Creating a team to navigate the modern health care environment

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After 5 years of private practice with clinical faculty appointment at the University of Pittsburgh School of Medicine, I had a decision to make: stay on the traditional path of fee-for-service private practice or make a change. As one leader noted, it seemed all participants in the medical economy were about to cross a "valley of death" of sorts, and picking your caravan correctly was becoming essential.

There seemed to be a growing gap between my associates in the latter stages of their careers and my colleagues around the United States who were getting started. In pure private practice, annual reimbursements were declining, teaching residents and fellows was not valued, and major affiliation changes of primary referral sources had significant impact on patient volume.

Offset of lost clinical revenue demanded agile navigation of ancillary service ownership, rigorous overhead management and participation in medical-legal consulting. While these endeavors were interesting and rewarding, the sustainability over a longer career horizon seemed uncertain. Further, early exposure to the barriers to innovation through hip arthroscopic surgery revenue cycle management confirmed the precarious nature of private practice and in-network performance of cutting edge procedures.

Considering the available choices and looking for a more viably sustainable option, I chose to join the faculty at the Allegheny Health Network, a newly created Integrated Delivery Network (IDN) in the Pittsburgh area. Through acquisition of the former West Penn Allegheny Health System, Highmark Inc., an independent licensee of the Blue Cross Blue Shield Association, created a new business species. Under the banner of "patient-centered, provider-led," I joined other physicians and administrators in what can only be described as a new business start-up on a massive scale. Currently, I am part of a large subspecialty orthopedic-physician sub-practice of this IDN called the Allegheny Clinic, and we host an ACGME-accredited orthopedic residency program and several fellowship programs.

In an environment where the rules change hourly, the experience of learning from and working with the leadership at the Allegheny Health Network as well as private practice leaders in my former practice has been invaluable. In this *Orthopedics Today Round Table* providers who got involved with the changing world outside the operating room walls, share the value of their experiences.

John J. Christoforetti, MD
Moderator

John J. Christoforetti, MD: *How has the incorporation of provider services changed the landscape within the payer as a business?*

Donald R. Fischer, MD, MBA: There is a general consensus among experts in health policy that quality of health care in the United States is not optimal and costs are high. Highmark's large employer accounts complain that they do not receive adequate value for the dollars that they spend on health care. Highmark Health has moved to a model of an integrated delivery and financing system, where the Highmark Health Plan and Allegheny Health Network (the provider arm) are part of a single enterprise. We believe this strategy will facilitate increased value, by addressing some of the root causes of poor quality. First, we are building an integrated provider electronic health record which will be linked to the health plan databases, and to sophisticated decision support, to assure that full information is available to the clinician at the point of care, and to increase adherence to standardized evidenced based pathways. While installing a system is necessary, we must also undergo transformational culture change in both the provider organization and the health plan to realize our goal of better care. Secondly, we are committed to replacing the perverse incentives of the fee-for-service reimbursement model. With an integrated delivery system, we can pilot new models such as risk-based capitation, pay-for-value, episode based payment, gain sharing and risk sharing, doing so in a more nimble fashion than is feasible with providers who are not aligned around a common mission.

Christoforetti: *Is there a measurable correlation between a surgeon's ability to show their outcomes and payer reimbursement or incorporation of covered services?*

Fischer: Reimbursement at this time is focused almost exclusively on performance of activities. More encounters with the patient and more procedures are the methods to increase revenue. During the past 10 years, a movement to reward quality has resulted in pay-for-performance payment mechanisms that have focused on various process indicators which align with evidence-based guidelines, and which are generally fairly easy to measure from claims data. But following recommended processes does not assure that outcomes are actually better. Our large self-insured accounts are demanding that quality be measured based on outcomes, and that pay-for-value programs be developed that only provide rewards if outcomes can truly be differentiated among providers. A prerequisite to building a pay-for-value program is having reliable provider-based registries of patients in order to track outcomes. In the case of hip and knee replacement, these outcomes would include postoperative infection rates, readmission rates, reoperation rates, functional status, and timing of return to work. In the future, episodes of care that are of higher quality and lower cost will be more highly compensated, providing a greater margin for the provider. Doing better work will be aligned with a better business model for both health plan and provider, and will bring more value to the patient and his employer.

Christoforetti: *At what level can providers working within an IDN have input to the process of coverage and reimbursement from the payer?*

Fischer: Highmark has welcomed input from the provider community as we have developed our Quality Blue pay-for-performance programs over the years. These programs have focused on primary care and hospital inpatient care, and have been modified periodically based on the thoughtful feedback from physicians who are enrolled in the programs. Success in the newer pay-for-value (P4V) models in which better outcomes are rewarded, will also depend on input from specialists who understand quality and process improvement. That input can come

from within the IDN, which has the benefit of allowing a faster pace of development and revision. However, the IDN input must be aligned with national quality standards. We know that unwarranted variation in practice exists, and there can be striking regional variation in quality. An IDN cannot afford to be provincial in their perspective. We encourage national specialty societies to develop evidence-based pathways of care, to set appropriateness criteria for common tests and procedures in their field, and to advise on reasonable quality and outcomes metrics on which to base a health plan's P4V rewards. The American College of Cardiology leadership has been an excellent partner for health plans in driving quality measurement for their members. We look forward to similar collaboration and input from the American Academy of Orthopaedic Surgeons.

Christoforetti: *What is the value of incorporating innovation and basic research to an IDN initiative?*

Alan Russell, PhD: IDNs are expanding and diversifying at a disruptive pace. The overarching assumption of such business models is that IDNs are a compelling vehicle through which care can transition from provider/revenue-centric models to patient/value-centric models. Transitioning to value driven care can either be embraced or resisted by those that govern the status quo. Technology and science have key roles to play in supporting and enabling the transition. Few would argue that much of clinical practice today, particularly in orthopedics, is a high art versus an information science. Decisions on how to reconstruct a torn ACL, for example, may be made on the basis of an individual surgeon's experience versus detailed science and information about the injury and the utility of a given therapy-patient match. As value-based medicine expands, spearheaded by integrated delivery networks that focus on delivering the right care at the right time and in the right place, there is an opportunity for orthopedic care to transition into an information science-driven enterprise. Research has to be at heart of that endeavor.

Christoforetti: *How does the IDN environment distinguish itself from traditional university based research model?*

Russell: Large academic medical centers have enjoyed massive investment in their research enterprises and many have expanded at an unsustainable pace. By their nature, such systems will and should be draw to tackle complex issue and to advance game-changing science and therapies. Progress is by its nature slow, expensive and rarely measurable by anything other than grants, contracts and publications. In the history of disruptive innovations across all industries, it is often easier for small focused entities to drive real change on shorter timescales. From concussion diagnosis to management of back pain, major disruptive innovations (innovations that change the game rapidly and at lower cost) are most likely to come from outside large academic health centers. No large industries have successfully led the way to their own disruption and this will be no different in health care delivery.

Christoforetti: *What will be the keys to successful innovation through research in the post ACA economy?*

Russell: They key to success lies in effective partnership. Countless creative hours can be wasted by wading through bureaucracy that expands in organizations that lack trust in themselves and each other. By building innovation enterprises from the ground up that are designed to be nimble and effective partners with industry and other innovation centers is the essential missing ingredient in too many research centers of excellence. World class research

centers of excellence do not necessarily drive change in clinical practice through their work. Nor do clinical centers of excellence automatically become welcoming of research-driven change. Enabling a culture of creativity requires breaking down the barriers that separate the clinical and research communities and embracing the reality that no entity has all the answers to solve important problems alone.

A note from the editors:

Look for part 2 of this *Round Table* in the September issue in which the moderator asks **John W. Paul** and **Patrick J. DeMeo, MD,** about an integrated delivery network.

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Disclosures: Christoforetti and DeMeo are employees of the Allegheny Clinic; Fischer is an employee of Highmark Inc.; Paul and Russell are employees of the Allegheny Health Network.