Are You Ready for Integration? (Neither Were We)

A Case Study: Bassett Healthcare Network

October 23, 2014
Mr. Frank Panzarella FACHE, CMPE, Vice President

- Frank Panzarella is Vice President of Operations for the Bassett Medical Group (BMG).
- Since 2008, Mr. Panzarella has been the executive leader for BMG’s professional staff of 435 providers and 900 employees.
- He is co-chair of the BMG’s governing body, which directs operational and strategic initiatives.
- Prior to Bassett, Mr. Panzarella spent 6 years in progressively responsible positions at Partners Healthcare System. He completed a MHSA at the University of Michigan.

Mr. Joshua D. Halverson, Principal

- Mr. Halverson has more than 15 years of experience in healthcare strategic and business planning and financial management.
- He possesses extensive knowledge of strategic, operational, and financial best practices among large physician groups and in the context of their integration within health systems.
- Mr. Halverson specializes in economic alignment between physicians and hospitals involving acquisition, group development, compensation planning, and operations improvement.
- He leads ECG’s Dallas office.
Agenda

I. Setting the Stage
II. High-Functioning Physician Organizations
III. Case Study – Bassett Healthcare Network
I. Setting the Stage
I. Setting the Stage

Overview

During this presentation, we will address several of the top issues on the minds of health system/hospital CEOs.

**Question:** What are the top three areas your organization must improve in order to reach your financial targets in the three-year time frame?

• Budgetary constraints of federal and state programs are compressing reimbursement to providers.
• Consolidation of commercial payors and their resulting market power contribute to minimal revenue growth.
• As a result, operating margins of integrated healthcare systems across the country are under pressure.
• The sustainability of the current configuration of physician organizations without structural change is being questioned.

The nation is looking to healthcare organizations to innovate and improve care delivery through better coordination and more efficient use of resources.
I. Setting the Stage

**Increased Physician Employment**

As professional service reimbursement flattens or falls and uncertainty over reform continues, physicians are increasingly becoming employed by hospitals and health systems.

**Growing Trend**

- Newly trained physicians see health systems as a “safe haven” from uncertainty.
- Health systems see primary care as a necessary investment to lock in future business.
- Smaller multispecialty groups are dissolving as select specialties pursue hospital employment to improve compensation levels.

“More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems, a trend fueled by the intended creation of accountable care organizations and the prospect of more risk-based payment approaches.”

I. Setting the Stage
Phases of Physician Employment

Employed physician networks tend to migrate through the four phases shown below. The phase that your organization is in will shape your planning efforts.

**Four Phases of Physician Network Evolution**

- **Phase 1 – Recruitment**
  - Objective: Meet Community Need
  - Network Maturity: Low

- **Phase 2 – Growth**
  - Objective: Secure Market Share
  - Network Maturity: High

- **Phase 3 – Service Expansion**
  - Objective: Expand Clinical Expertise
  - Network Maturity: High

- **Phase 4 – Value-Based Network**
  - Objective: Manage Population
  - Network Maturity: High
I. Setting the Stage
Implications of Physician Employment

**Hospitals need to have clear and realistic expectations of how practices will change after employing physicians.**

**Practice Revenue**
- Physicians’ payor mix is likely to be less favorable than pre-acquisition as independent physicians refer Medicare, Medicaid, and uninsured patients to employed physicians.
- A loss in physician productivity is common.
- The level of physician engagement in the business may decline.

**Practice Expenses**
- Salaries and benefits typically, though not always, increase.
- Infrastructure requirements are significant and will be higher than in the private practice setting.
I. Setting the Stage

Investment Per Physician Increases

Notwithstanding these trends, hospitals/health systems are experiencing increasing losses in physician organizations.

Integrated Health System Investment/(Loss) Per Physician

<table>
<thead>
<tr>
<th>Year</th>
<th>Investment Per Physician</th>
<th>Percentage of Net Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$(138,724)</td>
<td>-29.7%</td>
</tr>
<tr>
<td>2010</td>
<td>$(148,791)</td>
<td>-33.2%</td>
</tr>
<tr>
<td>2011</td>
<td>$(148,025)</td>
<td>-28.3%</td>
</tr>
<tr>
<td>2012</td>
<td>$(181,407)</td>
<td>-33.6%</td>
</tr>
</tbody>
</table>

Source: ECG 2013 surveys.
II. High-Functioning Physician Organizations
II. High-Functioning Physician Organizations

Organizations with aligned/employed physicians are seeking to reorganize themselves in order to establish high-functioning “systems of care” that create value by demonstrably improving quality outcomes and reducing costs.

The market appears to recognize that high-functioning, integrated multispecialty group practices are most likely to be successful in a value-based reimbursement system.
II. High-Functioning Physician Organizations

Mechanisms for Group Integration

Physician group integration is achieved through the following elements:

<table>
<thead>
<tr>
<th>Structure</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance and Management</td>
<td>• Common vision and shared direction with physician participation.</td>
</tr>
<tr>
<td></td>
<td>• Clearly articulated roles and authorities of governing bodies.</td>
</tr>
<tr>
<td></td>
<td>• Delegated leadership with a strengthened governance structure to facilitate efficient and effective decision making.</td>
</tr>
<tr>
<td></td>
<td>• Consolidated leadership for key functions and overall physician enterprise.</td>
</tr>
<tr>
<td>Operations</td>
<td>• Implementation/enforcement of standards for patient care processes, practice characteristics, and administrative functions.</td>
</tr>
<tr>
<td></td>
<td>• Electronic medical records (EMRs) that provide a common platform to collect information and coordinate care.</td>
</tr>
<tr>
<td>Financial Arrangements</td>
<td>• Consolidation of compensation methods.</td>
</tr>
<tr>
<td></td>
<td>• Consistent incentives among physicians.</td>
</tr>
<tr>
<td></td>
<td>• Financial alignment between providers of care (i.e., hospitals and physicians).</td>
</tr>
</tbody>
</table>
II. High-Functioning Physician Organizations
Viewing Physicians as Strategic Assets

In any type of relationship, the things people argue over often are not the real issue.

**Underlying Causes of Conflict**

- Excessive focus on what they want to gain out of the relationship instead of what they can contribute to it.
- Naive and unrealistic expectations about how the relationship should work.
- Failure to discuss needs and expectations in advance.
- Not knowing how to be a couple.

*Lack of preparedness to be a good partner in a mutually beneficial relationship.*
II. High-Functioning Physician Organizations
Viewing Physicians as Strategic Assets

Clear decision-making processes and shared governance can improve the “relationship” between physicians and hospitals.

<table>
<thead>
<tr>
<th>Limited Governance</th>
<th>Ad Hoc Committee</th>
<th>Standing Committee</th>
<th>Governance Council</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No established mechanism for governance. Individuals informally consulted.</td>
<td>Formed to discuss specific issues (e.g., new products, workforce planning) as they arise.</td>
<td>Established governance body responsible for wide range of oversight functions.</td>
<td>Council maintains complete accountability for service line performance, reporting directly to the health system CEO.</td>
</tr>
<tr>
<td><strong>Strategic Planning</strong></td>
<td>No role.</td>
<td>Informed.</td>
<td>Advisory.</td>
</tr>
<tr>
<td><strong>Management Selection</strong></td>
<td>No role.</td>
<td>Input on hiring.</td>
<td>Input on hiring and performance review.</td>
</tr>
<tr>
<td><strong>Budgeting</strong></td>
<td>No role.</td>
<td>Occasional advisory.</td>
<td>Advisory.</td>
</tr>
<tr>
<td><strong>Physician Compensation</strong></td>
<td>Individual physicians may be consulted.</td>
<td>Limited physician involvement.</td>
<td>Significant physician composition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Balanced physician and executive composition.</td>
</tr>
</tbody>
</table>
Because physician compensation is by far the largest expenditure, special attention should be paid to align compensation with organizational goals. The elements listed below represent an example physician compensation philosophy.

- Median compensation for median work effort.
- Emphasis on individual and/or group productivity.
- Payor-neutral compensation.
- Introduction of nonproductivity-based incentives over time.
- Income protection for specialties only on an as-needed basis.
- A common compensation methodology across specialties wherever possible.
III. Case Study – Bassett Healthcare Network
Overview

- Bassett Healthcare Network is an integrated healthcare system that provides care and services to people living in an eight-county region covering 5,600 square miles in upstate New York.

- The organization includes:
  - Six corporately affiliated hospitals.
  - Skilled nursing facilities.
  - Community and school-based health centers.
  - Home health.
  - DME companies.
  - Medical school.
  - Health partners in related fields.

Mission – “Who we are…”

Bassett Medical Center is an academic medical center that exists to advance the healthcare of rural populations through:

- Providing excellence in the continuum of care.
- Educating physicians and other healthcare professionals.
- Pursuing health research.
III. Case Study – Bassett Healthcare Network

Location Growth

Bassett Healthcare Network

1984

2013

Affiliated hospital
Clinic
School based
Multispecialty complex
Skilled Nursing
Home Health
DME
Similar to other organizations across the country, Bassett has significantly increased its number of employed physicians.

III. Case Study – Bassett Healthcare Network

Physician Growth

Bassett Healthcare Network

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1940</td>
<td>8</td>
</tr>
<tr>
<td>1950</td>
<td>16</td>
</tr>
<tr>
<td>1960</td>
<td>30</td>
</tr>
<tr>
<td>1970</td>
<td>42</td>
</tr>
<tr>
<td>1980</td>
<td>72</td>
</tr>
<tr>
<td>1990</td>
<td>150</td>
</tr>
<tr>
<td>2013</td>
<td>260</td>
</tr>
</tbody>
</table>

Number of Physicians
III. Case Study – Bassett Healthcare Network

Initiatives

Strategies in Play

• Insurance partnership
• NEWCO IPA Expansion of network
• Value-based insurance: ACO, ACQA, MA, EXG
• Medicaid Health Home
• Bassett Health Plan
• PCMH, the Care Team Model, and Care Coordination
• Business Intelligence

Effective Operations

• ECG – Medical Group Efficiency and Performance
• Inpatient Efficiency, Capacity, and Flow
• External Benchmark and Regional Peer Comparisons
• Systematic Cost Reductions
• Health Plan Management
• Targeted Program Reviews
• Unity (Epic) Optimization
III. Case Study – Bassett Healthcare Network Initiatives

Growth (Traditional/Insurance-based)
- Primary Care providers
- Primary Care sites
- Rome, Utica
- IPA with other physicians
- Insurance products
- The Manor

Finance – Difficult Transition from FFS to Capitation
- Volume
- Capital
- Reserves
- Transitional funding
III. Case Study – Bassett Healthcare Network
Process Mapping

High-Level Clinic Process and Control Points

<table>
<thead>
<tr>
<th>SCHEDULING</th>
<th>REGISTRATION</th>
<th>BALANCE COLLECTION</th>
<th>CARE EVENT</th>
<th>CHARGE ENTRY</th>
<th>SCHEDULING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call Center</td>
<td>Schedule Appointments</td>
<td>Automatic Account Generation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registration/Charge Entry</td>
<td>Arrive Patient; Collect Auth/Referral</td>
<td>Post Payment</td>
<td>Medtech for Supplies</td>
<td>Post Technical Fee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bassett Clinics/Department</td>
<td>Schedule Appointments</td>
<td>Surgery/CTC: Arrive Patients for Clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Flowcast Centricity Business
Epic
Paper or Reports
Meditech

= Manual input/transfer of data.
= Automatic input/transfer of data.
There were three major areas of opportunity to create a more productive clinic environment.

**Bassett Healthcare Network**

**Optimization of Clinical Time:**
- Maximize the productivity of existing provider time in the clinic through the implementation of:
  - More effective master schedules.
  - Efficient and effective scheduling processes.
  - A reduction in lost capacity due to no-shows and last-minute cancellations.

**Staffing for Throughput:**
- Identify the ideal staffing model for each clinic, with redefined responsibilities for each support role.
- Then develop a training and transition plan to maximize the use of existing staff and ensure they are working to the top of their license.

**Access and Patient Satisfaction:**
- Capture return and follow-up visits before the patient leaves the clinic space in order to improve patient service and reduce the need for duplicative work.
III. Case Study – Bassett Healthcare Network

Load Balancing

While there is time available for more patients in existing schedules, volumes may not be possible if they are added to the busiest days in clinic.

Bassett Healthcare Network

**Middle Surgery Clinic**

- Providers in Clinic

**Orthopedics Clinic**

- Providers in Clinic

**NOTES:** In both figures, the lines indicate the maximum/minimum values; the bars represent the 25th and 75th percentiles.

Standard practice in an orthopedic clinic is three exam rooms per physician in the clinic, plus one additional room if that physician is supervising an APC.
To increase appointment availability, session durations could be established. A 4-hour expectation could be standardized while maintaining independent decision making for the provider in relation to start/stop times.
III. Case Study – Bassett Healthcare Network

Process Redesign

Current State

Nursing Pool
- Utilization of Whomever Is Available
- Limited Clinic Prep
- Limited Clinic Discharge
- High Staff Dissatisfaction
- Provider-Centric vs. Patient-Centric

Future State

RN Triage and Clinical Support

- Team-Based Care
- MA Assignment
- RN Scope of Practice
- Appropriate Staff Levels
III. Case Study – Bassett Healthcare Network

Opportunities for Error

*Unnecessary complexity in scheduling creates opportunities for error, difficulty finding appropriate slots, and challenges for planning staff schedules.*

### Bassett Healthcare Network

#### Opportunity – Visit Type Utilization

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Visit Types</th>
<th>Types With Volumes &lt;100</th>
<th>Visit Types With Volumes &lt;10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>22</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>12</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>General Surgery</td>
<td>20</td>
<td>15</td>
<td>5</td>
</tr>
</tbody>
</table>

- In many specialties, there are visit types with extremely low utilization.
- In general surgery, 95% of all cases are scheduled into the top five visit types.

#### Opportunity – Unclear Visit Types

- Without clear appointment types, it is difficult to ensure accuracy in central scheduling.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Visit Type</th>
<th>Arrived Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>Procedure 3</td>
<td>73</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>Procedure 4</td>
<td>60</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>(blank)</td>
<td>177</td>
</tr>
</tbody>
</table>

#### Opportunity – Undefined Providers

- Without clear schedules, clinic managers find it difficult to plan ahead.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Arrived Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHED, USE479</td>
<td>817</td>
</tr>
<tr>
<td>SCHED, USE97</td>
<td>1,157</td>
</tr>
<tr>
<td>(blank)</td>
<td>10,819</td>
</tr>
</tbody>
</table>
III. Case Study – Bassett Healthcare Network

Lost Capacity

- The ability for schedulers to maximize available provider time varies by clinic.
- All the clinics have some loss of capacity due to same-day no-show rates, with most clinics in the 8% to 10% range.
- Some clinics may have inherent inefficiencies due to their physical space, such as the GI physicians needing to travel between buildings throughout the day.

Approximately 28% of existing appointment times were underutilized due to scheduling inefficiencies and no-show rates.

Existing Clinic Slot Utilization

- Improving the scheduling process could increase volumes without needing to change provider time in the clinics or physician behavior.

NOTE: Assumed 46 weeks per year. Calculations include only physicians who were or are currently employed.
Based on benchmarks and existing resources, it was estimated physicians can increase productivity in patient volumes without opening new clinic sessions or changing provider clinical practices.

**Bassett Healthcare Network**

**Key Assumptions**

- Staffing schedules are able to be adjusted as needed.
- Scheduled visit durations are accurate to reality.
- Scheduled visit durations and visit type mix remain consistent.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Description</th>
<th>Constraint</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Actual</td>
<td>Actual 2012 visit volumes.</td>
<td>N/A.</td>
<td></td>
</tr>
<tr>
<td>75% Appointment Slot Utilization</td>
<td>Assumes provider schedules remain as they are, but with an increase in slot utilization up to 75%.</td>
<td>Hours per week.</td>
<td>+12%</td>
</tr>
<tr>
<td>4-Hour Session Standard</td>
<td>Assumes provider sessions remain as they are, but are extended to a full 4-hour session where they are not already.</td>
<td>Sessions per week</td>
<td>+20%</td>
</tr>
</tbody>
</table>
## III. Case Study – Bassett Healthcare Network
### Rapid Improvement

**Bassett utilized Lean management tools to improve operations.**

### Bassett Healthcare Network

<table>
<thead>
<tr>
<th>Component</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Statement</td>
<td>Many patients are leaving the clinic building without the necessary follow-up appointments scheduled, creating additional work for the patient, opportunities for miscommunication, appointment volumes not being captured, and additional calls through the call center.</td>
</tr>
<tr>
<td>Scope</td>
<td>Redesign of checkout function after provider clinical visit has been completed.</td>
</tr>
<tr>
<td>Measure Definition</td>
<td>Portion of patients leaving the clinic building with all follow-up appointments scheduled.</td>
</tr>
<tr>
<td>Goal Performance</td>
<td>TBD.</td>
</tr>
<tr>
<td>Tasks</td>
<td>The team will work to establish a reliable measurement for both current performance and the reasons for failure. This information will be utilized to conduct an RIE that ultimately culminates in a new checkout process.</td>
</tr>
<tr>
<td>Timeline and Plan</td>
<td>45 to 60 days. Change management plan, TBD.</td>
</tr>
</tbody>
</table>
III. Case Study – Bassett Healthcare Network

**Performance Dashboard**

- **Metric**
  - Square Feet Per FTE: 775
  - On-Time Registrations: 80%
  - Lead Time: 44 Days
  - No-Show Rate: 11.7 Per Day
  - Add-On Volumes: 3.5 Per Day
III. Case Study – Bassett Healthcare Network
Outcomes

Across-the-board changes have yet to be implemented; however, pilots of key enhancements have demonstrated significant results.

Balanced Scorecard Domains

<table>
<thead>
<tr>
<th>Quality</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and</td>
<td>Cost</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
</tr>
</tbody>
</table>

Expected Outcomes

- Increase access. ✓
- Team-based care. ✓
- Integrate ARNPs. ✓
- Reorganize care model. ✓
- Increase patient satisfaction. ✓
- Enhance economic sustainability. ✓
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