Austin Regional Clinic
Seton Health Alliance

Clinical Integration Through the Eyes of an Independent Multispecialty Physician Group

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Norman H. Chenven, M.D.
Founder & CEO, ARC
chenven@arcmd.com
512-231-5514

Gregory Sheff, MD
President & CMO, SHA
gsheff@arcmd.com
512-338-8490

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Overview

1. Goals
2. Austin Regional Clinic Overview
3. Seton Health Alliance Overview
4. Formation Challenges
5. Unresolved Challenges
6. Closing

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1. Goals

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Today's Goals: Goal #1

Clinical Integration is typically discussed from the perspective of a hospital or healthcare system.

We want to provide the perspective of an independent multispecialty physician group which is choosing to clinically integrate with a healthcare system in our community.

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Today's Goals: Goal #2

Present an honest assessment of the complexity of partnership between a large physician group and a hospital system.

This complexities exist even when both organizations have the same goal: An organized, clinically integrated, value based delivery system

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Today's Goals: Goal #3

Present a "food for thought" talk.

This is not meant to be a roadmap or a showcase of our successes.

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What We Won't Cover

- Analysis of scope, size, or specialty/geographic gaps in forming a clinically integrated network
- Operational steps in network formation and management
- Operational committee structure
- IT and analytic solutions
- Specifics on quality improvement work

- Don't worry – you'll hear all that today as well!

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2. ARC Overview

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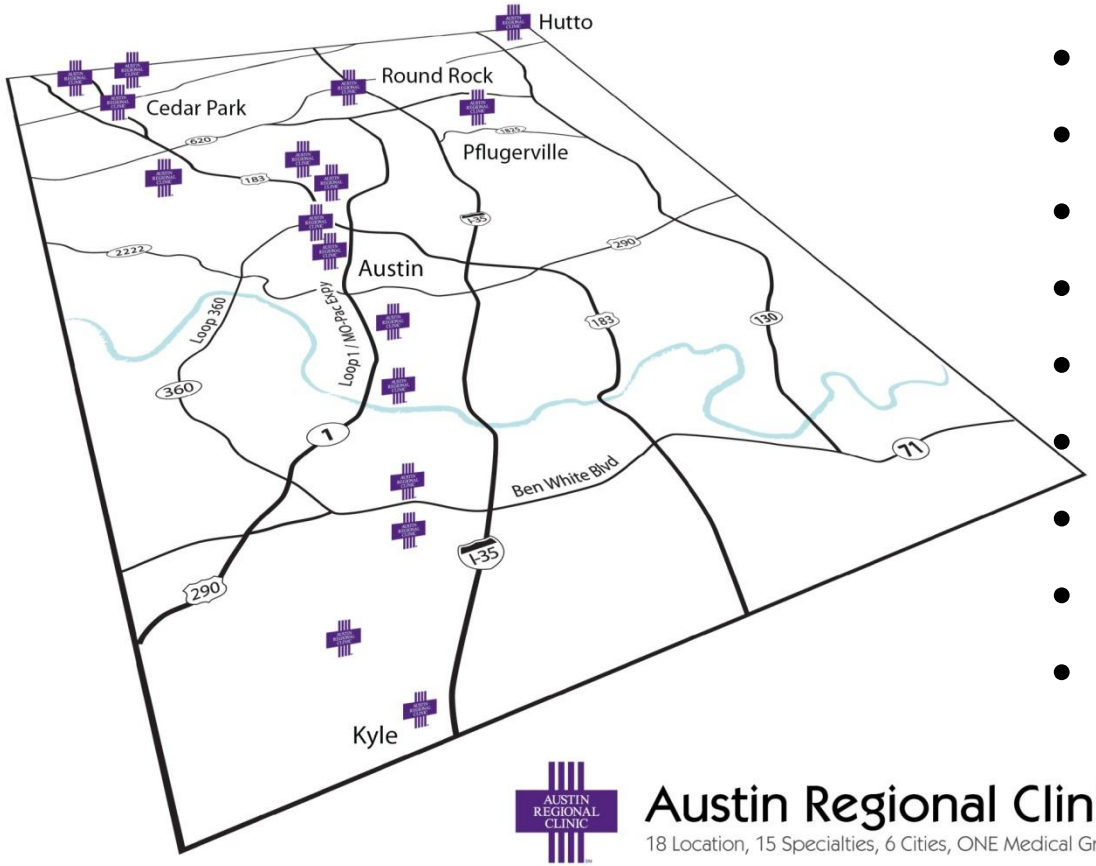
Austin Regional Clinic



- **1,000,000** patient visits
- **380,000** active patients
- **1,500** employees
- **320** physicians
- **18** locations
- **16** specialties
- **6** cities
- **3** counties
- **1,000** square miles

Austin Regional Clinic
18 Location, 15 Specialties, 6 Cities, ONE Medical Group

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Key Aspects of Austin Regional Clinic

- Physician owned/Physician governed
- Multi-specialty group built on a primary care base
- Though a joint venture MSO as well as a Hospitalist Service, a history of productive partnership with the Seton Healthcare Family

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Our History in a Nutshell

- Founded 1980 - in an exclusive contract with PruCare HMO (group model).
- Strong growth from onset (17,000 health plan members within first 18 months).
- Health plan/medical group alignment started to fray in 1987 with Prudential management changes.
- Termination of ‘exclusive’ PruCare contract in 1993 (80,000 fully capitated lives).
- 1993-2000: contracted with 7 regional and national health plans (HMO).

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Our History in a Nutshell, *cont'd*

- 1999: MSO formation with Seton Hospital provided a capital infusion allowing ARC to recover, reinvest & grow.
- 2000-2003: unwinding of all capitated contracts
- 2007: Physician's Health Choice (2,000 Medicare Advantage patients) contract. Purchased by UHC (2012).
- 2011: BCBSTX PCMH pilot (44,000 patients)
- 2012: SHA Pioneer ACO (9,000 patients).
- Currently: PCMH discussions with United, Humana, Aetna and large employers in progress.

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Austin Regional Clinic (ARC) brought managed care to Central Texas in 1980. ARC spent it's first two decades focused on delivering high quality capitated care. Multiple environmental factors dictated a retreat from capitation in Austin and Central Texas in 2000. The passage of PPACA and the decision of Seton Healthcare Family to apply for Pioneer ACO designation drew ARC back to its future to participate in Seton Health Alliance in 2012.

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- The conditions required to provide value based care are:
  - Motivated customers – commercial or governmental
  - Committed leadership in the provider community
  - Significant capital to build infrastructure
  - And *ideally* pricing mismatches

These conditions existed in 1980 and appear to be reoccurring with the catalyst of PPACA.

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ARC has the culture, primary care base, and hospitalist program to excel in value based care.

ARC lacks the analytic and IT infrastructure, broad specialty coverage, and balance sheet for comprehensive delivery system transformation.

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3. Seton Health Alliance Overview

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Seton Healthcare Family Overview

- Acute Care Hospitals – 11
- Employed Physicians – 300+ (excluding residents)
- Clinic Locations – 38
- Own a health plan (Seton Health Plan)
- Only Level I Trauma Center
- Only Level I Children's Facility
- Partnership with UTSW – 11 Residencies
- 2011 Uncompensated Care - $303M
- Number of Employees – 12,000
- Member of Ascension Health

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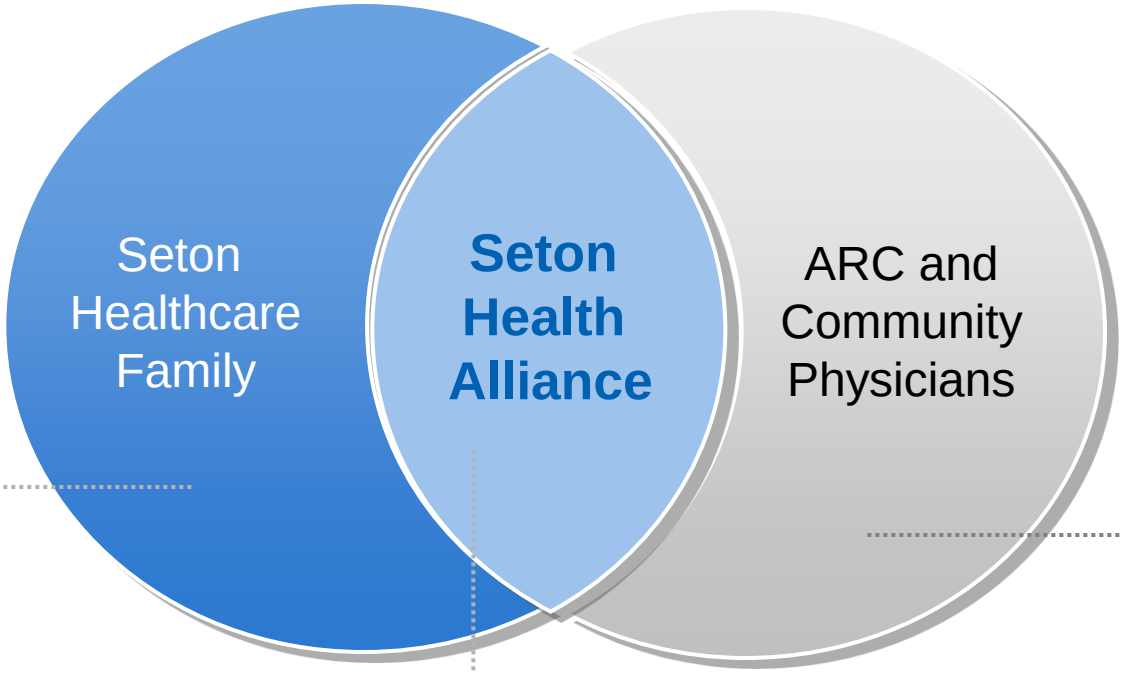
Seton Health Alliance

- Ownership
- Board representation
- Capital Investment



- Board representation
- Care Management Redesign

- Clinically Integrated Network
- Care management and Analytic & Reporting Infrastructure
- Distributes Shared Savings

- Governing Board comprised of 15 members, 9 physician members
- 5 Seton members, 5 ARC members, 5 community members
- Supramajority for essentially all votes

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Strategic Vision: Seton Health Alliance

Build a Better Healthcare System for Central Texas

- Align with Seton's goal to care for 1M Central Texans
- Achieve Triple Aim: Improve quality, population health and patient satisfaction while reducing overall cost of care

Develop a Viable Operating Platform for Seton and Community Providers

- Build physician alignment and trust through physician participation in governance and care redesign
- Manage the transition from fee for service to value-based payment models
- Align incentives with providers

Respond to Changing Market Dynamics

- Bend cost curve while increasing quality of care
- Test innovative value-based payment models
- First-to-market advantages

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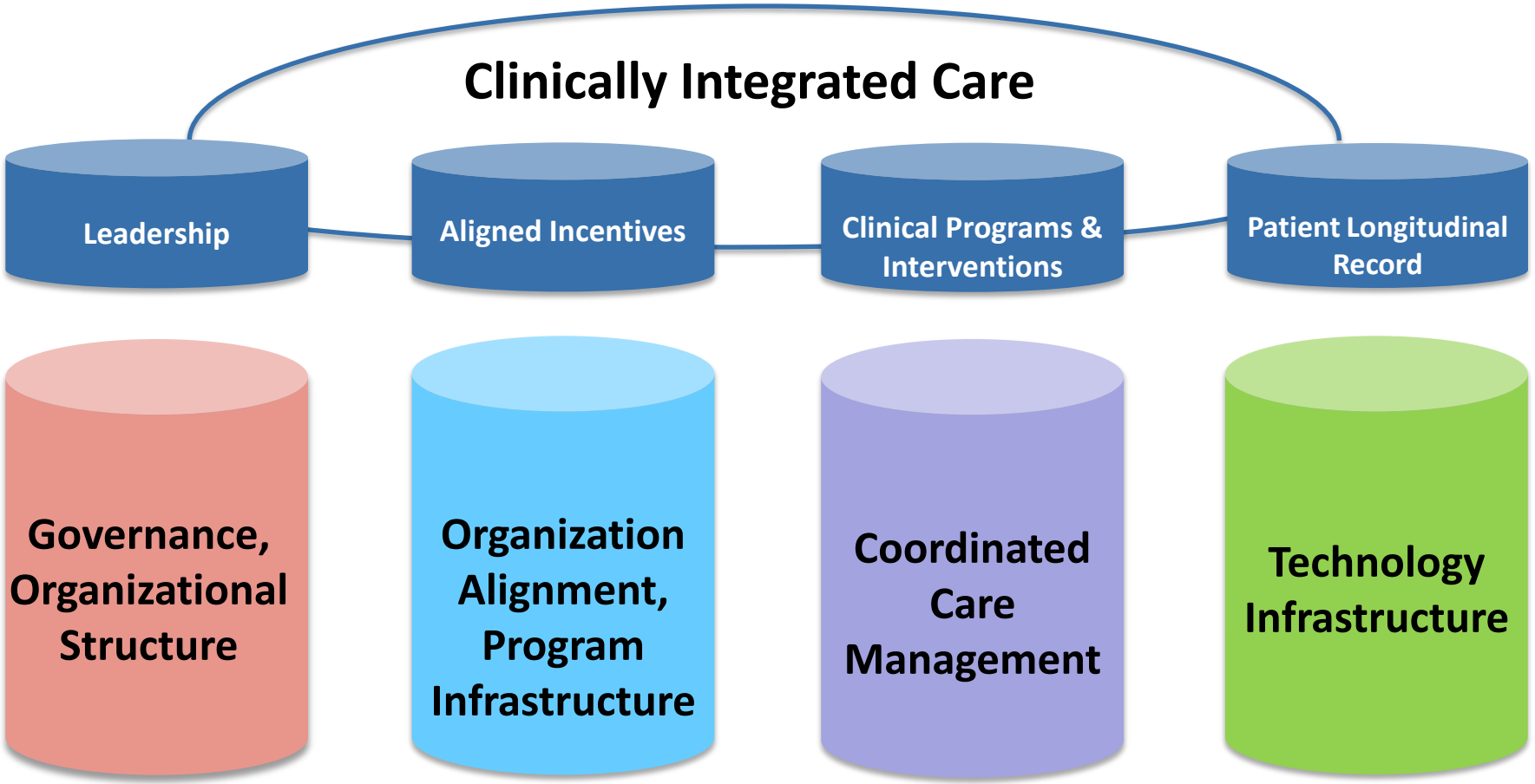
Clinically Integrated Care



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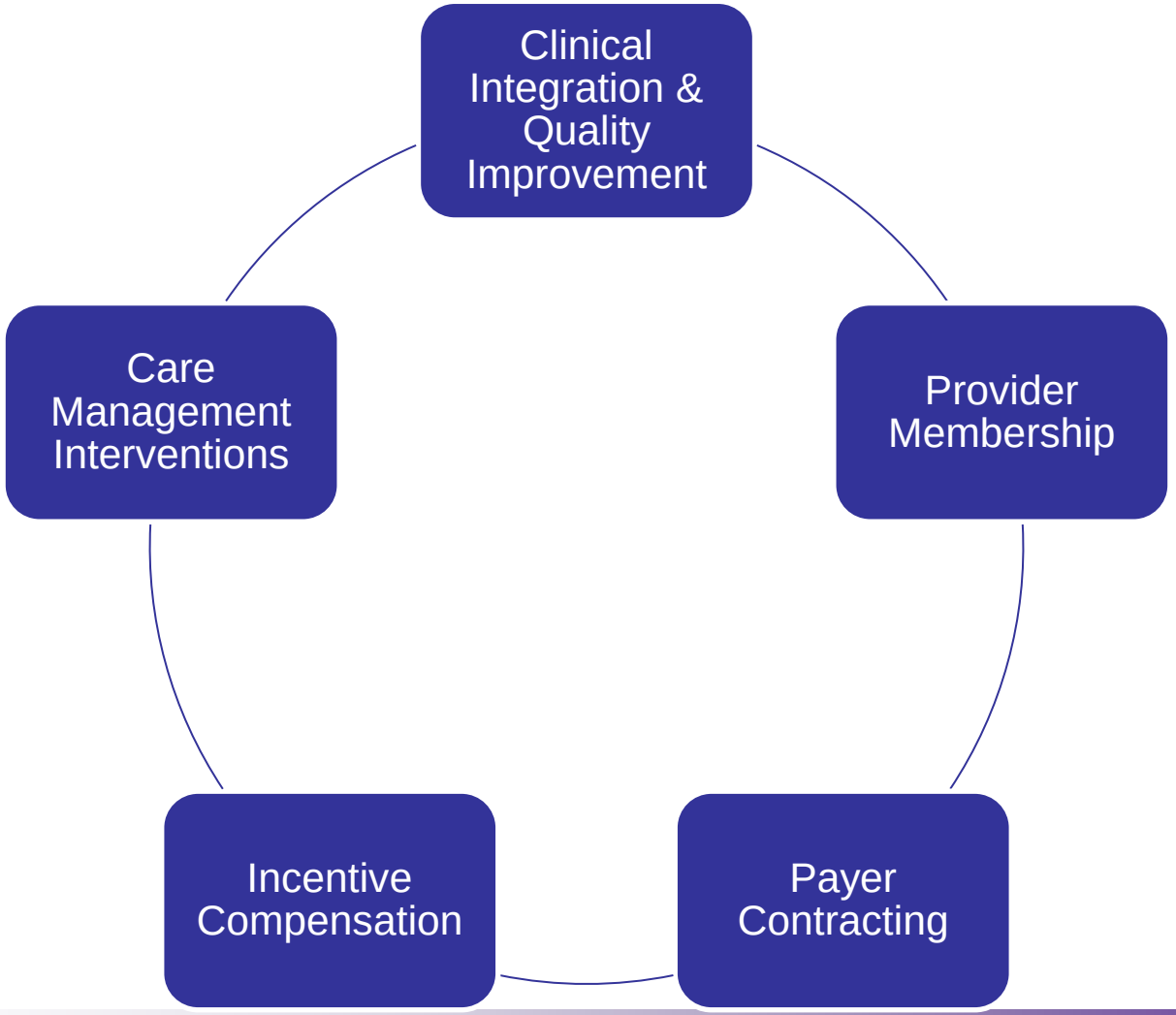
SHA – Key Domains of Focus



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4. Formation Challenges

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Questions:

1. What challenges were faced in developing SHA – the hospital/physician contracting entity?
2. What does the hospital need?
3. What do the physicians need?
4. What inherent challenges and conflicts exist?
5. What are the opportunities for alignment and future success?

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Developmental Challenges of SHA

- All capital came from the Seton system – physicians wouldn't (couldn't) participate.
- Physician leadership and commitment is an existential requirement.
- Austin physician community almost exclusively FFS
- Austin specialist community largely organized in highly dominant single-specialty groups that span hospital systems
- IT systems and data analytic capability almost nil at outset.
- Resources for post acute coordination and/or palliative care relatively basic
- Governance and physician incentive challenges.

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What Does the Hospital System Need?

- Must be able to grow market share.
- Must have a committed primary care base.
- Must identify committed specialty groups.
- Must move down a path toward true “clinical integration” for both operational and FTC reasons.
- Must be prepared to integrate IT systems ($$).
- Must be committed to invest in data analytics ($$).
- Committed leadership and competent management.

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What Does the Physician Group Need?

- Committed and sophisticated physician leadership.
- Funding for currently un-reimbursed professional services.
- Comprehensive, accurate, convenient, real time clinical data.
- Nurse navigators, behavioral health specialists, outreach staff to support patient engagement.
- Predictable financial reward for predefined quality goals.

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High-Performing Health System

Organized System of Care
- Continuum of care provided for populations
- Integrated or has partnerships
- Physicians as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

Efficient Provision of Services
- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

Quality Measurement & Improvement Activities
- Preventive care & chronic disease management
- Patient outreach programs
- Continuous learning & benchmarking
- Research to validate clinical processes & outcomes
- External & transparent internal reporting
- Patient experience surveys

Care Coordination
- Team-based approach with team members working at the top of their field
- Single plan of care across settings & providers
- Shared decision making

Compensation Practices
- Incentivize improved health & outcomes of populations
- Affiliate with patient experience or quality metrics

Use of IT & Evidence-based Medicine
- Meaningfully use IT, scientific evidence, & comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of Rx

Accountability
- Shared financial & regulatory responsibility & accountability for efficient provision of services

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Inherent Challenges and Conflicts

- Revenue decline is certain and cost of care savings aren't.
- Culture trumps strategy – always.
- Patients have no skin in the game.
- IT sucks (and costs a lot).
- Analytics are over-rated.
- The industry remains fragmented with powerful vested interests.
- National politics preclude rational consensus driven change.

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What Are The Real Opportunities?

- Reduction in unnecessary variation in care
- Coordination and control of post acute care.
- End of life and palliative care.
- Behavioral problems as they affect adherence.
- Top of the pyramid -- complex poly-pharmacy, poly-specialty, high utilizers
- Redirecting care to a redesigned outpatient environment
- Closed (narrow) networks.
- Clinical Integration across care silos.
- Patient engagement ($$).

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5. Unresolved Challenges

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Unresolved Challenges

1. Value based payments to physicians
2. Valuing the patient base brought by the physicians
3. Working through versus around the physicians
4. Moving volume through the value based system

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Value Based Payment

Our group's business culture is conservative and risk-adverse.

Our physicians are interested in taking performance risk, but not insurance risk and not execution risk on parts of the delivery system beyond our control.

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Patient Base as an Asset

A primary care base, and the patient lives that come with it, is a critical requisite to manage any population.

How do you value this asset in a provider group-hospital system partnership?

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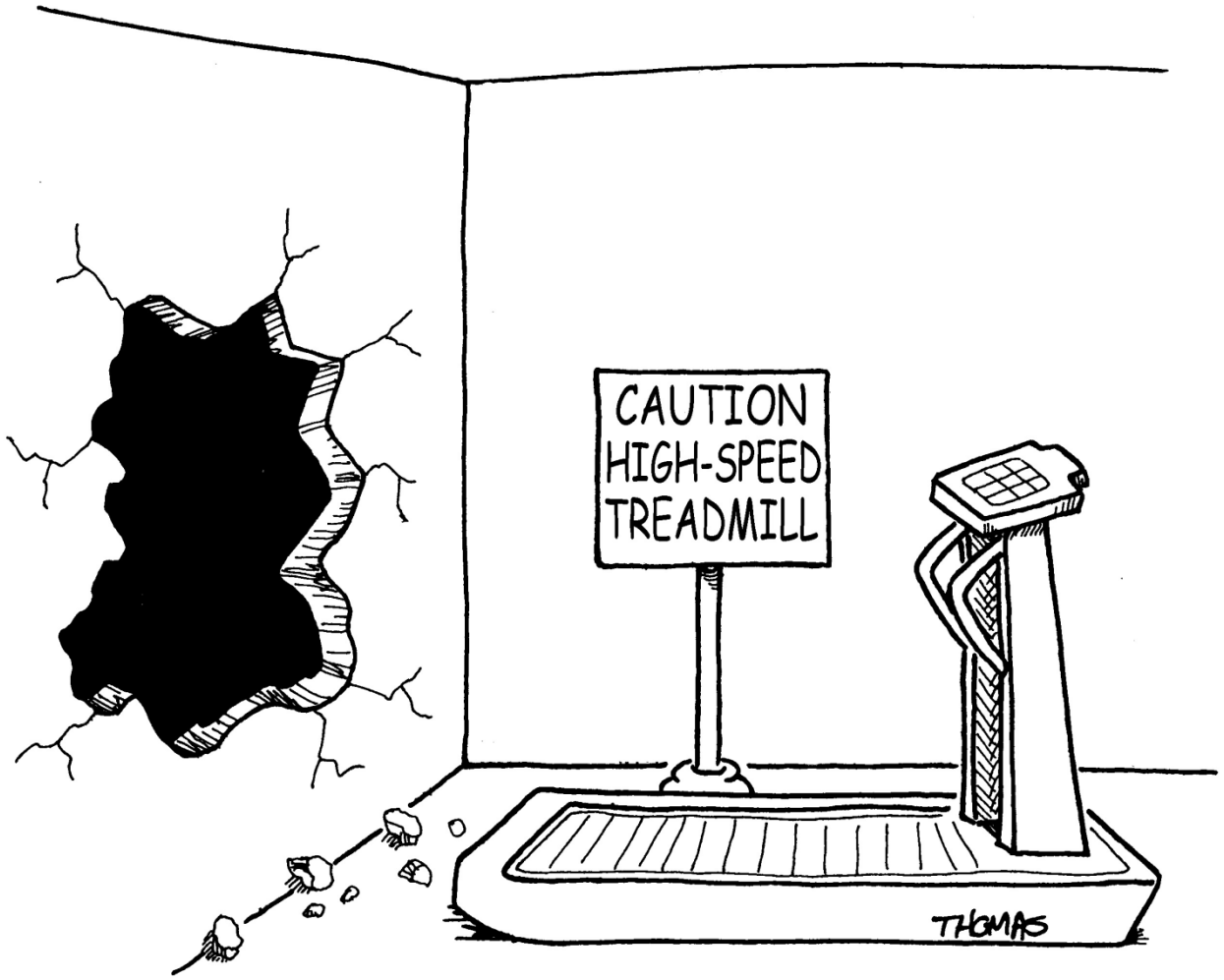
Through the MD vs. Around the MD



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Volume Through a Value Based System

If referral network is managed for a defined population, providers often change their overall referral patterns.

This has tremendous value for all in the Clinically Integrated Network.

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6. Closing

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Why CI for a Large Physician Group?

Clinical Integration with a hospital system gives our group a funding and infrastructure path to value based care.

We believe that the development of an organized delivery system is a benefit for our patients, community, and group.

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Questions?

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