HEALTHLEADERS MEDIA
CEO EXCHANGE

Insights Report

April 2014 | Report 3 of 3

DANA THOMAS

FLEXIBILITY AND ACCOUNTABILITY

CHIEF EXECUTIVES ON EVOLVING CLINICAL STRATEGIES

Analysis and in-depth discussions from healthcare CEOs taken from the HealthLeaders Media CEO Exchange in November 2013

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Analysis

LEADING PHYSICIAN SPEED, PRESSURE, AND TEMPERATURE

JIM MOLPUS

Leadership Programs Director
HealthLeaders Media

When it comes to managing a network of physicians, today's health system CEO is like a governor. No, not the kind that sits in the state house, but the kind of governor in mechanical engineering that "is used to provide automatic control, as of speed, pressure, or temperature." The CEO is not the fuel or the gears, but is basically in the system to keep the physician engine moving at peak horsepower, and to keep it from blowing up.

The chief executive officers who gathered at the annual HealthLeaders Media CEO Exchange represent a diverse set of providers, from independent community hospitals to large regional health systems. What all of them share is a renewed willingness to explore new and creative partnerships with their physicians that advance the goals of the health system. Among those goals is a higher degree of accountability for physician performance.

Strategies are still largely dictated by the physician micro-market, where some cities may have a physician culture and history of independence, while others are more comfortable in employment arrangements or closer clinical integration. The CEOs who gathered in multiple sessions agreed that there is no single strategy that can be deployed across markets with universal success, and a key to leadership is knowing the risk tolerance of your physicians. Push too hard toward clinical integration and physicians may revolt, but staying too far behind the movement to value-based healthcare could leave the health system, and its physicians, competitively vulnerable in an evolving market.

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Sponsor Perspective

BUILDING CAPABILITIES FOR THE NEW HEALTHCARE MARKET

KYLE DOLBOW
President
Vree Health, LLC

The healthcare delivery world is at a crossroads. Some organizations may not currently see it that way, but it's true. While talk of the implications of the Patient Protection and Affordable Care Act has raged for multiple years now, for some organizations, the shift from a volume-based to a value-based reimbursement environment has caused profound shifts in their own thinking about what capabilities are required for success. This includes capabilities such as:

Aligning your care network: Whether your network is primarily owned, formal partnerships, or informal partnerships, taking steps to align the entire care team is critical. Think incentives and communication of information.

Planning for risk management: Identifying your key areas of risk at an organizational level and patient level, and deploying strategies to mitigate these risks is essential.

Understanding and managing patient care in your blind spots: Engaging your patients to influence appropriate healthcare behaviors is necessary, even when they aren't in your facilities. Yes, that means knowing and improving their health behaviors at home and elsewhere, and capturing important behavioral information to deliver care better is crucial.

One thing is likely clear as you talk to your health executive colleagues: There is a "not us" sentiment among some in the industry. Not everyone is feeling these pressures in the same way or to the same extent. If ever there were clear delineations in market characteristics, this may be it. While one market may have one or more health systems participating in Medicare Pioneer or Shared Savings Program ACOs, others may have none. Commercial insurers may be pushing risk-based contracts in your markets, or traditional contracting may seem firmly entrenched. You may be contemplating the creation of your own insurance plans to better capture the "upside" of taking risk, or this may be the furthest thing from your mind.

Regardless of the current characteristics of your market, relatively rapid shifts can occur. One move by a dominant player—whether it is a hospital, physician group, or insurer—can cause a significant shift in what defines success for the entire market.

Building relationships and capabilities now is your best defense. I hope that this report from HealthLeaders Media is as enlightening to you as it is to me. After all, learning from one another is the quickest way to enlightenment!

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Discussion

PHYSICIAN ALIGNMENT STRATEGIES HAVE TO BE FLEXIBLE, LOCAL, AND ACCOUNTABLE

JIM MOLPUS

No industry transforms itself cleanly or quickly. The movement of hospitals from high-volume procedure factories to trusted partners in the patient's well-being is not just a switch that can be flipped.

Even the most innovative health systems find themselves in the testing and evaluation stage of the journey right now. The most essential and testy partners in this journey are the health systems and their physicians, with chief executive officers left to orchestrate a mandate to transform against the reality of physician practice patterns, competitive histories, and compensation models.

Physician mixology

Chuck Stark, CEO of Columbus (Ga.) Regional Healthcare System, says his organization is making sure it has the right physicians as partners, and then making sure those physicians have the right tools to measure progress.

"We have a large physician hospital organization with maybe 400 physicians in the community, and 320 are members of our PHO," Stark says.

"We've got a number of contracts that are incentive-based with payers based on clinical performance. We're using the Crimson software product to help our physicians become better-performing practitioners so that as competitive market forces narrow the network, we can have an opportunity to better ensure that the maximum incentives are realized by all the providers," Stark says. The health system is "in a community where we still embrace independent physicians, and feel that physicians should be independent for as long as they want to be," he says. Still, Columbus Regional is developing employment options, comanagement agreements, and a physician services agreement.

Michael Ugwueke, executive vice president and chief operating officer of Methodist Le Bonheur Healthcare in Memphis, Tenn., says that his health system has close to 400 employed physicians, but "the market is still very

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THE PARTICIPANTS

Keith Alexander
CEO
Memorial Hermann Memorial City Medical Center, Houston

Kurt A. Barwis, FACHE
President and CEO
Bristol (Conn.) Hospital and Health Care Group, Inc.

Britt Berrett
President
Texas Health Presbyterian Hospital Dallas

David T. Brooks, FACHE
President
St. John Hospital & Medical Center, Detroit

C.R. Burke
President and CEO
St. Joseph Heritage Healthcare, Irvine, Calif.

Patrick Cawley, MD, MHM, FACHE
CEO
Medical University of South Carolina Medical Center;
Vice President for Clinical Operations
Medical University of South Carolina, Charleston

Alan H. Channing
President and CEO
Sinai Health System, Chicago

Patrick A. Charmel
President and CEO
Griffin Health Services Corporation, Derby, Conn.

Jonathan Davis, FACHE
President
Methodist Charlton Medical Center, Dallas

Jerry Fedele
President and CEO
Boca Raton (Fla.) Regional Hospital

Joseph Golbus, MD
President
NorthShore Medical Group, Evanston, Ill.

Charles E. Hart, MD, MS
President and CEO
Regional Health, Inc., Rapid City, S.D.

John M. Haupert, FACHE
President and CEO
Grady Health System, Atlanta

William S. Hussey
President of Division IV Operations
Community Health Systems, Franklin, Tenn.

J. Thomas Jones
President and CEO
West Virginia United Health System, Fairmont

John A. (Jack) Kolosky
Executive VP and COO, President of the Hospital
H. Lee Moffitt Cancer Center & Research Institute, Tampa, Fla.

independent with close to 80% of the physicians still independent." For those physicians, the healthcare system is working with established alignment tools to drive clinical integration.

"We have a PHO called Health Choice with about 2,000 physicians in it," Ugwueke says. "The group is just beginning to reinvent itself. This PHO has been the vehicle for contracts for physicians and the hospitals; this is done in partnership with MetroCare, which is an IPA. Their new goal is to become a clinical integrated network capable of becoming an ACO over the next several years. Obviously, our goal is to align with them. The other piece we recently started looking at is using service line concepts to begin to realign some of our physicians, particularly in cardiovascular, neurosciences, oncology and, hopefully, create some clinical integration around these areas."

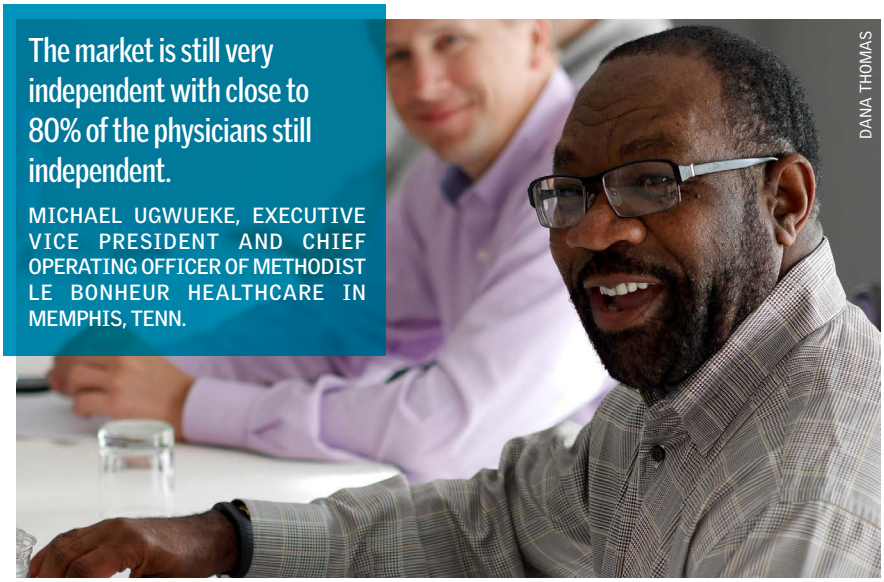
Keith Alexander, CEO of Memorial Hermann Memorial City Medical Center in Houston, describes the area's physician market as "still the wild, wild West."

"The average size of a physician group in southeast Texas is 1.7 doctors," Alexander says. "We have a large IPA with which we work, with over 3,000 physicians, and most are private-practice doctors." Memorial Hermann has approximately 150 physicians in a 501(a) group, a specific model organized under the state's Medical Practice Act, he says. "But it pales in comparison to the size of the market of physicians out there."

The size of the IPA allows for some traction in the market, but the real progress has been its governance

The market is still very independent with close to 80% of the physicians still independent.

MICHAEL UGWUEKE, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER OF METHODIST LE BONHEUR HEALTHCARE IN MEMPHIS, TENN.



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THE PARTICIPANTS

Seth Kronenberg, MD
Medical Director
Crouse Medical Practice, Syracuse, N.Y.

Wright L. Lassiter III
CEO
Alameda Health System, Oakland, Calif.

Todd C. Linden, FACHE
President and CEO
Grinnell (Iowa) Regional Medical Center

Douglas Luckett
President and CEO
CaroMont Regional Medical Center and CaroMont Health, Gastonia, N.C.

Dan Moen
CEO
LHP Hospital Group, Dallas

Alan Murray
President
North Shore-LIJ CareConnect Insurance Company, Inc., Great Neck, N.Y.

Steve Newton
West Region Executive, Baylor Health Care System, Dallas
President, Baylor Regional Medical Center at Grapevine, Texas

Ronald A. Paulus, MD, MBA
President and CEO
Mission Health System, Asheville, N.C.

John Popovich Jr., MD
President and CEO
Henry Ford Hospital
Executive Vice President and Chief Medical Officer
Henry Ford Health System, Detroit

Richard K. Rothberger
Corporate Executive Vice President and Chief Financial Officer
Scripps Health, San Diego

Michael T. Rowan
President of Health System Delivery and Chief Operating Officer
Catholic Health Initiatives, Englewood, Colo.

Steve Simonin
CEO
Iowa Specialty Hospital, Clarion, and Iowa Specialty Hospital, Belmond

Charles A. Stark
President and CEO
Columbus (Ga.) Regional Healthcare System

William F. Streck, MD
President and CEO
Bassett Healthcare Network, Cooperstown, N.Y.

structure, which lets the physicians set clinical priorities, Alexander says.

"The large IPA has aligned a lot of incentives to try and get physicians aligned with the system strategy, and by and large they're driving our clinical strategy," he says. Alexander says historically there was some tension between Houston physicians and Memorial Hermann, which was viewed as "an 800-pound gorilla." That has changed, he says.

"Over the past few years, our system board delegated to this large IPA the authority to establish clinical policy. The governance structure is pretty broad, and [the physicians] develop most all of the clinical policies around evidence-based medicine, quality and patient safety; and [make] decisions to standardize products. Then the IPA submits its recommendations back to each of the hospitals' medical executive committee structure. It's become pretty powerful," Alexander says.

Incentives built around gainsharing in the IPA have also been powerful, he says.

Memorial Hermann and its large IPA received permission from the Federal Trade Commission (FTC) to clinically integrate. With clinical integration, "we had nearly $14 million of incentives for various targeted goals last year for the doctors. Those quality, safety, and cost incentives are now north of $40 million. So 2,000 doctors competing for about $40 million of incentives to align their behaviors is a pretty significant carrot for us. We're starting to make some significant strides in terms of alignment."

Steve Newton, president of Baylor Regional Medical Center at Grapevine


DANA THOMAS

> With clinical integration, we had nearly $14 million of incentives for various targeted goals last year for the doctors.
>
> KEITH ALEXANDER, CEO OF MEMORIAL HERMANN MEMORIAL CITY MEDICAL CENTER IN HOUSTON

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THE PARTICIPANTS

Troy Thibodeaux, MHA, FACHE
Executive Vice President and CEO
Covenant Health System, Lubbock, Texas

Jeffrey E. Thompson, MD
CEO and Chairman of the Boards
Gundersen Lutheran Health System, La Crosse, Wis.

Nathan Tudor
CEO
Beauregard Memorial Hospital, DeRidder, La.

Michael O. Ugwueke, DHA, FACHE
Executive Vice President and Chief Operating Officer
Methodist Le Bonheur Healthcare, Memphis, Tenn.

Allen S. Weiss
President and CEO
NCH Healthcare System, Naples, Fla.

Todd Werner
CEO
Banner Gateway Medical Center, Gilbert, Ariz.

Michael (Mike) Wiechart
President and CEO
Capella Healthcare, Franklin, Tenn.

Mike Wiltermood
President and CEO
Enloe Medical Center, Chico, Calif.

DANA THOMAS

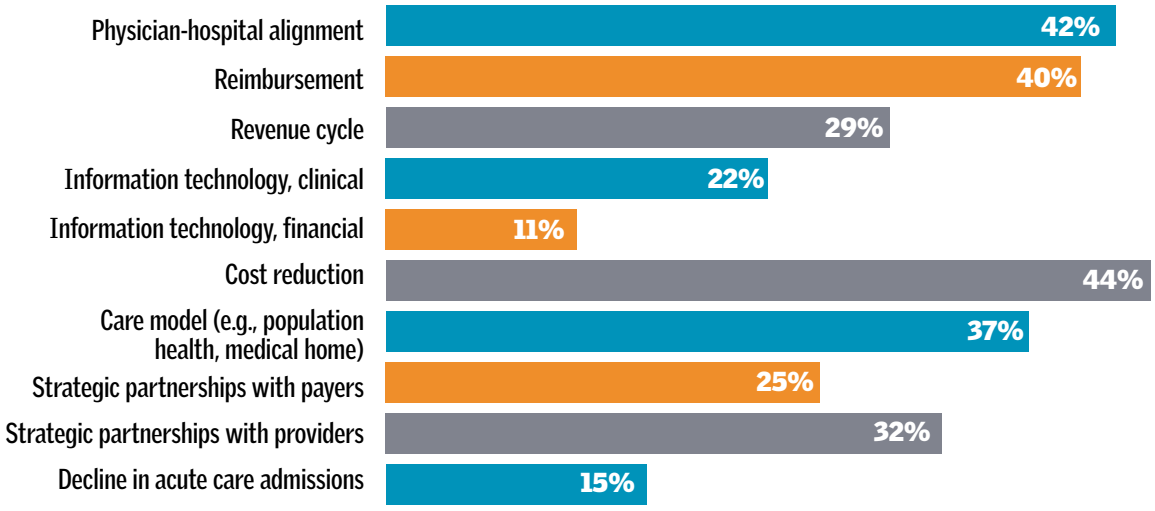
> We're trying to remove cost associated with the adherence to evidence-based clinical practice.
>
> STEVE NEWTON, PRESIDENT OF BAYLOR REGIONAL MEDICAL CENTER AT GRAPEVINE AND EXECUTIVE DIRECTOR OF THE WEST REGION OF BAYLOR HEALTH CARE SYSTEM IN DALLAS

and executive director of the west region of Baylor Health Care System in Dallas, says the system's goal is to turn its physicians from "a very disparate group historically into a more unified group."

"To that end, one of the strategies that we're working on that's been very exciting is an enterprise called the Baylor Quality Alliance, which is almost like a private-label ACO. We are embracing both our own physi-

TOP THREE IMPROVEMENT AREAS

Which are the top three areas your organization must improve or address in order to reach your financial targets in the three-year time frame?



Multi-response
SOURCE: *HealthLeaders Media Industry Survey 2014, CEO Report: The Winners and Losers of Healthcare Reform,* January 2014

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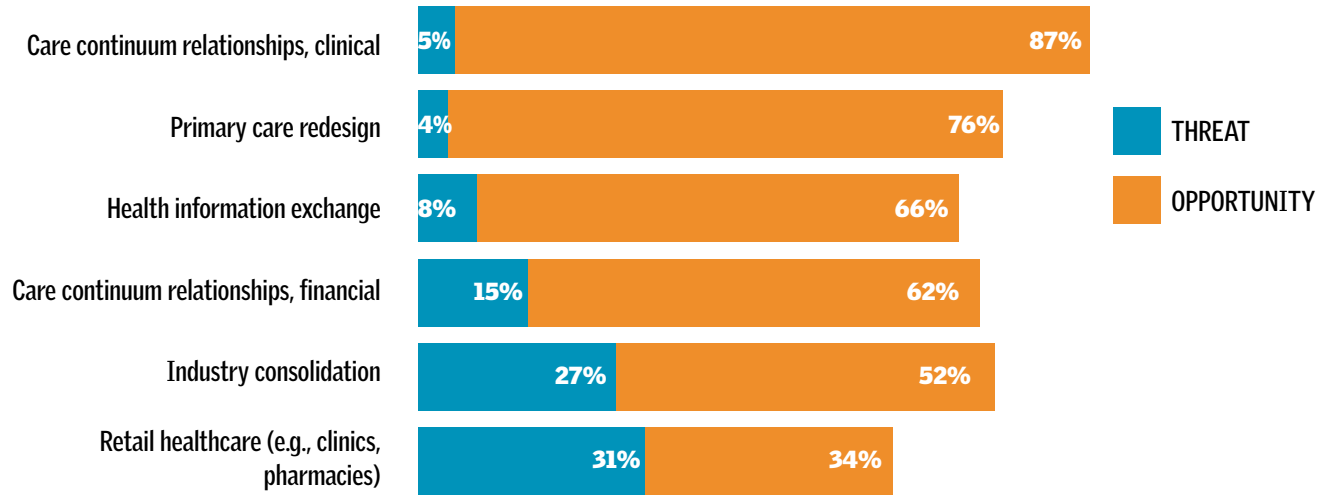
THREAT OR OPPORTUNITY?

Does your organization consider each of the following to be a threat or an opportunity?



Multi-response

SOURCE: *HealthLeaders Media Industry Survey 2014, CEO Report: The Winners and Losers of Healthcare Reform,* January 2014

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cians and our independent doctors in a shared clinical enterprise with a board that's populated exclusively by physicians with specialty area subcommittees that are deciding on clinical protocols," Newton says. "We're trying to remove cost associated with the adherence to evidence-based clinical practice."

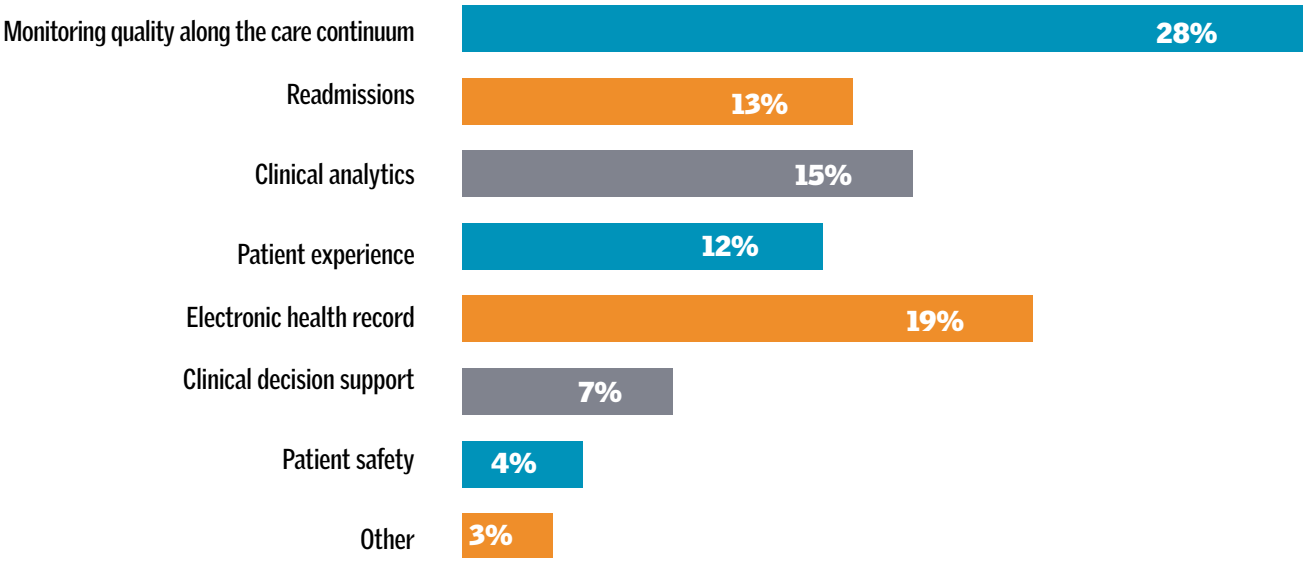
New goals

California has regulatory restrictions on the corporate practice of medicine that restrict the arrangements hospitals and physicians can make, including direct employment. C.R. Burke, who is president and CEO of St. Joseph Heritage Healthcare medical group in Orange County, Calif., as well as the senior vice president of physician practice operations for St. Joseph Health System, says his physician practice has grown from 55 physicians 20 years ago to more than 250 now. The revenue base of $550 million is split with approximately $300 million in global capitation arrangements and $250 million still in fee-for-service.

> **Today we can demonstrate outcomes and clinical measures across a wide spectrum on the commercial and Medicare Advantage patients.**
>
> C.R. BURKE, PRESIDENT AND CEO OF ST. JOSEPH HERITAGE HEALTHCARE MEDICAL GROUP IN ORANGE COUNTY, CALIF.

CLINICAL QUALITY, GREATEST CHALLENGE

Regarding clinical quality improvement, which of the following areas represents the single greatest challenge for your organization?



SOURCE: *HealthLeaders Media Industry Survey 2014, CEO Report: The Winners and Losers of Healthcare Reform*, January 2014

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Burke says the group's experience with capitation has served it well with the advent of the ACO era.

"We had to put in heavy productivity measures back in the late '90s because some of the mid-career docs looked at HMO as a four-letter word," Burke says. "Actually, it proved to be a good thing, because rather than denial management, we really did care management. Today we can demonstrate outcomes and clinical measures across a wide spectrum on the commercial and Medicare Advantage patients."

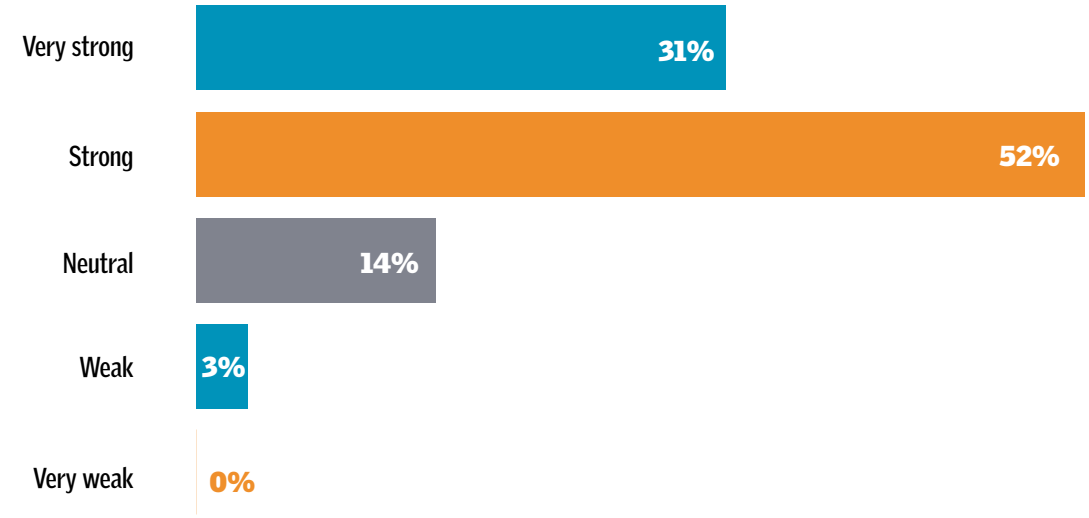
Troy Thibodeaux, CEO of Covenant Health in Lubbock, Texas, says his health system has created its own clinically integrated physician network called Covenant Health Partners, which has been in existence for seven years and is physician-governed.

"For the past six years, we've done a hospital efficiency agreement with that group; we use about 25 to 30 indicators and quality metrics to

> We just completed the first year of that shared savings agreement with Covenant Health Partners, and the total savings to our health plan was $4 million.
>
> TROY THIBODEAUX, CEO OF COVENANT HEALTH IN LUBBOCK, TEXAS

FISCAL MANAGEMENT, OVERALL PERFORMANCE

How would you rate your organization's current performance in fiscal management?



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pay those physicians on their performance," Thibodeaux says. "We use the Crimson tool to monitor individual and aggregate physician performance. That's been very successful. It's been the building block for us, and now we're utilizing this platform to participate in population health and shared savings agreements with that group. We started with our own health plan, which is about 9,000 covered lives. We just completed the first year of that shared savings agreement with Covenant Health Partners, and the total savings to our health plan was $4 million. We were able to share a significant portion of those savings with our Covenant Health Partners physicians in recognition for their performance toward earning these savings."

Coming up with compensation models, clinical guidelines, and measurement tools skips over one critical step: merging cultures. Patrick Cawley, MD, who is CEO of Medical University of South Carolina Medical Center and vice president for clinical operations of MUSC, says his hospital and its physicians were historically "very separate."

"The first thing we did was we got everybody together and formed what we call our clinical leadership council. And we said when everybody comes into that room, you can't put your hospital hat on or your practice plan hat on. You have to think for the system. Every decision that is made in that room is what's good for the system," Cawley says. "And that didn't happen right away, but over the course of a year or 18 months, we have had everybody in that room starting to think more around what's good for the system."

Jim Molpus is leadership programs director for HealthLeaders Media. He may be contacted at *jmolpus@healthleadersmedia.com*.

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HealthLeaders Media

Vice President and Publisher
RAFAEL CARDOSO
rcardoso@healthleadersmedia.com

Leadership Programs Director
JIM MOLPUS
jmolpus@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Senior Leadership Editor
PHILIP BETBEZE
pbetbeze@healthleadersmedia.com

Senior Finance Editor
RENÉ LETOURNEAU
rletourneau@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

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HEALTHLEADERSMEDIA.COM

75 Sylvan Street, Suite A-101 > Danvers, MA 01923 > 781-639-3390
100 Winner's Circle, Suite 300 > Brentwood, TN 37027 > 800-650-6787
For general inquiries, please email: sales@healthleadersmedia.com.