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FREE SUMMARY REPORT

APRIL 2013

Collaborative Care:

Hospitals Balance Risk and Revenue With Physicians and Payers

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Collaborative Care:

Hospitals Balance Risk and Revenue With Physicians and Payers

This report outlines proven strategies for making collaborative care work right the first time—for patients, physicians, payers, and the bottom line.

- Discover strategies for forging and strengthening partnerships across the care continuum
- Learn how to build a culture of collaboration where all providers recognize their interdependence
- Deep-dive into over 400 charts with segmented peer data
- Learn from case study examples: **Aetna, Atrius Health,** and **Providence Regional Medical Center Everett**

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the April 2013 HealthLeaders Media Intelligence Report, *Collaborative Care: Hospitals Balance Risk and Revenue With Physicians and Payers*. In the full report, you'll find a wealth of additional information, including the results of all the survey questions. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (i.e., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Richard Lopez, MD, Chief Medical Officer of Atrius Health, based in Newton, Mass., the Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Atrius Health, based in Newton, Mass.; Aetna, the Hartford, Conn.–based insurer; and Providence Regional Medical Center Everett in Washington.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Locked items are available in the Premium and Buying Power editions.

Methodology

The *Collaborative Care Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In January 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 356 completed surveys are included in the analysis. 288 of the respondents participate or plan to participate in a collaborative care model. The margin of error for a sample size of 356 is +/-5.2% at the 95% confidence interval.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Charles Kennedy, MD
CEO, Accountable Care Solutions
Aetna
Hartford, Conn.

Richard Lopez, MD
Chief Medical Officer
Atrius Health
Newton, Mass.

Joanne Roberts, MD
Chief Medical Officer
Providence Regional Medical Center Everett
Everett, Wash.

Upcoming Intelligence Report Topics

MAY: ***Emergency Department Strategies***

JUNE: ***Service Line Strategies***

JULY: ***Patient Quality & Safety***

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

HealthLeaders Media
A Division of HCPro

Intelligence Report Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Publisher
MATTHEW CANN
mcann@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
PHILIP BETBEZE
pbetbeze@healthleadersmedia.com

Intelligence Report Contributing Editor
MARGARET DICK TOCKNELL
mtocknell@healthleadersmedia.com

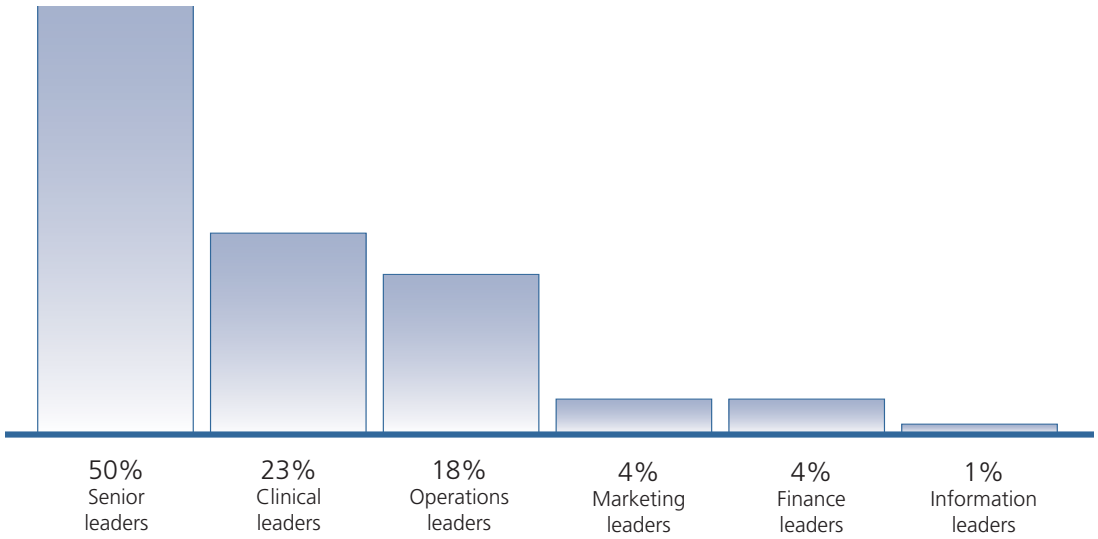
Intelligence Report Design and Layout
BRENDA ROSSI
brossi@hcpro.com

Respondent Profile

Respondents represent titles from across the various functional areas, including senior leaders, clinical leaders, operations leaders, and information leaders. They are from a variety of healthcare provider organizations.

Title

Base = 356



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/ Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 356

Hospital	39%
Health system	23%
Physician org.	18%
Long-term care/SNF	8%
Health plan/insurer	5%
Ancillary, allied provider	4%
Government, education/academic	2%

Number of beds

Base = 139 (Hospitals)

1–199	38%
200–499	46%
500+	16%

Number of sites

Base = 82 (Health systems)

1–5	23%
6–20	27%
21+	50%

Number of physicians

Base = 63 (Physician orgs.)

1–9	38%
10–49	17%
50+	44%

ANALYSIS

Crossing the Chasm to Collaborative Care

BY MARGARET DICK TOCKNELL

Collaborative care, which holds the promise of bringing together stakeholders to lower the cost and improve the quality of patient care, is a relatively new business model that is being embraced by providers and health plans. While there is a high level of confidence among healthcare leaders that collaborative care will improve population health, the potential for such a model to deliver cost savings is a concern.

Collaborative care, it seems, is caught in a transition that is all too familiar to those who are on the frontlines of healthcare reform implementation: making large investments today in anticipation of returns (reduced healthcare costs) somewhere down the road.

According to the results of the *2013 HealthLeaders Media Collaborative Care Survey,* 69% of healthcare leaders are in at least the early stages of considering participation in a formal collaborative care model with 25% already participating in one. "Collaborative care is definitely on everyone's radar," says John Katsianis, senior vice president and CFO of DeKalb Regional Health System, a two-hospital system in Decatur, Ga. "When you think about HCAHPS and readmission penalties ... we have the most money at risk if we don't perform."

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments concerning the outlook for collaborative care.

"This is a primary factor in successfully managing the costs—to improve the health and care of the patients to reduce avoidable complications or hospitalizations."

—Chief information officer for a medium hospital

"Our model is a joint partnership with our largest insurer. It is focused on improving the health of members/patients with multiple chronic conditions, which we think should be a fairly rich group for documenting health improvements."

—Vice president of operations for a large health system

"A lot of responsibility falls back on the patient to follow instructions and continue to take medication as prescribed and to follow up with the referrals. This falls outside of the wall of physician offices and hospitals and therefore is very difficult to manage."

—Chief compliance officer for a medium hospital

"We've seen both positives and negatives come out of the arrangement. Staff is not happy with extra work. Patients don't like parts of it because they feel it does not respect HIPAA enough. Too many hands involved. However, it does improve patient health because we can call out different MRIs, scans, and notes."

—Medical director for a medium physician organization

Analysis (continued)

Indeed, respondents are setting a fast pace of adoption with 78% expecting to have their collaborative care model fully operational by 2014. That will be something of a watershed year for healthcare reform: In every state, a health insurance marketplace will offer individuals and small businesses competitively priced insurance, and access to Medicaid will grow to include those earning 133% of the federal poverty level. Millions of previously uninsured people are expected to descend on the healthcare system, straining capacity and further challenging reimbursements.

As is often the case with any major change, the implementation of a new system takes time and often involves cultural shifts at all staffing levels. So it is welcome news that survey respondents indicate their organizations recognize the importance of C-suite involvement in the pursuit of collaborative care. Some 55% have assigned C-suite–level business leadership and 44% have assigned C-suite–level clinical leadership to manage their model. Collaborative care will change the fundamentals of the delivery of healthcare services as well as reimbursement for those services. Such profound changes can only succeed with a commitment at the top level
of leadership.

Our report advisors suggest that healthcare leaders are embracing collaborative care because they figure just about anything will be better than the system in effect now. "It's a proposed solution, a proposed alternative to fee-for-service," says Richard Lopez, MD, the chief medical officer at Atrius Health, a Newton, Mass.–based nonprofit alliance of six medical groups with more than 1,000 physicians serving about 1 million patients, as well as a home health and hospice agency. "We know where traditional fee-for-service has the healthcare market: ever-increasing healthcare costs and ever-increasing utilization. We know that system."

"We know where traditional fee-for-service has the healthcare market: ever-increasing healthcare costs and ever-increasing utilization. We know that system."

—Richard Lopez, MD, Chief Medical Officer, Atrius Health, Newton, Mass.

The top motivation for embarking on collaborative care, cited by 73% of respondents, is improving quality care. Some 91% of those who have not ruled out participation in collaborative care are at least slightly confident that the model will improve patient health with 75% at the moderately confident and very confident levels. There's a significant rate of confidence (66%) even among respondents who have no plans to pursue collaborative care that the model will improve patient health.

At the same time, 45% of respondents who are participating in or pursuing a collaborative care model identify concerns about cost savings among their top three challenges. Ted Miller, vice president and CFO for Floyd

Analysis (continued)

Memorial Hospital and Health Services, a 230-bed acute care hospital in New Albany, Ind., poses the cost savings question this way: "If there is cost savings, when will it be?"

Floyd Memorial could be described as being on the fence regarding collaborative care, at least in a formal way. Miller notes that the hospital is located just a few miles from Louisville, Ky., and competes for customers there with services such as an open-heart center, a spine center, and a cancer center. It is taking some preparatory steps to put in place personnel and programs that lend themselves to managing patient populations, including nurse navigators, quality programs, and a team dedicated to improving hospital readmission rates. Floyd Memorial has also achieved stage 1 meaningful use.

"We continue to prepare ourselves from a readiness standpoint and we continue to educate ourselves around population health," says Miller, but the hospital is "still exploring its options" about a formal entry into collaborative care.

Concerns about cost savings are also cited by providers in describing the primary roadblock with payers in the adoption of collaborative care. Some 24% of leaders say payers want too much gain share. Another 15% say payers are unable or unwilling to share risk, and 14% cite an inability to reach contract terms with payers. "That's just the nature of the negotiations," says Charles Kennedy, MD, the CEO of accountable care solutions for Aetna. "These are complicated relationships and so reaching terms can be a challenge."

Scott Trott, vice president of payer management and faculty services for UNC Health Care System in Chapel Hill, N.C., notes that developing such arrangements can get to a point where physicians may wonder why make the effort if "the savings they come up with just evaporates or goes to a payer's profits."

> "If providers take on risk, at the end, will they save money? There's a lot of skepticism."
>
> —Joanne Roberts, MD, Chief Medical Officer, Providence Regional Medical Center Everett, Everett, Wash.

Of course, sharing risk is a basic tenet of collaborative care. At least in theory, it means that everyone along the care continuum has skin in the game and thus is inspired to work toward common goals in patient treatment, which will produce better outcomes at a lower cost. Some of the aversion to risk may be a holdover from the risk failures of the 1970s and 1980s. It is also a situation where today's realities temper excitement over tomorrow's potential. "If you were doing something that didn't cause any risk to you, it might be less of a concern. But when you hang risk on a new idea, it just raises anxiety," states Lopez.

Analysis (continued)

In addition to anxiety, there are trust issues. Indeed, 13% of provider leaders pursuing collaborative care say their primary roadblock with payers is lack of trust.

"If providers take on risk, at the end, will they save money?" asks Joanne Roberts, MD, the chief medical officer for the 491-staffed-bed Providence Regional Medical Center Everett in Washington. "There's a lot of skepticism."

Providence Regional has a long-term collaborative care relationship with the Everett Clinic, a 400-physician medical group with 16 locations in the Puget Sound area. Still, Roberts says her CFO often talks about how the medical center lives in a primarily fee-for-service world in 2013. "In 2014 we'll probably live in a 50-50 risk world and in 2015 maybe we'll live in a 70-30 risk world. Then it will be an obvious improvement. But here's where we are stuck. We know it's the right thing to do, but moving in that direction probably means a new loss today."

"It's the crux of the challenge in the healthcare industry today," states Roberts. "Who can survive the losses that will come until the healthcare system rights itself? Given the timeline we face, I worry that the only institutions that are going to succeed will be either upstarts that are highly innovative or stalwart healthcare companies."

That's why Kennedy says payers must do their homework. "They have to create the return for providers. No one is going to invest in collaborative care without a financial return. You can't just say collaborative care is a good thing and you should do it. There has to be a business model that creates the financial wins to execute those strategies."

> "You can't just say collaborative care is a good thing and you should do it. There has to be business model that creates the financial wins to execute those strategies."
>
> —Charles Kennedy, MD, CEO, Accountable Care Solutions, Aetna, Hartford, Conn.

Despite their risk reservations, among healthcare leaders actively pursuing or in the early stages of collaborative care development, the most mentioned reimbursement models expected to be in place within three years are bundled payments (56%), commercial payer contracts (55%), and the Medicare Shared Savings Program (46%).

In preparing for collaborative care, respondents indicate that they have in place today some of the components of the model: case or care managers (76%), quality data (74%), and mid-level clinicians (64%). Both Lopez and Roberts describe these items as some of the easier components to put in

Analysis (continued)

place. Lopez notes that they are common in the fee-for-service world. "They are commodities, straightforward. They don't necessarily touch the deep infrastructure and cultural issues that are involved in putting all the collaborative care pieces together."

Lopez notes that cost centers tend to occupy bottom-rung positions. He says there is less early attention paid to items such as health information exchanges, integrated IT, and patient registries because they are "cost centers not revenue generators."

Compensation-based incentives are mentioned as being in place by only 32% of respondents, but Roberts expects that to evolve. "That will be a tough discussion to have over time. What are the metrics by which we will reward or punish one another?"

She points to the relative value unit system, which is often criticized as lacking a financial incentive to either cut costs or to efficiently and effectively help the patient. "We all know that the RVU system can't stand in an at-risk model. We'll have to develop ways of doing things like paying physicians for electronic communications with patients and seriously rewarding for outcomes. Not just 1% or 2% but more like 20%, 30%, or 40% of physician compensation based on some sort of quality."

"We all know that the RVU system can't stand in an at-risk model. We'll have to develop ways of doing things like paying physicians for electronic communications with patients and seriously rewarding for outcomes. Not just 1% or 2% but more like 20%, 30%, or 40% of physician compensation based on some sort of quality."

Physician participation is, of course, critical to the collaborative care world but 21% of survey respondents identified physician desire to remain independent as a primary roadblock to their organization's adoption of collaborative care. Independence is a complex issue. "If you look at our physician training, we're trained to be very independent," says Kennedy. However, he notes that younger physicians are often more interested in work-life balance than independence. Down the road, physician independence may be less of an issue for collaborative care.

> "It's the crux of the challenge in the healthcare industry today. Who can survive the losses that will come until the healthcare system rights itself?"
>
> —Joanne Roberts, MD, Chief Medical Officer, Providence Regional Medical Center Everett, Everett, Wash.

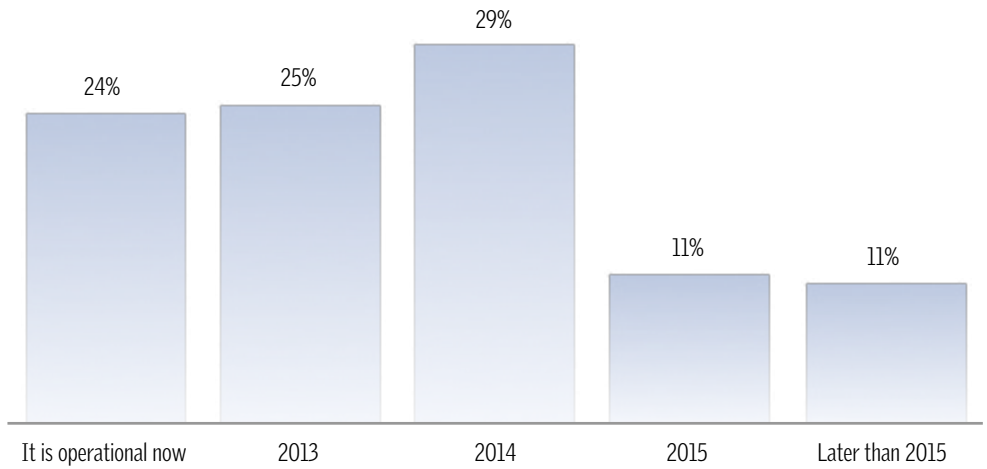
Margaret Dick Tocknell is health plans editor for HealthLeaders Media. She may be contacted at *mtocknell@healthleadersmedia.com*.

FIGURE 2 | Timing for Operational Collaborative Care Model

Q | When will your collaborative care model become fully operational (not a pilot)?

Among those reporting

Total responses



Base = 288

TAKEAWAYS

- Overall, one-quarter of respondents (24%) have their coordinated care model fully operational now, including 30% of health systems and 26% of physician organizations.
- More than half of respondents (54%) are moving quickly and expect to be operational this year or next.
- Only 22% expect to be operational starting in 2015 or later.

WHAT DOES IT MEAN?

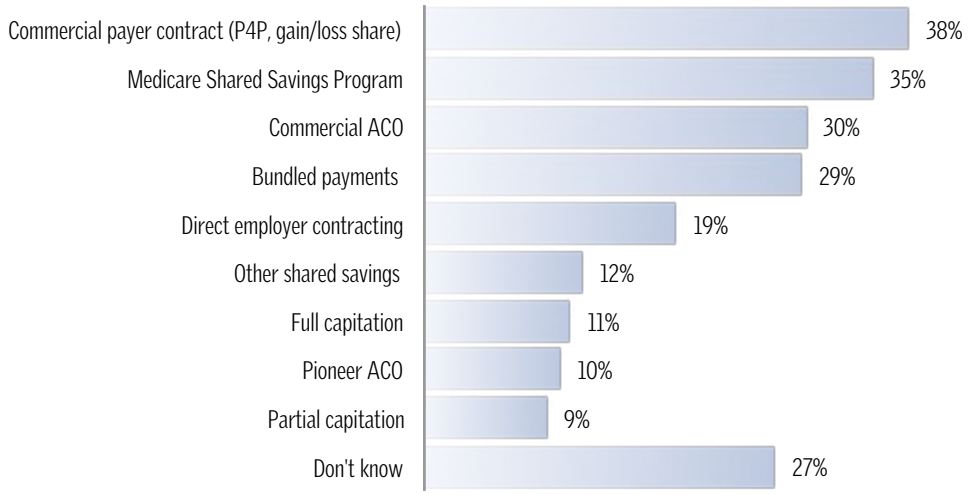
The timetable for participating in collaborative care maps closely with the healthcare reform rollout. Many providers, who anticipate a rapid expansion of Medicaid rolls and a reduction in the Medicare fee-for-service reimbursement model, are preparing for a value-based world. They are moving quickly to create the teams they will need to successfully manage cost and ensure quality.

DATA SEGMENTATION TOOL
Click on these icons to dig deeper
VIEW BY SETTING
VIEW BY NUMBER OF BEDS
VIEW BY NUMBER OF SITES
VIEW BY NET PATIENT REVENUE
VIEW BY REGION
MAIN CHART AND TAKEAWAYS

FIGURE 11 | Top Collaborative Care Program Revenue Contributors in Three Years

Q | Which collaborative care programs will be the top three revenue contributors in three years?

Total responses



Base = 288, Multi-Response

TAKEAWAYS

- Respondents are more confident about projecting which revenue sources they expect to use than they are about how much revenue might flow. When asked about which reimbursement models would be used in the three-year time frame (Figure 9), 18% said they do not know. Here, asking about top revenue contributors, 27% do not know.
- Large organizations seem particularly wedded to commercial payer contracts, with more than half of respondents (53%) with net patient revenue in excess of $1 billion identifying them as a top revenue contributor; that's compared to 33% of organizations with NPR between $250 million and $999 million, and 36% of those with NPR below $250 million.
- Commercial ACOs and bundled payments were mentioned almost equally by hospitals and health systems.

WHAT DOES IT MEAN?

With 27% unsure of which collaborative care program will be the top revenue generator in the three-year time frame, and none of the choices garnering a mention by even 40% of the respondents, we get a measure of the degree of uncertainty healthcare reform brings to revenue.

FIGURE 11 *(continued)* | Top Collaborative Care Program Revenue Contributors in Three Years

Q | Which collaborative care programs will be the top three revenue contributors in three years?

DATA SEGMENTATION TOOL

Click on these icons to dig deeper

BUYING POWER Who controls the money?

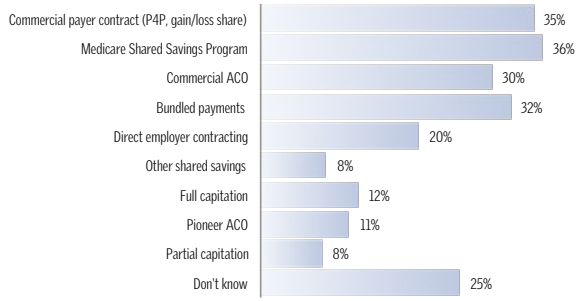
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

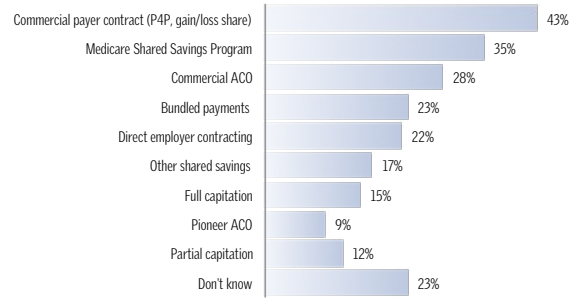
PRODUCTS/SERVICES

Clinical products



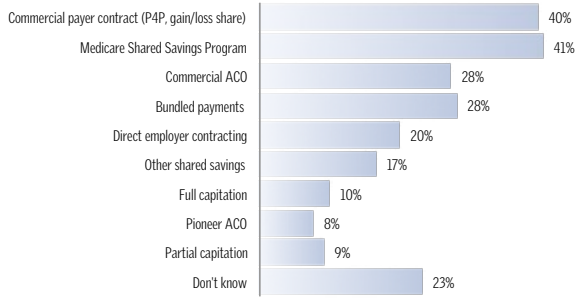
Base = 169, Multi-Response

Financial services



Base = 106, Multi-Response

Executive search



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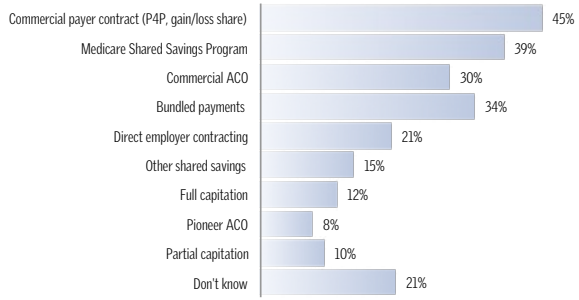
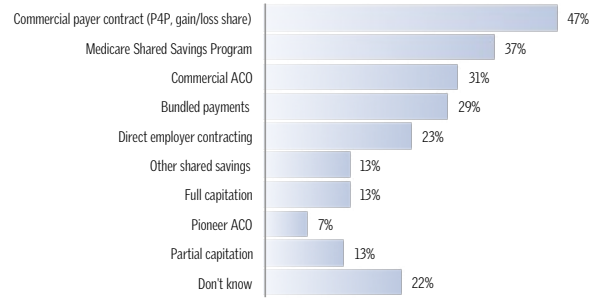
Consulting services



Base = 149, Multi-Response

Outsourcing services



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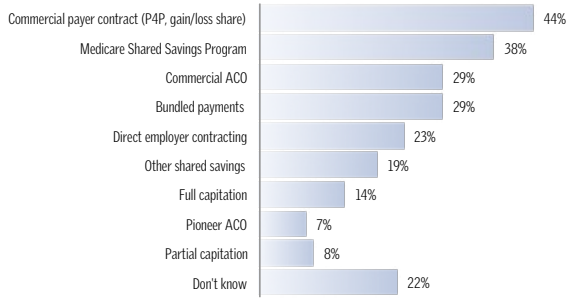
Legal services



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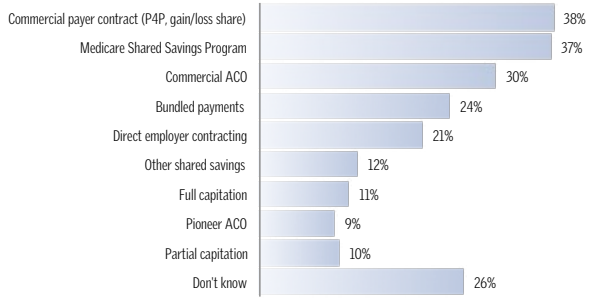
Information technology



Base = 169, Multi-Response

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