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THE ADVISORY BOARD COMPANY

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## **Creating Physician Alignment Through a Clinical Integration Program**

Case Study from Memorial Hermann Health System



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### About this Publication

This white paper reports on the development of a Clinical Integration program at Memorial Hermann Health System. We would like to express our deep appreciation to Dr. Shawn Griffin, Chief Quality and Informatics Officer, for his generosity of time and insight in making this paper possible.



## Executive Summary

Memorial Hermann Healthcare System (MHHS) is the largest health care system in the Houston metropolitan area, a 9-hospital system with 3,600 beds and annual admissions of 138,000. Since 2008, the physician group associated with MHHS (formerly HNP, now MHMD), has been deeply involved in advancing a Clinical Integration program across the entire system. To date, over 2,000 physicians from the Memorial Hermann physician group participate in the Clinical Integration program, which, in exchange for commitments to improving quality and efficiency, enables physicians to jointly contract for higher fee schedules and performance-based bonus payouts. Critical success factors in launching the program included MHHS' strong internal physician governance structure; a history of engaging physicians directly in improving quality outcomes; and implementation of the Crimson physician performance technology to collect and track data on individual physician performance.

In 2009 Memorial Hermann's own health plan MHealth and its physician providers signed a contract that provided a shared savings opportunity. In 2010, following the first year of the contract, documented results included a 9% reduction in overall plan costs for their employed population. Participating physicians who met the bonus criteria received their first bonus payout in fall 2010 as part of the program.

## Clinical Integration Overview

Always a top-of-mind issue for hospital executives, physician alignment has assumed an even greater importance and urgency in today's market. Facing an aging population, a changing payer mix, and physician shortages, hospitals are under pressure to tighten bonds with physicians to ensure quality, cut costs, and secure referrals. At the same time, the rise of new accountable payment models—which will shift the risk for cost and quality to providers—places a premium on physician alignment as a means to effect more efficient, coordinated and consistent care.

To survive in this environment, hospitals and physicians will have to engage in a level of functional integration far deeper and broader than most have in place today. Even the most basic shift—an increased use of pay-for-performance within the traditional fee-for-service structure, will require widespread, performance-based engagement with the entire medical staff to improve the quality and cost-effectiveness of care. The imperative for close coordination will grow only stronger should hospitals take on risk for the performance of providers across the delivery system under more expansive payment reforms such as bundled payments or shared savings reimbursement.

An increasing number of hospitals are looking to Clinical Integration as a mechanism to marshal both employed and independent physicians into a unified, performance-focused alignment platform. In a CI organization, physicians voluntarily commit to invest heavily in robust and active performance improvement infrastructure and initiatives. Participation in a CI program requires several key elements:

- A commitment by physicians to evidence-based care standards
- Data-based mechanisms to monitor and manage physician performance across the continuum of care
- An organization-wide commitment to selective partnerships with high-performing providers

In exchange, CI creates an FTC-recognized “safe harbor” from the usual antitrust proscription of collective bargaining. This allows independent physicians to jointly negotiate for commercial contracts that generally reward participants financially—via higher base rates or performance-based bonuses—for their investment in quality and efficiency improvement.

## Origin of Clinical Integration at Memorial Hermann

Memorial Hermann’s physician group Health Network Providers (HNP) was formed in 1982 as a “messenger-model IPA” and existed in that form until 2007, when the organization discovered Clinical Integration. Although the Federal Trade Commission (FTC) had given Clinical Integration its blessing in 1996, the model became particularly attractive for health systems as the landscape of payer reform evolved in the early 2000s.

As MHHS began to focus on evolving to meet the changing payer environment and rising health care costs, the medical leadership determined that finding a way to more closely align physicians to the organization was critical to their future. The leadership of HNP was also seeking a way to reinvigorate the physician group and to focus them on quality outcomes. Memorial Hermann’s physician leadership saw Clinical Integration as a vehicle for extensive and ongoing alignment with physicians, while avoiding potential legal and regulatory risks, and quickly became an early adopter in the Houston marketplace.

Two key factors worked in Memorial Hermann’s favor as they launched the CI program. First, the organization already maintained a strong system of internal governance by and for physicians. In addition to physician board membership and the like, there was a well-structured system of Clinical Programs Committees, specialty-specific committees that spanned the entire system. Historically they had successfully achieved formulary standardization across the hospital system. In the CI program, they were leveraged to take on the role of determining the appropriate standards of quality for their specialty, and deciding the associated order sets and protocols.

Second, by 2007 the Crimson technology platform was well established at Memorial Hermann. Physicians increasingly knew about its capacity to track and display physician performance data on inpatient admissions. The next step for Memorial Hermann’s physician leadership was to expand the use of Crimson throughout the physician network, and to find a way to add tracking of outpatient clinic data.

## Role of the Crimson Technology

The MHHS-Crimson partnership began in summer 2004 with the collaboration to build a visually intuitive system to track physician performance data, including the ability to drill down to patient-level information. The initial program targeted 78 non-employed hospitalists at five hospitals, accounting for 10,000 admissions. Data were reviewed with the physicians in one-on-one sessions with the system’s medical director to address any questions or resistance and discuss opportunities for improvement. In one year this process of using data to drive change resulted in significant savings.

### *Hospitalist Oversight Program at Memorial Hermann*

In 2005 HNP launched the Hospitalist Oversight program with the goal of reducing variability and improving utilization and quality. The program involved 78 physicians across five hospitals and 10,000 admissions. Realizing the need for a vehicle to track individual physician performance data, MHHS partnered with Crimson to develop a technology platform capable of collecting physician performance data and displaying it in a visually intuitive format. The Oversight program combined face-to-face meetings with physicians and review of individual performance data tracked through the Crimson technology platform. Within a year, the program experienced net improvements in the Oversight-managed physicians. The improvements were in utilization: costs, ALOS and use of consultants; quality: complications, readmissions and core measures compliance. The program resulted in an estimated savings of \$358 per patient admission. (See our publication *Achieving Cost Savings and Quality Improvements Through a Physician Oversight Program* for more detail on this initiative).

### *Cross-Continuum Performance Measurement*

Today, the use of Crimson data to track inpatient physician performance continues. With the launch of Memorial Hermann's CI program, outpatient data was added through the Crimson Ambulatory module, which tracks billing data, quality data, and EMR data for clinics that have outpatient EMR. Crimson's strong record on the inpatient side facilitated physician comfort with adopting it in the outpatient setting. In addition, at Memorial Hermann's request, Crimson developed a module for reporting on the PQRS measures.

### *A Data-Capture Solution for Even the Smallest Clinics*

With the average practice size of non-employed physician groups at 1.8 physicians, Memorial Hermann needed a way to capture those clinics' data; most lacked robust IT systems. Memorial Hermann sought Crimson's guidance and asked that a tool be developed to enable these small private practices to enter data into the system. The result was a registry through which physicians could manually enter their data into the Crimson database. This proved critical in the first year of the CI program, since one of the requirements for the bonus was to demonstrate they were tracking and reporting on measures. In addition, these practices could enter all of the required information without transmitting potentially sensitive billing information.

Not surprisingly, the issue of confidentiality and control over what data went into the database was especially important to private practices, which were understandably wary about who might get access to their data. The use of Crimson as a data repository helped secure the trust of private practices. "Having a third-party vendor [Crimson] who receives those files, and who is governed by a contractual relationship that governs what is given to MHMD, is very important to the trust factor for some groups," Dr. Shawn Griffin, Chief Quality and Informatics Officer said.

In sum, with the Crimson technology in place to track performance across the continuum of care; a strong system of governance by physicians in place; and a growing familiarity with and comfort among physicians with the regular review and analysis of their own data, Memorial Hermann had the foundation to move forward with a formal Clinical Integration program. To ensure they were in the clear legally, they scheduled a meeting with the FTC to review their proposed program prior to implementation.

## Decision Point: The FTC Meeting, May 10, 2008

Memorial Hermann’s physician leaders brought a strong case for the clinical integration program to the FTC meeting in 2008. Key elements of included:

- A well-structured, highly functioning governance infrastructure, including a system of specialty-specific Clinical Programs Committees responsible for determining appropriate measures of quality for their specialty, and appropriate protocols, guidelines and order sets to promote optimal care
- Data reporting method based on Medicare’s PQRS measures
- A deep integration of the Crimson data collection platform into Memorial Hermann physician management practice and a culture of transparency in data tracking, review and performance improvement

*“Our FTC presentation was received with enthusiasm and interest, especially around the large number of physicians participating in the development of the program, our tie-in with the hospital system, the Crimson tool, and using the PQRS measures for data reporting.”*

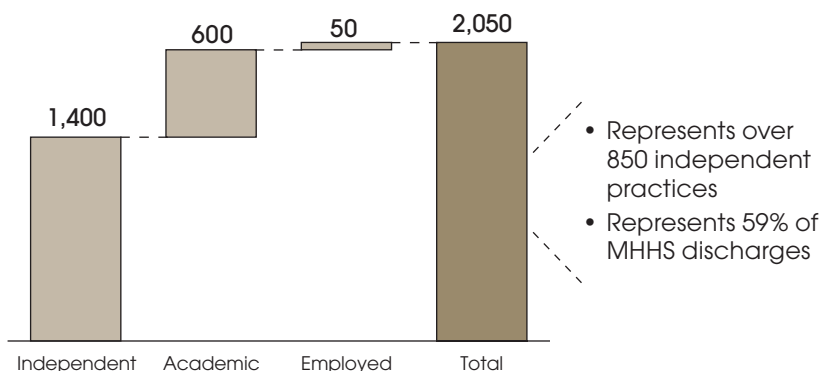
Dr. Richard Blakely  
Chief Medical Officer

According to Chief Medical Officer Dr. Richard Blakely, “Our FTC presentation was received with enthusiasm and interest, especially around the large number of physicians participating in the development of the program, our tie-in with the hospital system, the Crimson tool, and using the PQRS measures for data reporting.” Memorial Hermann had fulfilled the FTC’s requirements that they demonstrate a true commitment to improvements in quality and efficiency at the system level, and the FTC indicated there was no reason to not move forward with joint contracting.

## Recruiting Physicians to the CI Program

Once MHHS decided to move forward with the Clinical Integration program, it was “all hands on deck” to communicate program details to physician leaders across the system. Blast faxes and newsletters were deployed, as well as in-person meetings with the MEC’s at each hospital, and personal communications by board members to key players on their respective campuses. The “ask” was that physicians be willing to participate in transparent tracking of quality measures; fulfilling associated CME requirements; and joint contracting. Of the 3,500 HNP physicians, about 2,000 physicians signed on right away. This group included employed, independent and academic physicians. Crimson data revealed that these “first-movers” were physicians whose inpatient performance was already above their peers who chose not to participate.

### Physicians Now Participating in Clinical Integration



Messaging about the Clinical Integration program stressed the need for physicians to prepare for the future, and the demands of transparency and accountability that would be coming their way in the next few years. Dr. Griffin said his message to physicians



*“Several of the physicians had pride in Crimson, that we had it here, and that we started it here.”*

Dr. Shawn Griffin  
Chief Quality and  
Informatics Officer

was, “My job is not to grade you. My job is to help you for today and prepare you for tomorrow.” By this time, most HNP physicians had some familiarity with the Crimson system and the power of its data on the inpatient side; Dr. Griffin said that this helped convince physicians to get on board. He noted, “Honestly, several of the physicians had pride in Crimson, that we had it here, and that we started it here.” As recruitment to the program progressed, it was clear that physicians deeply valued the access to their own data, and the ability to use it to improve quality and efficiency; in addition, there was the hope of a concrete return in the form of a bonus.

## The First Contract, and Rebranding the Physician Group

Across 2009, MHHS worked with a local payer to structure a new health plan for MHHS employees. At the same time, the physician network leadership decided to change the name of the group, and to launch a rebranding campaign to reflect the nature of the new relationship between the physicians and MHHS. In June 2009 a letter went out to all physicians announcing the name change from HNP to MHMD-Memorial Hermann Physician Network (typically shortened to MHMD); this letter stated that the change was meant to “better symbolize...who we are and what we stand for today.”

MHealth, launched in June 2009, was a collaboration among UniCare, MHHS, and MHMD. A contract was signed covering 30,000 lives of MHHS employees and families. The contract was based on a shared savings model; both physicians and the hospital received base rate reductions from what they had been paid previously, with year-over-year savings going into a bonus pool.

Other provisions of the new contract included:

- Participation limited to MHMD physicians
- Bonus potential only for CI physicians
- No requirement for a CI PCP or a gatekeeper
- Higher copays required for out of network usage
- A higher base rate for CI physicians than non-CI physicians, with bonus eligibility only for CI doctors if savings were achieved

The proposed split of the bonus pool was a graduated scale (up to 50/50) based on savings percentages. Dr. Griffin noted “at the time, many doctors questioned whether we’d be able to deliver a bonus.” Optimism prevailed, and the physician leadership aimed to meet the established goals. The network’s physicians were known for lower inpatient costs, so some tools were put in place to elevate inpatient usage. The medical leadership was also optimistic that if they put quality targets in place, the physicians would strive to meet them.

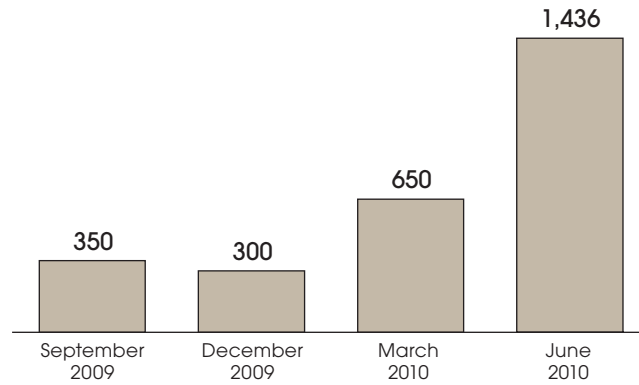
## Development and Refinement of Quality Measures

MHMD used a highly collaborative and flexible process to select the initial quality performance measures that physicians would report on. The CMS PQRS measures were the starting point, and each Clinical Programs Committee was directed to select 3–4 measures appropriate for their specialty. In some cases, the practice areas within a given specialty did not align well with the PQRS measures. In such cases (for example, a hand surgeon in orthopedics), the physician was asked to select measures that were

more appropriate. According to Dr. Griffin, the priority was to enable physicians to pick measures so that they could submit data in the first year of the program.

### Number of Physicians Reporting

Approved Quality Measures



Such flexibility had the advantage of facilitating widespread participation, and also encouraged physician buy-in to the program. But with so many measures included, the level of standardization across the measures left some room for improvement. The hope for the future is to increase standardization of measures, enabling a greater degree of differentiation in the data. The CPCs currently are working to identify measures for the coming year.

As MHMD and the CPCs continue to refine the quality measures, Crimson is easily able to accommodate the changes. The technology enables physician leaders to refine measures already selected, or swap out measures. Part of the challenge of clinical integration is that refining measures for which physicians will be responsible is an ongoing process. With changes and evolution in practice, and changes in regulatory requirements, refinement and adjustment in the reported measures is a part of the process; Crimson's technology enables that flexibility.

### First-Year Results and the First Bonus Payout

Results in the first year demonstrated a strong ROI on MHHS and MHMD's investment in the CI program. Overall results included:

- Year over year savings of \$300+ PMPY
- 9% year-over-year total plan savings
- Increased in-network retention of hospitalizations
- Demonstrated total cost savings of over \$500/year for each diabetic member with a CI PCP
- Money earned for the physician incentive

In this first year of the contract, the requirements for bonus eligibility were very simple—physicians had to collect and report on quality measures on a consistent basis, and complete an online course about CI for CME credit. Communications regarding the deadlines and requirements were robust and thorough in advance of the reporting deadline.

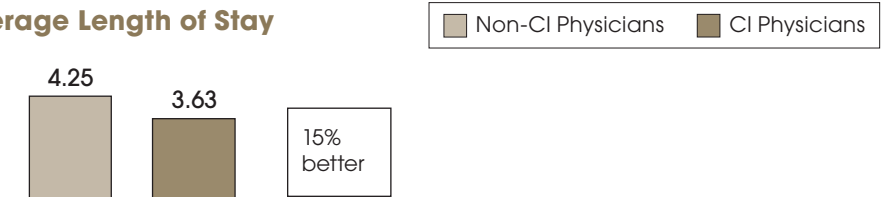
At the time of this writing, bonuses were due to be paid to about 1,000 physicians (70% of those eligible by contract). Physicians who fulfilled both requirements received 100 percent of the payout; physicians who met one requirement received a 50% payout. MHMD devised an appeals process to ensure that physicians who missed the reporting deadline had ample time and opportunity to have their data and CME participation reviewed.

Within days of the first bonus payouts, physicians who had previously declined to participate in the CI program had contacted MHMD leadership indicating a desire to sign on.

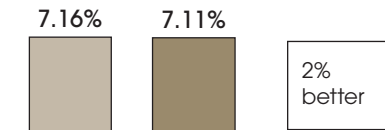
## Quality Outcomes

Data show that the MDMD CI physicians have documented better outcomes on several key metrics.

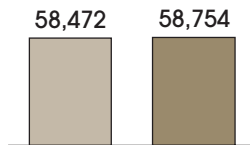
### Average Length of Stay



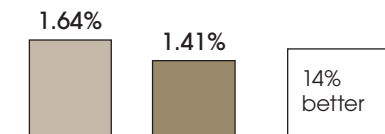
### 30-Day Readmissions



### Number of Discharges



### Mortality



## Looking to the Future

### *Refining and Standardizing QPMs*

As they prepared for 2011, MHMD continued to refine the performance quality measures for physicians. As already described earlier in this report, physicians had a great deal of flexibility in choosing which measures to report on in the first year of the Clinical Integration program, with the goal of encouraging participation. But in the coming year the list of measures will be refined—reduced in number, and sharpened in focus. This is to facilitate creation of more robust data sets so that benchmarks are even more meaningful. An additional factor is that health care reform and meaningful use incentives will require even greater quality reporting than MHMD's own program. MHMD also intends to standardize QPM reporting across multiple specialties. For example, for Adult Medicine, the proposed QPMs for 2011 are:

- Diabetes HgbA1c testing
- Diabetes Blood Pressure Control
- Hypertension Blood Pressure Control
- Mammography
- Colon Cancer Screening
- Influenza Vaccination

The Crimson platform is an able partner in supporting these changes at MHMD over time, as it allows for considerable customization of measures. As MHMD continues on its Clinical Integration path, this flexibility will be critical to success; advances in evidence-based will necessitate regular updates to the measures used to assess quality and performance.

### *Revising Bonus Eligibility Criteria*

Plans also include revising the criteria physicians must meet in order to be eligible to receive an annual bonus payout. Dr. Griffin described this as “turning on the lights now that the wires are strung.” MHMD feels that having fulfilled their bonus commitment this year, there is room to heighten expectations for participants.

Specifically, 2011 requirements for bonus eligibility include:

- 25% completion of approved CME programs
- 25% order set usage by campus
- 50% reporting to Crimson of approved QPMs

### *Preparing to Manage Shared Risk*

MHMD leaders see the Clinical Integration program and the Crimson technology platform as key to the eventual formation of their accountable care organization. A well-structured CI network and access to accurate data across the patient care continuum are both necessary to forming an ACO—this infrastructure creates the alignment necessary to pursue joint contracting. Moving forward, hospitals wishing to pursue the migration to accountable care will have to marshal physicians into a unified, performance-focused alignment platform—a selective group committed to evidence-based care standards, able to facilitate effective care management, motivated by meaningful incentives, and able to jointly negotiate commercial contracts to align incentives.

## Crimson in Brief

The Advisory Board's Crimson platform offers a multifaceted approach to physician performance improvement, combining best-in-class performance monitoring technology with dedicated utilization support, best practice research in care delivery and physician enfranchisement, and membership in a national peer collaborative. At the program's heart is a technological platform that pulls together physician data from repositories across the hospital, including patient billing, scheduling, clinical information systems, data reporting software, care management databases, and more. Crimson organizes this information into a unique Web-based dashboard that offers:

- Intuitive visual design to maximize ease of use
- Acuity-adjusted data
- Performance comparisons placed in statistical context
- Rapid, timely report generation
- Access to patient-level details for further analysis

Based in Austin, Texas, Crimson was founded in 2003 and worked closely with early hospital partners to refine the tool for maximum physician appeal.

In 2008, Crimson became part of The Advisory Board Company, a membership-based firm that provides best practices research, analysis, leadership development, decision support tools, and installation support services primarily to the health care industry. As of early 2011, membership in Crimson stood at more than 400 hospitals.

## About The Advisory Board Company

The Advisory Board Company is the leading provider of comprehensive performance improvement services to the health care sector—including operational best practices and strategic insights, business intelligence and analytic tools, management training and leadership development, unbiased technology evaluation, and consulting support. The Advisory Board Company is privileged to serve a membership of more than 2,700 organizations—including preeminent hospitals, health systems, and academic medical centers—all sharing a charter “above commerce,” a commitment to best-practice standards, and an unyielding insistence on continual improvement.

**2,700+ Member  
Organizations**

**1,000+  
Professionals**

**30 Years of  
Experience**

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