department of Justice (DOJ) and Federal Trade Commission (FTC) defines Clinical Integration as…

“An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”
Clinical Integration Spectrum

Independent Providers
- Multidisciplinary Performance Improvement Project
- ER Physicians
- Radiologists
- Intensivists
- Call Coverage
- Community Connect
- Centers of Excellence
- Affinity Project

Managed Services Agreement
- CINs
- HVI

Co-management phase 1
- phase 2

Employment
- Willamette Health Partners (WHP)
  - Hospitalists
  - Trauma Surgeons
  - ....

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Early Adopters

Advocate Physician Partners

Billings Clinic
Redefining

Typical Path of Patient Care

Preventing  Diagnosing  Preparing  Intervening  Recovering  Monitoring/Managing
## Next Generation Clinical Integration

<table>
<thead>
<tr>
<th>Aligning with Community Members</th>
<th>Aligning with Physicians</th>
<th>Aligning with Ancillary Providers</th>
<th>Aligning with Hospitals</th>
<th>Aligning with Payors</th>
<th>Aligning with Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Club</td>
<td>Clinically Integrated Networks</td>
<td>SNF</td>
<td>SW WA Medical Center &amp; PeaceHealth Merger</td>
<td>CMS Shared Savings Program &amp; BPCI Initiative</td>
<td>Walmart’s Centers of Excellence</td>
</tr>
<tr>
<td>Housing? Food?</td>
<td>Home Health</td>
<td>Home Health</td>
<td>Northwest Hospital Affiliation with UW Health System</td>
<td>Provider Network Alliances</td>
<td>Boeing ACO</td>
</tr>
<tr>
<td></td>
<td>PT/OT</td>
<td>DME</td>
<td>Virginia Mason &amp; Evergreen Healthcare Partnership</td>
<td></td>
<td>Worksite Clinic</td>
</tr>
</tbody>
</table>
Network

Physician Partners

- Employed: 50%
- Independent: 20%
- Aligned: 30%

Covered Lives

- Family of four
Salem Health

• Made up of Salem Hospital, West Valley Hospital Willamette Health Partners, and other services
• Community-based, not-for-profit institution since 1896
• Salem Hospital is one of the largest acute care hospitals in Oregon
  - Licensed for 458 acute-care beds
  - Busiest emergency department in the state
• Salem’s largest private employer, with approximately 3,900 employees
Salem Health’s CIN

- The Clinical Integration Network (CIN) is a partnership with Salem Health and a group of otherwise independent providers to co-manage services for the purposes of improving quality and cost (value) for patients in our community.

- Salem Health’s goal was to develop an adaptable alignment model for integration that meets the required clinical, operational, financial, and legal characteristics for success, while respecting Salem providers’ independence.
Key Characteristics of the CIN

1. Hospital
2. Contract
3. Cost
   - Evidence-based practice & data-driven information
4. Clinical
   + Financial
   + Operational
## Benefits of Clinical Integration

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>HOSPITAL</th>
<th>PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better coordination of care across providers and settings</td>
<td>Transform care delivery</td>
<td>Demonstrate their commitment to value</td>
</tr>
<tr>
<td>Safer, more timely and effective care</td>
<td>Align financial incentives</td>
<td>Achieve more control over the performance of patient care service across the continuum of care</td>
</tr>
<tr>
<td>More patient-focused experience</td>
<td>Engage in alternative payment models</td>
<td>Choose the clinical and operational measures with which they will be evaluated</td>
</tr>
<tr>
<td>Better value for their health care dollar</td>
<td>Move toward population management</td>
<td>Enhance revenue through better management of patients</td>
</tr>
<tr>
<td></td>
<td>Secure market share</td>
<td>Strategic growth and stability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access the resources, technologies, and support to control costs and increase quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Engage in alternative payment models</td>
</tr>
</tbody>
</table>

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you matter.
Clinical Integration is a strategy

VISION

MISSION

Salem Health: Exceptional Experience Every Time (E3)

To improve the health and well-being of the people and communities we serve.

HOSHIN:

7-10 year site vision

Strategy Deployment: 1-5 year operational strategies
Deployment is the hard part

Selection

Deployment

Selection

Deployment

Dennis, P. (2006). *Getting the Right Things Done*
Nursing Excellence

**S.H.I.N.E.**
Salem Hospital is interdisciplinary and nursing excellence

**Professional Practice Model**

**PATIENT OUTCOMES**

**EMPOWERMENT**

**MAGNET RECOGNIZED**

American Nurses Credentialing Center
Lean Management System
Physician Leadership Institute (PLI)

- Brings nationally recognized healthcare leaders and practitioners to Salem to share ideas and teachings that are transforming the way medicine is practiced.

- Four-month course challenges current methodologies, inspires new insight and delivers the tools to help local healthcare leaders institute positive change to improve the quality of the care they deliver.
Preparing for our future
Building the Infrastructure for Clinical Integration

- Physical Space
- Human Resources
  - Quality & Safety
  - Kaizen Specialist
  - Financial Analyst
  - IT Analyst
  - BI Analyst
  - Project Management
  - Field Operations Specialist
- Processes
  - Standard work for launching a CIN and keeping a cadence
- Policies
  - Restrictions and requirements for participation
- Technology
  - Data analytics for cost and clinical measures
  - Software to track and submit time
  - Anytime, anywhere access to the performance dashboard
Process for Clinical Integration Network (CIN)

1. Identify strategic partners
   - Affinity work mitigating variation completed or in process
   - High quality care outcomes demonstrated
   - Physician leadership on-board with standardization and guidelines
   - Mutual trust with hospital and providers
   - Providers organized as service line or collective reporting model
   - Collaboration opportunity(s) for capital investment/community need
   - Quality reporting system/dashboard/registry tracking in place
   - Expressed interest in exploring alternative alignment models
   - Pay for performance experience or expectation
   - Actively involved in cost control/efficiency metrics

2. Forming the Team

3. Consider services to be integrated
   - IP
   - OP
   - Ambulatory

4. Define alignment structure
   - Co-management contracted model
   - LLC as equity partners

5. Select Metrics, Valuation, and Contracting

6. Care Redesign
   - Bundled Payments
   - Risk based contracting

7. Prepare for payment reform

Process for Clinical Integration Network (CIN)
Potential Partners

- Family Practice
- Pediatrics
- Internal Medicine
- OB/GYN
- Emergency Medicine
- Anesthesiology
- Pathology
- Hospitalists
- Neurosurgery
- Cardiology
- General Surgery
- Medical Oncology
- Orthopedics
- Cardiac Surgery
- Radiology
- Sleep Medicine
- Endocrinology

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Service Line Readiness for Clinical Integration

1.

- Providers organized as service line or collective reporting model
- High quality care outcomes demonstrated
- Quality reporting system/dashboard/registry tracking in place
- Affinity work mitigating variation completed or in process
- Actively involved in cost control/efficiency metrics
- Physician leadership on-board with standardization and guidelines
- Mutual trust with hospital and providers
- Collaboration opportunity(s) for capital investment/community need
- Expressed interest in exploring alternative alignment models
- Pay for performance experience or expectation
Physician Readiness for Clinical Integration

- Quality
- Cost
- Cultural alignment with values
- Practice Characteristics
  - Years in practice
  - EMR utilization
  - Services offered
  - Equity and locations
  - Credentials
  - Level of alignment
Frequently Asked Questions

• Are there any participation restrictions?
• What are the requirements of a participating physician in the CIN?
• What is the cost to participate?
• Is the agreement with an individual physician or the practice group?
• Will participation in the CIN require me to change the way I practice?
• Will participation in the CIN affect my current contracts or ability to negotiate contracts?
Clinical Integration Network (CIN)
Take Advantage of Catalysts

Examples:

- Established practice group is disbanding
- Clinic is having financial woes
- Service area recognizes a need for resources to support clinical care
- ....
## Value Proposition

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Salem Health</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve quality and outcomes</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Foster innovation in care delivery</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Coordination of care across conditions</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pathway to population health</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Succession planning</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Control costs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Reduce time and effort spent on practice management</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Shared savings based on evidence and clinical outcomes</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Network to negotiate with insurance payors</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Management of hospital operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Road to employment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Accountability for results</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Loyalty</td>
<td></td>
<td></td>
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<tr>
<td>Improve access to care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet meaningful use objectives for maximum incentive capture</td>
<td></td>
<td></td>
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<tr>
<td>Brand identity</td>
<td></td>
<td></td>
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<tr>
<td>Growth</td>
<td></td>
<td></td>
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<tr>
<td>Ability to compete</td>
<td></td>
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</tr>
</tbody>
</table>
### Where do we start?

Scope of clinical services to be integrated

Example: Neurosurgery

<table>
<thead>
<tr>
<th></th>
<th>Lumbar Spine Fusion</th>
<th>Cervical Spine Fusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Outpatient Physiatry</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Interventional Pain</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Imaging</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Alignment Opportunities

Clinical Joint Venture
MedShare
Practice Management
EHR Provision
Marketing
Recruitment Assistance
Other agreements…
Dyad Leadership Model

Pairs a physician with a hospital manager to oversee a service area and drive clinical and operational excellence.

Joint Operating Committee
- 6 physician delegates
- 5 hospital participants

- Monthly

Cath Lab Subcommittee
- Up to 4 physician delegates including Service Area Medical Director
- Hospital participants

EP Subcommittee
- Up to 4 physician delegates including Service Area Medical Director
- Hospital participants

Non-invasive & Rehab Subcommittee
- Up to 4 physician delegates including Service Area Medical Director
- Hospital participants

New Technologies & Budgeting Subcommittee
- Up to 4 physician delegates including Executive Medical Director
- Hospital participants
## Compensation

**FMV Hourly Rate** × **Cap on Total Hours** + **Incentive Compensation Cap** = **Cap on Total Compensation**

<table>
<thead>
<tr>
<th>Incentive Metric</th>
<th>Source</th>
<th>Historical</th>
<th>Incentive Matrix - Payout</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Performance Over Average Lower</td>
</tr>
<tr>
<td>Metric #1 – Quality &amp; Safety</td>
<td>Registry</td>
<td>94.00%</td>
<td>94.00% – 95.72%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$xx,xxx</td>
</tr>
<tr>
<td>Metric #2 – Quality &amp; Safety</td>
<td>EMR Report</td>
<td>50.00%</td>
<td>75.00% – 79.99%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$xx,xxx</td>
</tr>
<tr>
<td>Metric #3 – Operational Efficiency</td>
<td>PACS Report</td>
<td>20.00%</td>
<td>75.00% – 79.99%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$xx,xxx</td>
</tr>
<tr>
<td>Metric #4 – Operational Efficiency</td>
<td>Internal</td>
<td>50.00%</td>
<td>75.00% – 79.99%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$xx,xxx</td>
</tr>
<tr>
<td>Metric #5 – Patient Experience</td>
<td>HCAHPS</td>
<td>92.00%</td>
<td>75.00% – 81.55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$xx,xxx</td>
</tr>
<tr>
<td>Metric #6 – Patient Experience</td>
<td>Press Ganey</td>
<td>85.00%</td>
<td>90.00% – 90.99%</td>
</tr>
<tr>
<td>TOTAL Possible Yearly</td>
<td></td>
<td></td>
<td>$xx,xxx</td>
</tr>
</tbody>
</table>
CIN Evolution

Quality Metrics Only P4P
Bonus payments for reaching satisfaction, quality, and outcomes metrics

Program & Protocol Development
Bonus payments to develop and follow protocols for delivering cost effective, quality care as well as active physician management.

Bundled Payments
Standardizing practice to provide high quality, low cost operations. Bearing risk for episodes of care. Negotiate contracts so physicians and hospital share in risk and rewards of episodic care.

Shared Savings and Global Payments
Participate in shared savings or global payment contracts with other physician specialties in CIN to manage total cost of care for population.

Potential for Compensation from Savings

Time / Risk / Expertise / Need for Physician Involvement

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How is this different from HVI

<table>
<thead>
<tr>
<th>New Agreement</th>
<th>HVI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure:</strong> Contract between Salem Health and physician groups</td>
<td><strong>Structure:</strong> A Salem Health program with cardiologists invited to participate</td>
</tr>
<tr>
<td><strong>Purpose:</strong> Participating Physicians directly manage aspects of Salem Health’s cardiovascular service line</td>
<td><strong>Purpose:</strong> Vehicle by which to engage physicians in clinical dialogue about how to enhance quality and satisfaction of the cardiovascular service line through physician collaboration and clinical leadership</td>
</tr>
<tr>
<td><strong>Physician Involvement:</strong> Hands-on day-to-day management in tandem with service line director (Finance, HR, Quality Review, and Operations), recommend strategic direction (e.g., which bundled contracts to pursue)</td>
<td><strong>Physician Involvement:</strong> Making recommendations through medical directorships and committees to hospital management and physician peers</td>
</tr>
<tr>
<td><strong>Remuneration:</strong> Includes hourly payments for physician time and bonus payments for performance on bonus metrics based on cardiologists</td>
<td><strong>Remuneration:</strong> Bonus payments and rate divided by multiple disciplines</td>
</tr>
<tr>
<td><strong>Governance:</strong> Joint operating committee (JOC) made up of physician majority and hospital leadership (Hospital COO to sit in JOC as a member)</td>
<td><strong>Governance:</strong> Reports to Hospital COO</td>
</tr>
</tbody>
</table>

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“Deep Thinking”

Does \( \uparrow \) quality \( \downarrow \) costs?

Does incentivizing $$$ drive change?
# HVI Program Highlights - Outcomes & Cost Savings Results

<table>
<thead>
<tr>
<th>METRIC</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCI less than 90 minutes</td>
<td>97.96%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCI patient compliance with cardiac rehab appointment</td>
<td>79.60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCI within 60 minutes of arrival (during business hours)</td>
<td>80.00%</td>
<td></td>
<td>97.00%</td>
</tr>
<tr>
<td>PCI patients prescribed statins at discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI 30-day readmission rate</td>
<td>11.83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI patient compliance with cardiac rehab appointment</td>
<td>68.60%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF core measure and medication reconciliation</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF 30 day readmission rate</td>
<td>32.83%</td>
<td>21.71%</td>
<td></td>
</tr>
<tr>
<td>HF order set usage (C01-02)</td>
<td></td>
<td>82.68%</td>
<td></td>
</tr>
<tr>
<td>HF diuretic protocol (C03-04)</td>
<td></td>
<td>24.88%</td>
<td></td>
</tr>
<tr>
<td>On Time Start EP cases with Anesthesia</td>
<td>66.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidents of lead dislodgement</td>
<td>0.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac tamponade following a-fib ablation (HRS-12)</td>
<td></td>
<td>5.45%</td>
<td></td>
</tr>
<tr>
<td>ACE-1/ARB at discharge for ICD patients with LVSD</td>
<td></td>
<td>97.44%</td>
<td></td>
</tr>
<tr>
<td>Beta Blocker at discharge for ICD patients with previous MI</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CABG prolonged vent time</td>
<td>10.20%</td>
<td>8.36%</td>
<td>7.53%</td>
</tr>
<tr>
<td>CABG PreOp beta blocker</td>
<td>99.50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CABG antiplatelet at discharge</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CABG beta blocker at discharge</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR block time utilization</td>
<td>74.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CABG, PCI, AMI tobacco cessation medication</td>
<td></td>
<td>89.40%</td>
<td>92.60%</td>
</tr>
<tr>
<td>Turnaround time for CVNIS services</td>
<td>21.06%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAT echo turnaround time ≤ 30 minutes</td>
<td></td>
<td>67.03%</td>
<td>89.32%</td>
</tr>
<tr>
<td>Statin therapy at discharge after lower extremity bypass</td>
<td>61.89%</td>
<td>85.30%</td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction Inpatient Overall</td>
<td>88.50%</td>
<td>87.81%</td>
<td>89.18%</td>
</tr>
<tr>
<td>Patient Satisfaction Inpatient - Time Physician Spent</td>
<td>82.20%</td>
<td>83.36%</td>
<td>84.50%</td>
</tr>
<tr>
<td>Patient Satisfaction Outpatient – ACATH</td>
<td>93.20%</td>
<td>93.21%</td>
<td>94.30%</td>
</tr>
</tbody>
</table>

## KEY
- Did not hit any tranches
- Met at least one tranche
HVI Program Highlights - Program Initiatives

<table>
<thead>
<tr>
<th>Catheterization &amp; Electrophysiology Laboratory</th>
<th>Echocardiography Laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opened a Radial Artery Catheterization Laboratory to shift care to an ambulatory setting and improve the patient experience for suitable patients undergoing cardiac catheterization.</td>
<td>• Established a cross-training program to train vascular ultrasound technologists to become echocardiography technologists, improving the coverage and turnaround time of echocardiography services.</td>
</tr>
<tr>
<td>• Introduced new procedures and technologies to improve the safety and feasibility of care, including Chronic Total Occlusion (CTO) procedures, the Impella percutaneous left ventricular assist device, and laser lead removal for pacemaker and defibrillator leads.</td>
<td>• Implemented a stat Transthoracic Echocardiography (TTE) information technology solution to improve the quality and timing of echo interpretations in potentially life threatening situations.</td>
</tr>
<tr>
<td>• Aligned the operations of the Interventional Recovery Unit (IRU) under the catheterization laboratory to foster efficiencies, like shifting loop recorder implementations to the IRU and freeing up a room in the catheterization laboratory for additional procedures.</td>
<td>• Introduced contrast echocardiography to improve echocardiographic resolution and provide real-time assessment of intracardiac blood flow.</td>
</tr>
</tbody>
</table>
HVI Program Highlights - Professional Recognition

TOP 50 CARDIOVASCULAR HOSPITAL, Truven Health Analytics
Top performer against peers in 2015 for cardiovascular outcomes, clinical processes, and efficiency (heart attacks, heart failure, PCI, CABG). The only Oregon hospital to achieve this award and one of only two hospitals in the Pacific Northwest!

FIVE-STAR RECIPIENT for Treatment of Heart Attack and Heart Failure, Healthgrades

THREE-STAR RECIPIENT for Adult Cardiac Surgery, The Society of Thoracic Surgeons

Accreditation in Cardiac Rehabilitation, American Association of Cardiovascular & Pulmonary Rehabilitation

Accreditation in Adult Transthoracic Echocardiography, Intersocietal Accreditation Commission
Readiness for Risk

- Warranty
- You Earned a Reward
- Buy One, Get One Free
- We Price Match - We Will Not be Beat!
- Have it Your Way

“Deep Thinking”
Key Takeaways

- Clinical Integration is a strategy.
- Need to build an infrastructure to support the strategy.
- Assess service line and physician readiness for clinical integration to identify ideal partners.
- Physician leadership is critical.
- Change is hard.