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Accountable Care NEWS

Clinical Integration at Dean Clinic

By Craig Samitt

You might say that Dean Clinic is a present-day Accountable Care Organization (ACO) and a model of Clinical Integration (CI). We've also been called other things, namely. a "structurally integrated organization," an "economically integrated organization," and even a "technologically integrated organization." We are admittedly all of these things because of the choice we made to pursue "better care at a lower cost," long before the ACA was passed and long before these descriptors of integration became all the rage. While this article is very much about Dean's experiences and lessons learned as a structurally, economically, and technologically integrated organization, it is as much about the fact that there are even more important types of integration than these to achieve Clinical Integration and succeed as a high-performing Accountable Care Organization.

Lesson 1: Shared Accountability is far more Important than Structure Integration

One of the more common misconceptions about an organization's ability to *succeed* in Accountable Care/Clinical Integration is the belief that vertical and structural integration needs to be a critical gateway to achieve synergy. The Dean/SSM Healthcare of Wisconsin partnership is a poster-child highlighting that this belief is not entirely accurate. We like to consider our organization a virtually-integrated system from a structural standpoint in that Dean and SSM Healthcare of Wisconsin are two separate corporations that have worked shoulder-to-shoulder over nearly 100 years with a common purpose and shared vision for excellence and value-based care. While we have, in recent years, become more structurally integrated via joint-ventures, including the co-ownership of a health-plan, ambulatory surgery centers, and technology assets, these forms of partnership have not nearly been as important as alignment of our value-based culture. Most specifically, we chose to have a common vision toward value, even at a time when financial incentives encouraged us to pursue a volume-based path. We chose together to abandon the ever-common tendency to divide a fixed and shrinking revenue pie between us and instead have found ways to share gains, share risks, share higher margin services, and share investments to improve our performance.

It appears as if there are three accelerating and competing structural integration verticals emerging today, each aimed at dominating regional (or even national) markets -- namely health plans that are seeking to acquire delivery systems, hospitals that are moving to employ doctors, and physicians that are embracing full-risk and vending downstream services to hospitals and others. In our view, the ability to become a high-performing ACO/ CI model is less about which of these models is preferred or even where their journey began, but rather more about achieving a state that represents a "team-of-equals." In our organization, each effort to improve patient satisfaction scores, raise ambulatory or core hospital quality measures, or improve efficiency involved the attention and expertise of physicians, hospitals and health plans in partnership. In short, it's the alignment over a common set of goals, it's the singular focus on a common set of metrics, and it's the power of shared accountability that is far more important than Structure Integration in driving our system's performance.

Lesson 2: Aligned Incentives are far more Important than Economic Integration

What instigated Dean's journey down the value-based path was our recognition that we had a "foot on a dock (volume-based revenues via FFS payors) and a foot in a canoe (capitated payments via our owned Health Plan)." To make it worse, our belief was that the dock was burning and the canoe was leaking. Ultimately, we chose to pursue the value path and deliver better care at a lower cost in earnest for all our patients, regardless of payor. Many organizations we've spoken to about our journey believe that we've had degrees of freedom to pursue value purely for reasons of economic integration, namely that we've owned our own health-plan (whereas others are starting standing on a burning dock with no canoe in sight). While there is some truth to that premise, we would argue that Dean's transformation to value has less to do with ownership of our health plan, but more to do with the fact that the bearing of risk has catalyzed a paradigm shift in our approach to care and a transformation of our operations. If it were not for our economic integration, we would not have the toolkit of processes, technologies, strategies, and innovations that maximize value-based care that we have today. However, at the end of the day, it's the toolkit along with aligned incentives (regardless of payor) that is far more important to us than the economic integration.

Clinical Integration at Dean Clinic*…continued*

Fast-forward to present day, and you would find that we have stepped off the burning dock and have patched the canoe. While our health plan is strong and growing, we have pursued gain-sharing and risk-sharing payment methodologies with most of our other payors, including Medicare via the Shared Savings Program (MSSP). In our view, the beauty of the MSSP, Pioneer, and Bundled Payments is that they offer systems, previously steeped in volume, the opportunity to begin to step into their own canoes. Successful ACOs/CIs will not only want to accept bundled-like payments, but will also need to master the expertise, as Dean has with SSM, in unbundling those payments and allocating risk/gain in a share-and-share-alike fashion with their "teams of equals."

Ultimately, our desired end-state is to not only be clinically accountable, but to be economically accountable for all our patients, and to have most if not all of our incentives aligned toward value over volume.

Regardless of payor, the deployment of our value-based tools in the setting of aligned incentives has been far more important to our transformation than economic integration. Likewise, we have found that alignment of incentives is not only important in the payor-provider relationship, but is even more critically important between a provider organization and its doctors. In short, we've learned quite clearly that you can't pay doctors for volume when your organization is paid for value. Needless-to-say, ACO/CIs need not only learn how to accept bundles, accept risk and share gain, but must also learn how to re-design physician compensation models and align incentives from the very top to the very front line of our organizations..

Lesson 3: The Ability to Compile, Compare, Analyze and Report Information is as Important as Technological Integration

Along with shared accountability and alignment of incentives, two of the most crucial drivers of our transformation at Dean have been our willingness to embrace the use of technology and the effective use of data to drive decisions and motivate change.

It should be quite clear to most ACOs/CI that implementation of an Electronic Health Records is essential, but not sufficient, to achieving high-performance as a system. Likewise, while many systems are working to maximize Meaningful Use attestation of EHRs, meaningful use of EHRs will be essential (in fact required), but not sufficient, to be "accountable" in the future. We would argue that our greatest organizational success will only be achieved when we "optimally use" our technologies and integrate them into the very fabric of our care-delivery model.

In the future, we'll want to assure that we're using EHRs to their fullest potential, and that specific capabilities of our EHRs that influence improvement in quality, preventive screening, service enhancements, patient adherence or cost reductions are maximally used.

But even all of that will not be enough to be sufficiently high performing in the world of Accountable Care. First and foremost, each of our organizations in its own right has insufficient information to address all of the needs of our patients and access all of the information that should be known to deliver population-based healthcare. As such, it would be hard to imagine a future healthcare world without Health Information Exchanges as part of a mainstream priority for ACOs. The benefits of information exchange are both readily apparent and already measurable by the Dean organization and by others doing it, and it's quite clear that exchanges will be essential elements of our systems as we seek to improve quality, improve safety, lower costs, and improve patient convenience.

But even that won't be sufficient for us to transform healthcare delivery so that we're truly Clinical Integrated. From our vantage point, the ability to compile, compare, analyze, and report information is the most important component of the world of integrated technology and data. As Dean has evolved from a system of volume-based care to population-based care, we have vigilantly benchmarked our performance against other organizations, shared un-blinded comparative data with clinicians regarding service, quality and cost, and transparently reported data to our markets as a means of growing our practices and competing in the world of health insurance exchanges. We've also developed a comprehensive "big data" data-warehouse and analytics shops so that we can predictively model clinical information, identify areas of quality/safety/cost concerns, and assess variations in practice patterns. While we struggle every day with the accuracy, transparency, format, and availability of data today, we've invested heavily in data creation, analysis, reporting and modeling at Dean because it is quite clear to us that data will be king in the world of value.

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