Integrated Health Networks and Healthcare Reform in the U.S.

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Sentara Healthcare
Norfolk, Virginia
USA

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Agenda

- **Current Structure of Healthcare Delivery in the U.S.**
- **Sentara Healthcare Integration History**
- **Sentara Integrated Cancer Program**
- **Future Direction of U.S. Healthcare Delivery Under Reform**
- **Implications for Sentara**

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Hampton Roads, Virginia

- Population 2.0 million
- 34th largest metro area
- 4.5 million visitors annually
- World's largest Naval Base
- One of largest international ports

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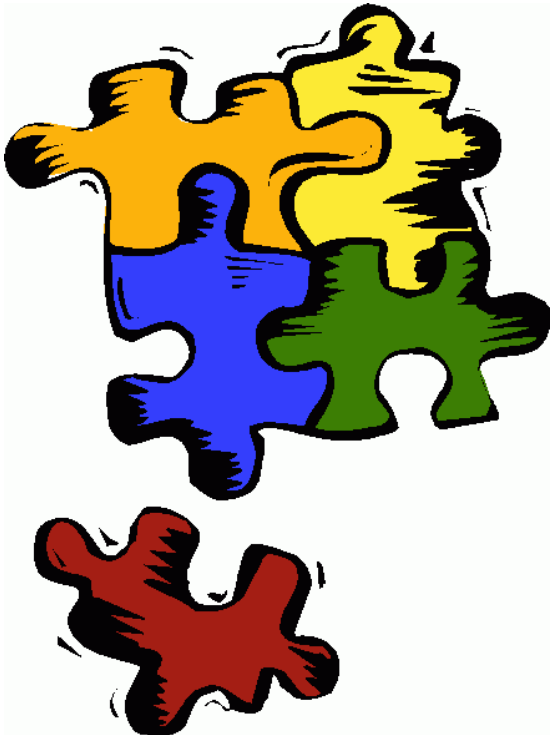
Healthcare Integration History in U.S.

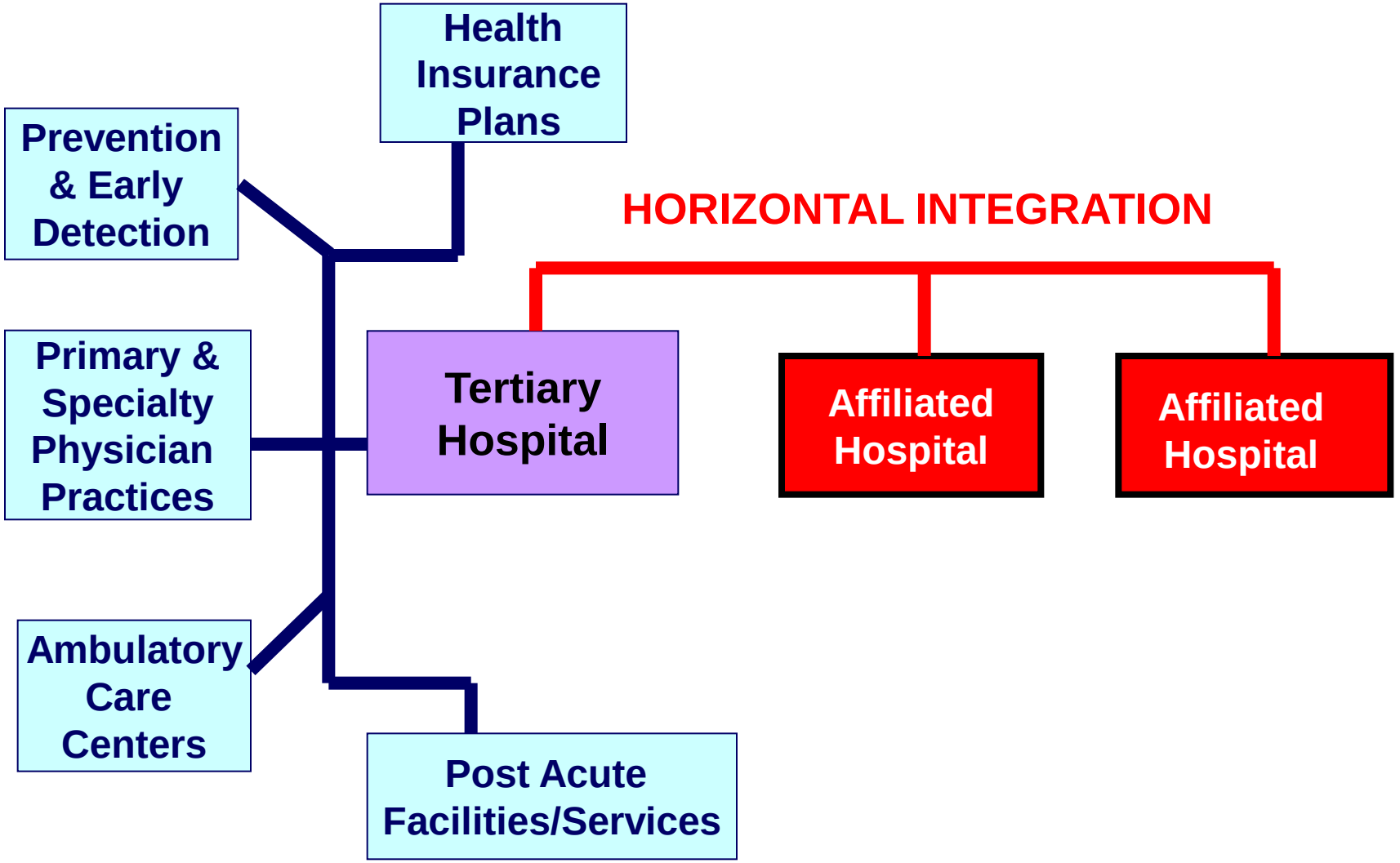


Integrated Health Network

"...a network of organizations that provides, or arranges to provide, a coordinated continuum of services to a defined population and is willing to be held fiscally and clinically accountable for the health status of the population served."

Stephen Shortell, et. al., 1993
University of California, Berkley
Dean and Professor, School of Public Health
Blue Cross of California Distinguished Professor Health Policy and Management
Professor of Organization Behavior

VERTICAL INTEGRATION



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Integration Drivers in the 1990's

- **Increasing cost of health care**
  - **Demanded lower cost/higher quality**
  - **Emphasized less expensive, non-hospital care (i.e. outpatient, home care, long-term care, etc.)**
- **Growth of managed care**
  - **Insurance company's focus on managing the utilization of care**
  - **Smaller hospitals had low negotiating leverage**
- **Financial stress on hospitals**
  - **1985-1990: Community hospital net margins decreased by 36%**
- **Decrease in inpatient care**
  - **Increase in outpatient**
  - **New technology**
  - **New pharmaceuticals**

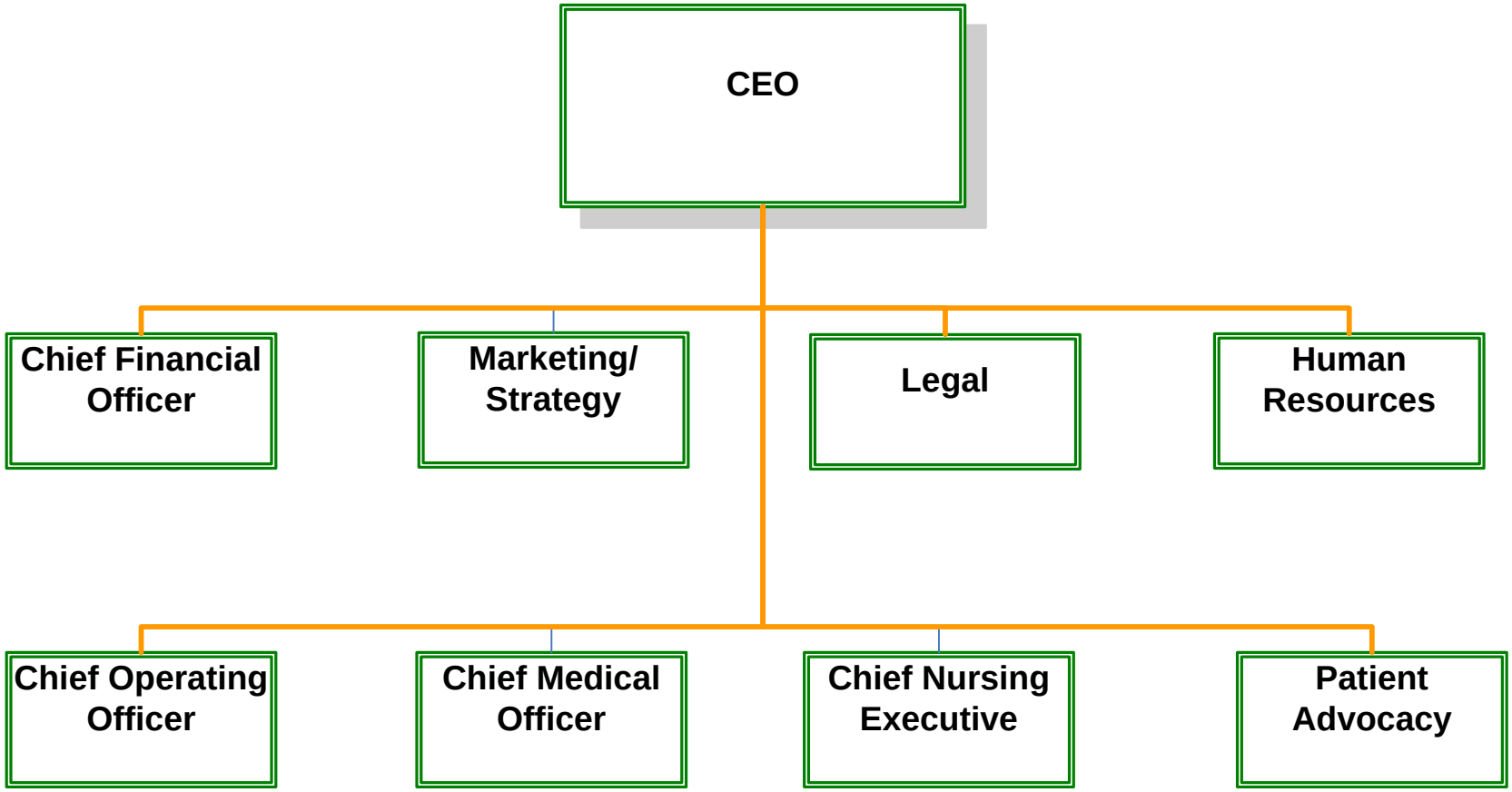
Integration in the 1990's Rationale For Integration

- **Cost efficiencies**
  - **Economies of scale in purchasing and negotiations**
  - **Back office consolidation (i.e. billing, marketing, finance, human resources, etc.)**
  - **Reduction of transaction costs between fragmented providers**
- **Coordinated care across provider types**
  - **Opportunity to improve quality and patient care across the continuum of care**
- **Diversification of risk**
  - **Less prone to shocks in any one sector of health care**
- **Structure can create and incent innovations that benefit entire system**

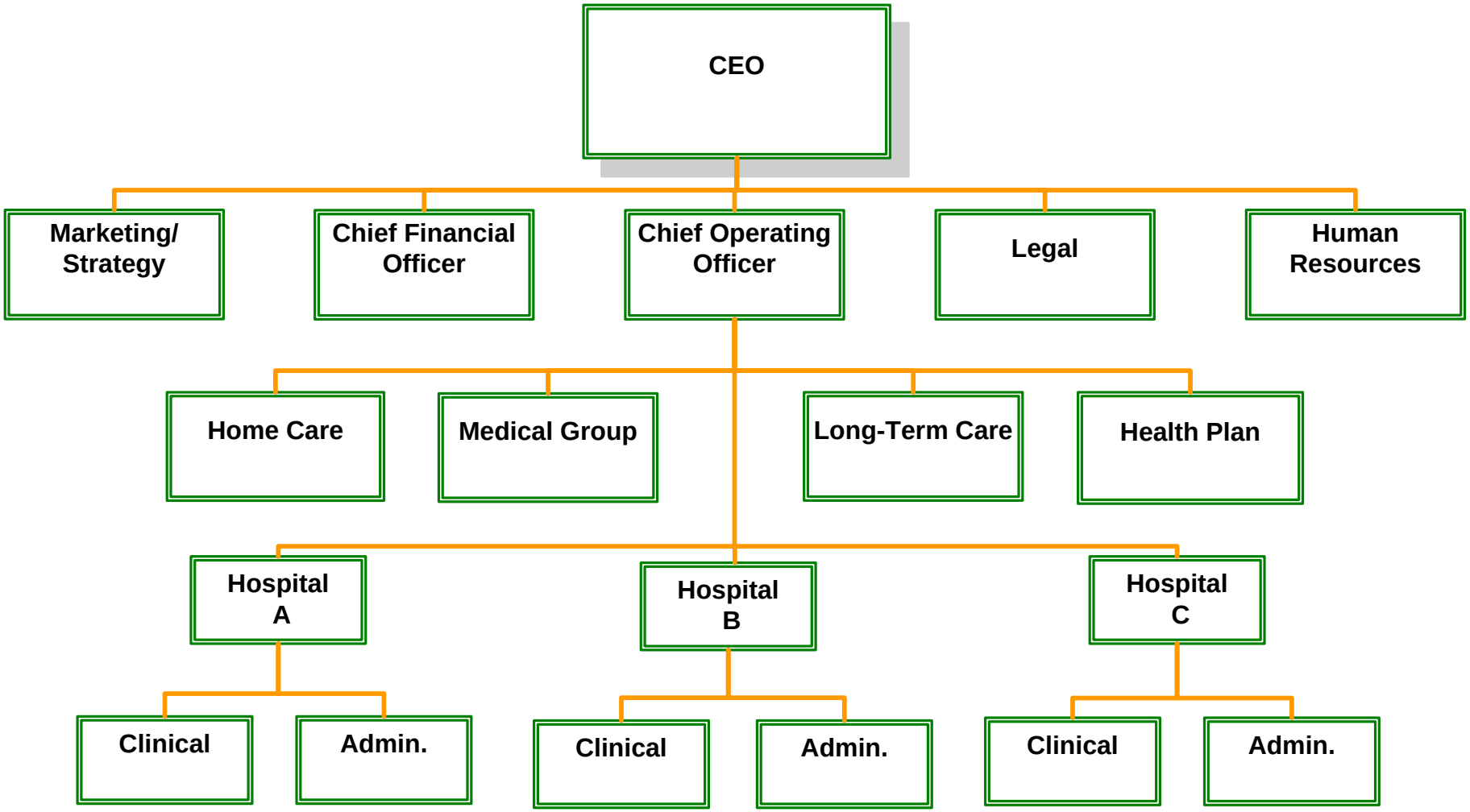
Differences in Management Between a Stand-Alone Hospital and an IHN

- **Requires coordination between previously unrelated, competing entities**
- **More emphasis on big picture -- how will this impact the system and health across the system**
- **Focus shifts from providing medical care in acute-care setting to improving health across the continuum of care**

Traditional Hospital Organizational Chart



IHN Organizational Chart



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Advantages of System Integration

- **Quality and Patient Safety**
  - **Consistency and rapid deployment of best practices across system**
- **Structure Can Create and Incent Innovations**
  - **Sentara Health Plan – Reimburses intensivists manning eICU center**
  - **Home-based congestive heart failure care**
  - **Medical Homes**
- **Diversification of Risk**
  - **Health Plan and Providers**
- **Flexible Responses to Environment**
  - **Post-Acute Array of Providers – Long-Term Acute Care Hospital, Skilled Nursing Facilities, Rehab, Home Care, Assisted Living and Adult Day Care**
  - **Sentara Medical Group Physician Employment – Multi-specialty Group**

- **Sentara #1 IHN**
  - **2001**
  - **2010**
- **Top 10 for all 13 years list has been published**
- **Top 5 for the past five years**

Modern Healthcare

SDI's IHN 100: 2010

Ranking	Name/Location	Total score
1	Sentara Healthcare Norfolk, Va.	91.21
2	St. John's Mercy Health Care St. Louis	90.71
3	St. John's Health System Springfield, Mo.	90.00
4	MultiCare Health System Tacoma, Wash.	88.39
5	Intermountain Healthcare Salt Lake City	88.03
6	Sharp HealthCare San Diego	87.56
7	University Hospitals Cleveland	87.35
8	Bon Secours Richmond Health System Richmond, Va.	87.30
9	ProMedica Health System Toledo, Ohio	86.65
10	Banner Health Phoenix	86.55

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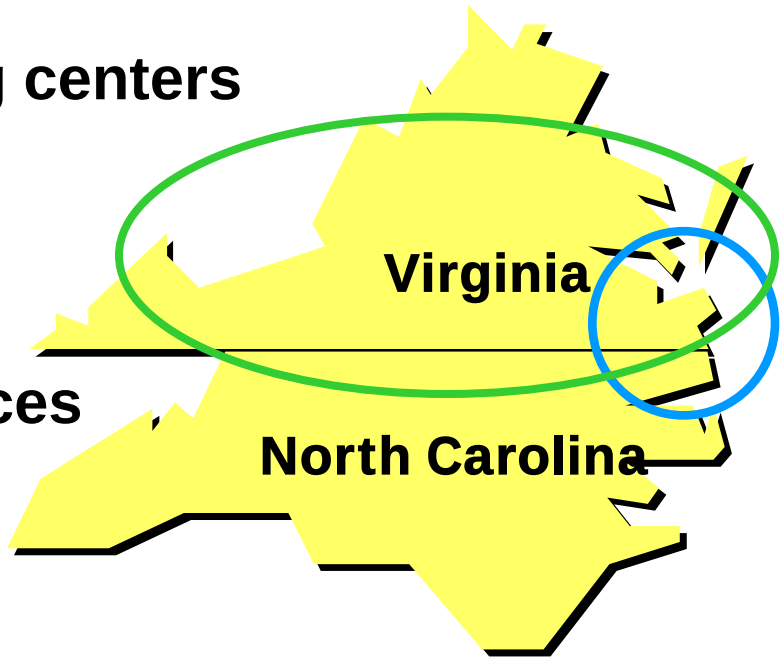
Sentara Healthcare

- **122-year not-for-profit mission**
- **8 hospitals; 1,911 Beds**
- **3,400 medical staff members**
- **10 long-term care/assisted living centers**
- **Extended stay hospital**
- **386-physician medical group**
- **440,000-member health plan**
- **Sentara College of Health Sciences**
- **$3.0B total operating revenues**
- **$3.2B total assets**
- **20,000 employees**



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Growth of Sentara Healthcare

1970's

Medical Center Hospitals (Sentara)

- Norfolk General Hospital
- Leigh Memorial Hospital

Independent Community Hospitals

- Virginia Beach General Hospital
- Bayside Hospital
- DePaul Hospital
- Norfolk Community Hospital
- Chesapeake General Hospital
- Portsmouth General Hospital
- Maryview Hospital
- Louise Obici Hospital
- Hampton General Hospital
- Newport News General
- Riverside Hospital
- Williamsburg Hospital

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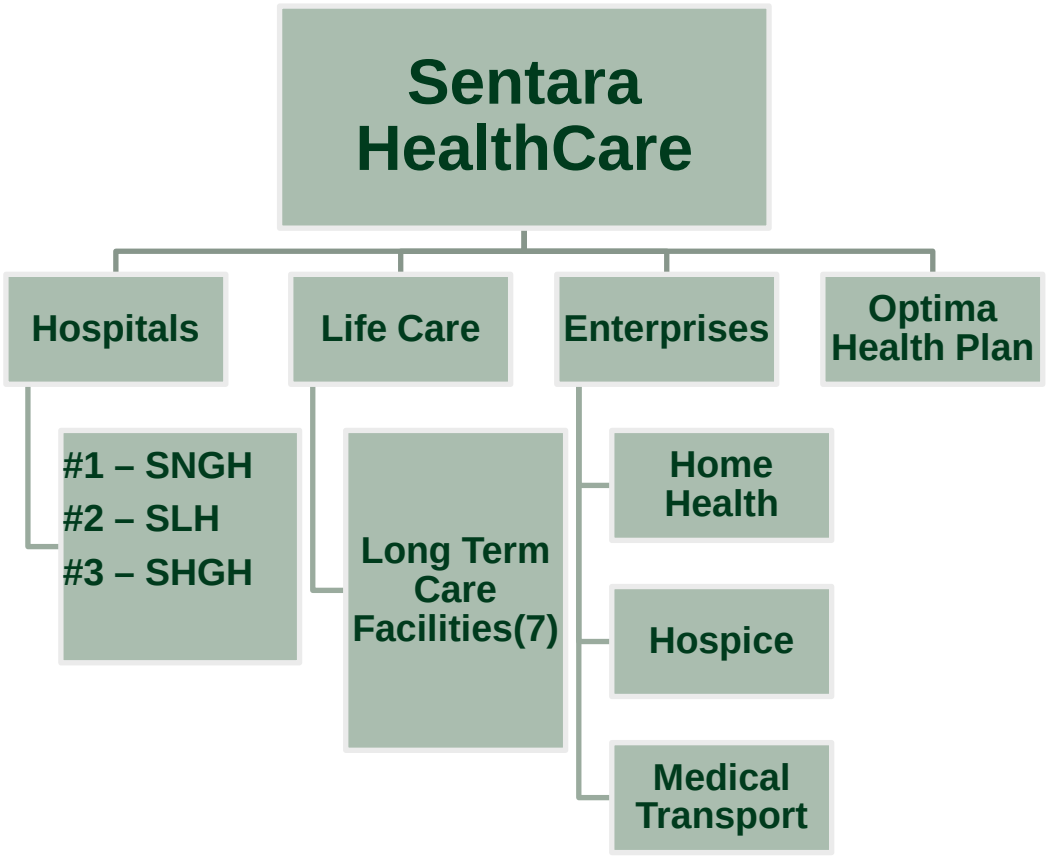
Growth of Sentara Healthcare

1980's



Independent Community Hospitals

- Virginia Beach General Hospital
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Integrated Health System

Continuum of Care

Prevention & Early Detection

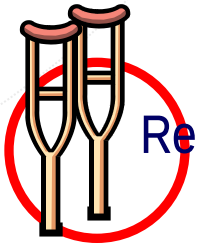
Health Plans

End-of-life Care

Long-term Care

Home Care

Rehabilitation



Hospital Care

Medical Transport

Emergency Care

Mental Health Care

Pharmacies

Primary & Specialty Care

Family & Community Services

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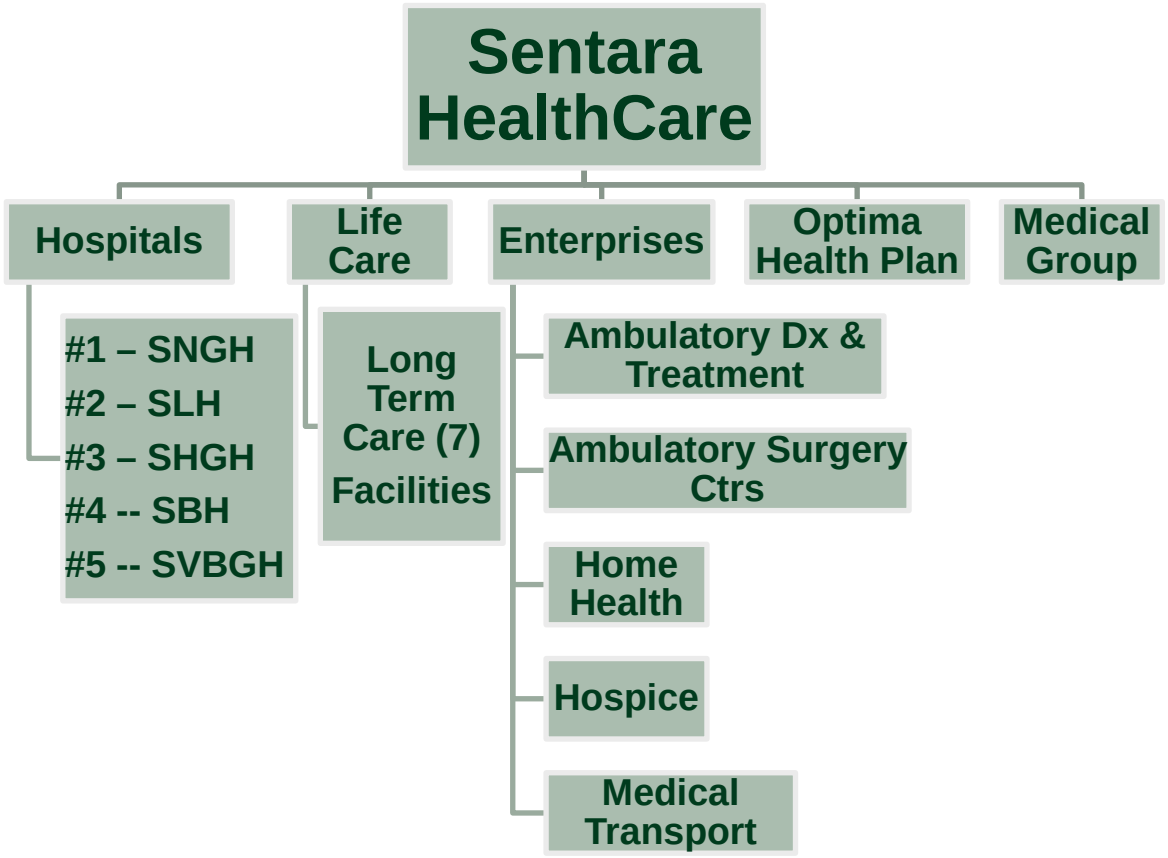
Growth of Sentara Healthcare

1990's



Independent Community Hospitals

- DePaul Hospital
- Closed - Norfolk Community Hospital
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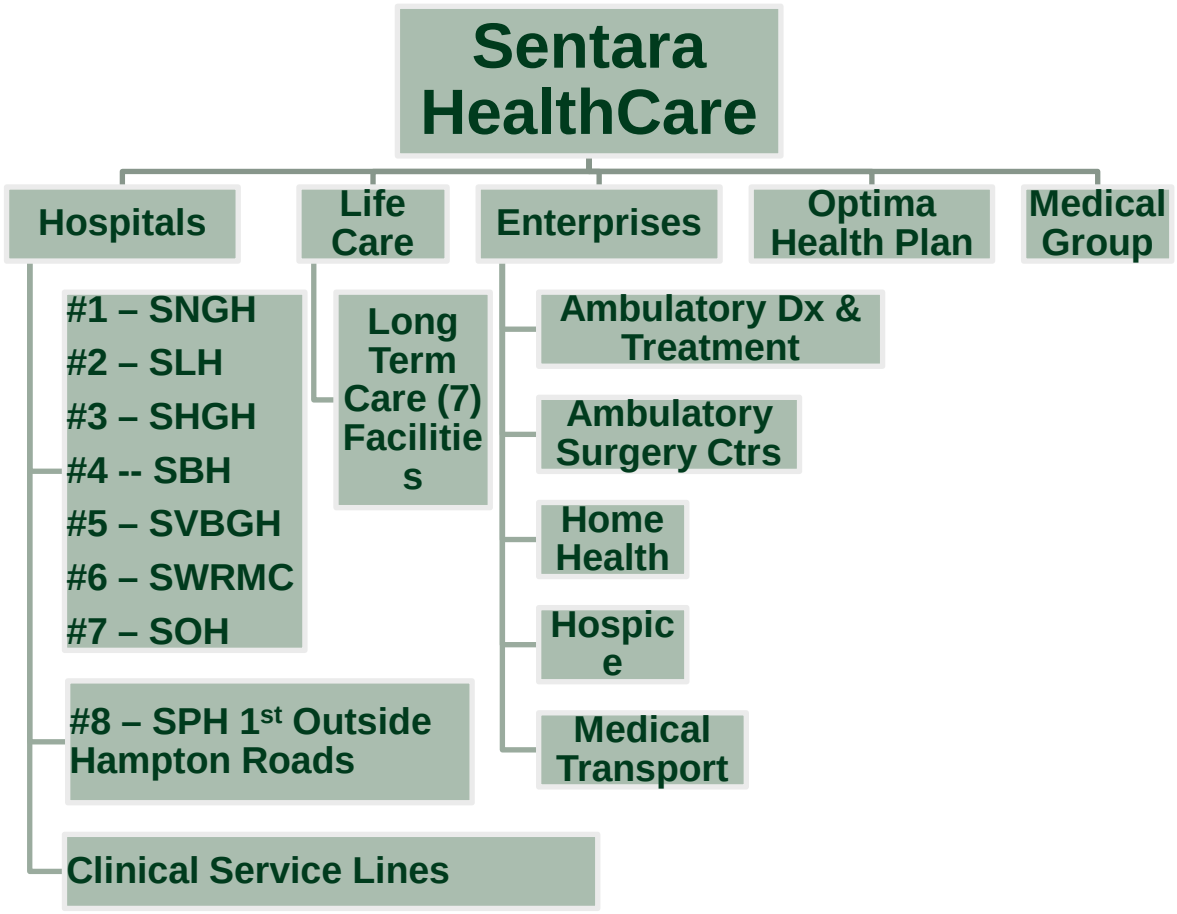
Growth of Sentara Healthcare

2000's



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Sentara Cancer Services
Vision Statement

The Sentara Cancer Network will be the preferred regional provider for comprehensive cancer care and will pursue NCI-designation

Sentara Cancer Services

2005-2009
Create the Network

- Build the Infrastructure
- Improve Early Detection and Access to Services
- Develop a Comprehensive Continuum of Care
- Expand Multidisciplinary Care
- Excel in Quality and Clinical Outcomes

2010-2012
Leverage the Network

- Governance/Management Structure
- Comprehensive Cancer services through a network of providers
- Personalized care for our patients; improved patient experience
- Integrated data; improved outcome measurement
- Collaborative Cancer Research Institute

2012-2015
Earn the Reputation

- Proof of Performance – Quality + Efficiency + Patient Service
- Regional Best
- Major National Research

2015+
Leverage the Reputation

- Destination for Specialized Capabilities
- Magnet for Additional Research
- NCI-designation evaluation and application submission

Multi-disciplinary Care
Clinical Advancements
Clinical Trials
Data Acquisition and Analysis (Clinical, Cost, Service)
Professional Resources and Specialized Talent

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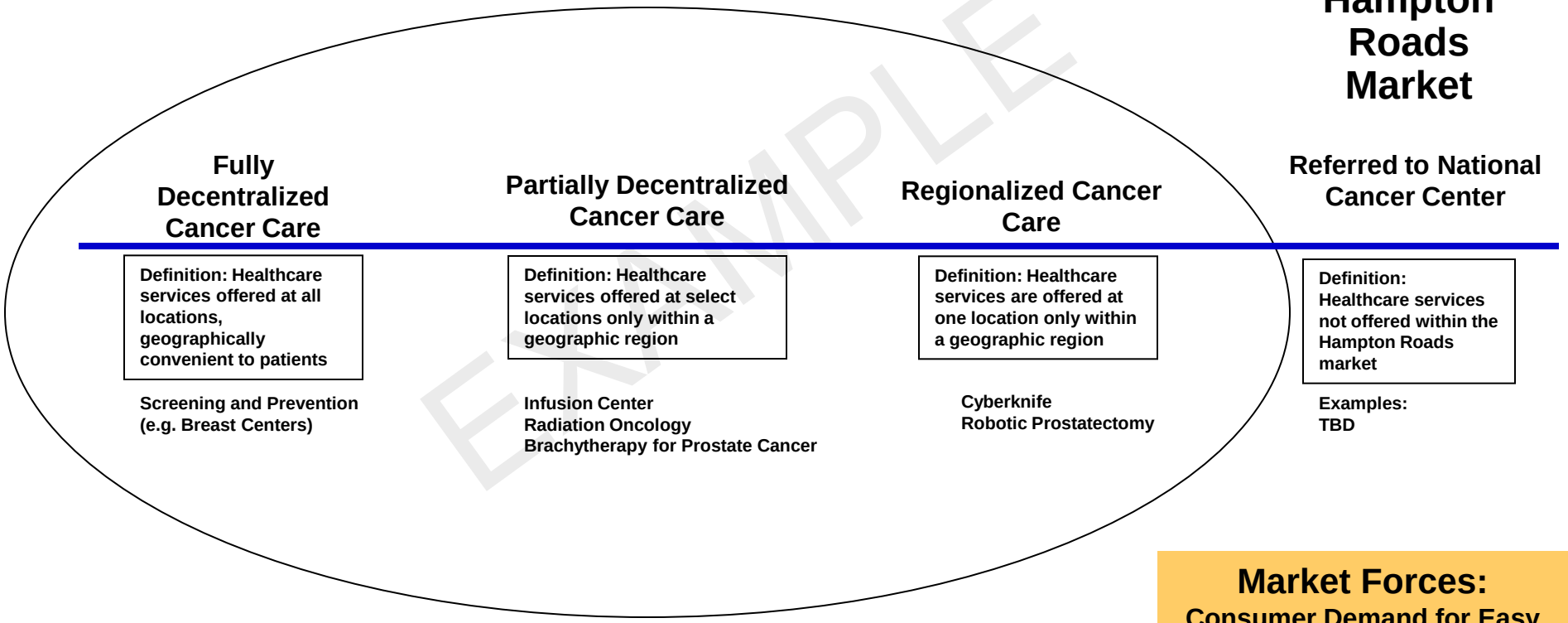
Distribution of Cancer Care

Market Forces:
MD Resources
Declining Payments
Economies of Scale Savings
Technology Investment Required



Market Forces:
Consumer Demand for Easy Access
Competition
Technology Advances

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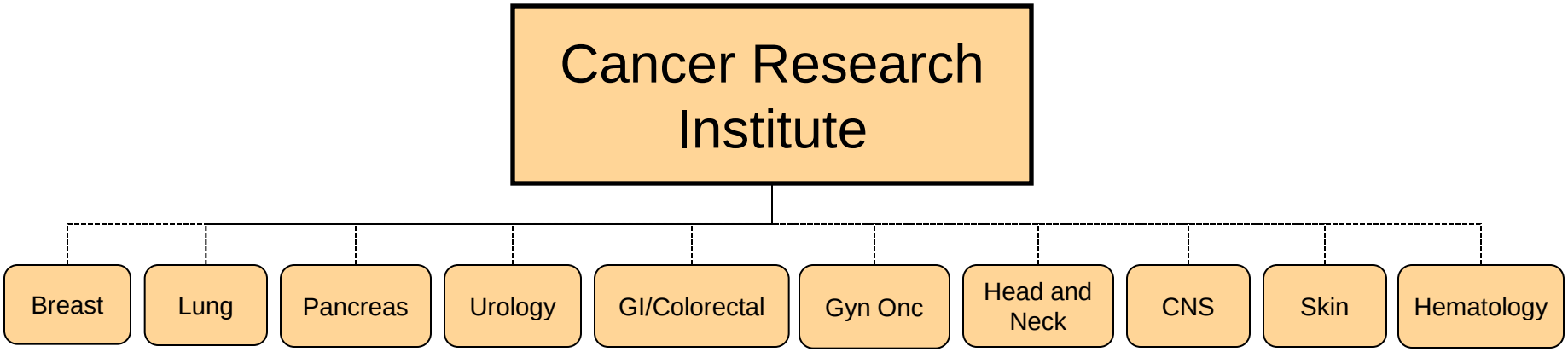
Cancer Research Institute

- **Cancer Research Institute**
  - **Separate LLC with partners each contributing financially**
  - **Cancer Research Institute coordinates Cancer clinical trials and Cancer research efforts, across all organ specific teams and all sites of care**
  - **Cancer Foundation performs fundraising for Cancer Research Institute**



- Benefits
  - Required for NCI-designation
  - Shared resources reduce the overall cost of performing research
  - Overhead fee can be charged to each study to cover the following expenses:
    - Scientific Director, Epidemiologist
    - Manager, Secretary, Non-salary cost of running department
  - Increased number of research studies can be coordinated simultaneously

JV Structure & Mission

- **LLC (Cancer Centers of Virginia)**
- **50/50 Ownership**
- **Radiation Therapy and PET/CT**
- **Clinical Effectiveness**
  - **Joint composition; 5 clinical indicators/year; joint decision re performance thresholds; QOPI; 2 independent national experts**
- **Community Cancer Education**
- **Indigent Care Commitment**

Health Care Reform From 50,000 Feet Up

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Health Care Reform

- **March 22, 2010: President Obama signed the Patient Protection and Affordable Care Act.**
- **All of the changes are scheduled to take effect by 2019. Massive regulatory/ implementation effort will be required as well as likely legislative corrections expected.**
- **Goals of the new law include:**
  - **Expand Access to Coverage**
  - **Control Health Care Costs**
  - **Transform Health Care Delivery System**
- **Cost of the law is estimated to be $940 billion over 10 years**
  - **According to the Congressional Budget Office**

2010: Reform Starts Now

- **Unmarried dependents may stay on parents' health plans until age 26**
- **Mandated benefit changes for insurers, including:**
  - **Prohibition against denying coverage for children with pre-existing conditions**
  - **Prohibition against rescinding coverage once enrollee is covered by plan**
  - **Setting lifetime benefit caps**
  - **Other mandates**
- **Mandated medical expense ratios for insurers**
- **National high-risk pool for those with pre-existing conditions who have been denied coverage**
- **Tax credits for small business to offset premium costs**
- **Tax on indoor tanning**

Expand Access to Coverage

- **Require most U.S. citizens and legal residents to have health insurance (2014)**
- **Create state-based American Health Benefit Exchanges through which individuals can purchase coverage (2014)**
- **Impose new regulations on health plans in the Exchanges and in the individual and small group markets (2014)**
- **Expand Medicaid to individuals under age 65 with income up to 133% of the FPL (2014)**
- **32 million people to be covered by health insurance under various plans**

Control Health Care Costs

- **Reduce annual market basket updates for inpatient hospitals, home health, SNF, hospice and other Medicare providers (various dates)**
- **Establish an Independent Payment Advisory Board to make recommendations to reduce the per capita rate of growth in Medicare spending (2013)**
- **Reduce Medicare Disproportionate Share Hospital payments (2014)**
- **Simplify health insurance administration (2012)**

Improve Health Care Delivery System Performance

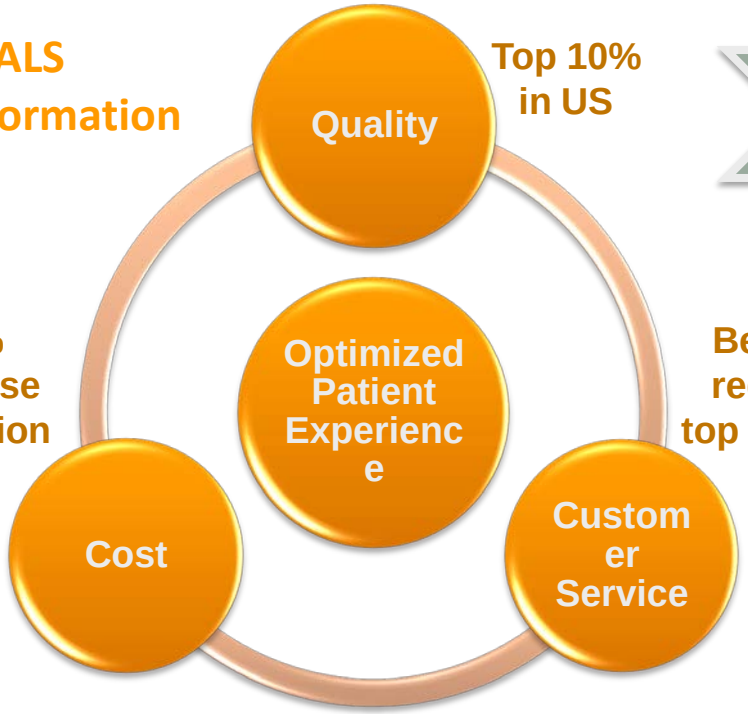
- **Set up Institute for comparative effectiveness research (2010)**
- **Establish Medicare pilot program for bundled payment and for “Independence at Home” (2012/2013)**
- **Establish hospital value-based purchasing program to pay hospitals based on quality measures; extend to other providers (2013)**
- **Award demonstration grants for states for alternatives to current tort litigations (2011)**
- **Develop a national quality improvement strategy (2010)**

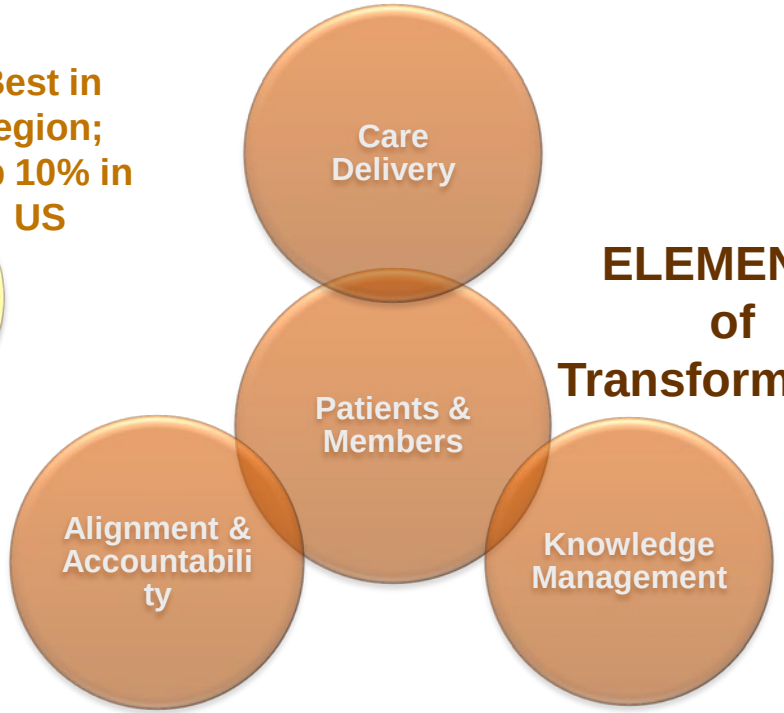
Financing Details

- **Taxing high-premium insurance plans (Cadillac plans) (2018)**
- **Raising Medicare tax for high-income individuals (2013)**
- **Imposing annual fees on pharmaceutical, medical device, clinical laboratory, and health insurance industries (various dates)**
- **Reducing Medicare provider payments (2010)**

Transformation of Care

GOALS of Transformation





ELEMENTS of Transformation

A fundamental change in the delivery of services we provide to patients and members.

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Primary Care Redesign

Primary Care Physician

2,000
patients in panel
seen by physician

PRIMARY CARE TEAM

4,000
patients in panel
managed by physician

- Patient-Centered Medical Home
- Physician Extenders
- Low Acuity Visits – Alternatives to MD
- At-Home Monitoring for Intervention
- Open Access
- Disease Registry & Proactive Patient Mgmt.

Turning physicians into leaders.

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Primary Care Redesign

Primary Care Redesign

- Open Access & Transparent Scheduling
- Patient Registries with Disease Maintenance
- Embedded Evidence-based Care Models
- Patient Self-Management Support
- Advanced Patient-Provider Communications
- MyChart with Rx and Test Tracking
- Targeted Quality Reporting with Benchmarks
- Meaningful Conversations for Advance Care Planning

Optimized Patient Experience

Epic

lean

Transforming the patient experience.

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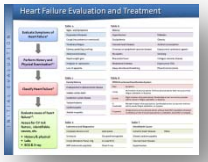
Chronic Disease Care Coordination

Disease-Specific

Shared Definition
(All Care Settings)



Common Model
for Care Process

Clinical Protocols
& Order Sets

Discrete Clinical
Data from EMR

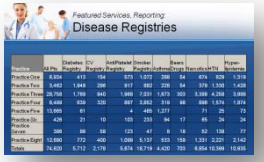
Embedded Analytics

Stage A
Stage B
Stage C
Stage D

Stratification

Clinical Pathway
and Care Plan
with Targets

Sentara MyChart



Disease Registry

Clinical Performance
Management System

Episode
Grouper

Total Cost of Care

Intelligent, targeted, high-value care.

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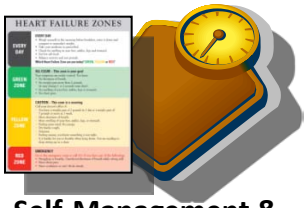
Chronic Disease Care Coordination

Disease-Specific Clinic & Team

Remote Clinical Monitoring



Self-Management & Lifestyle Modifications

Patient Portal & Communities

Patients & Members

Primary Care Team

Specialists

Unit Specialization & Readmission Assessment

Standardized Transitions in Care

Advance Care Planning

Community Health Resources

Coordinating each patient's care across the entire continuum.

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Alignment & Accountability

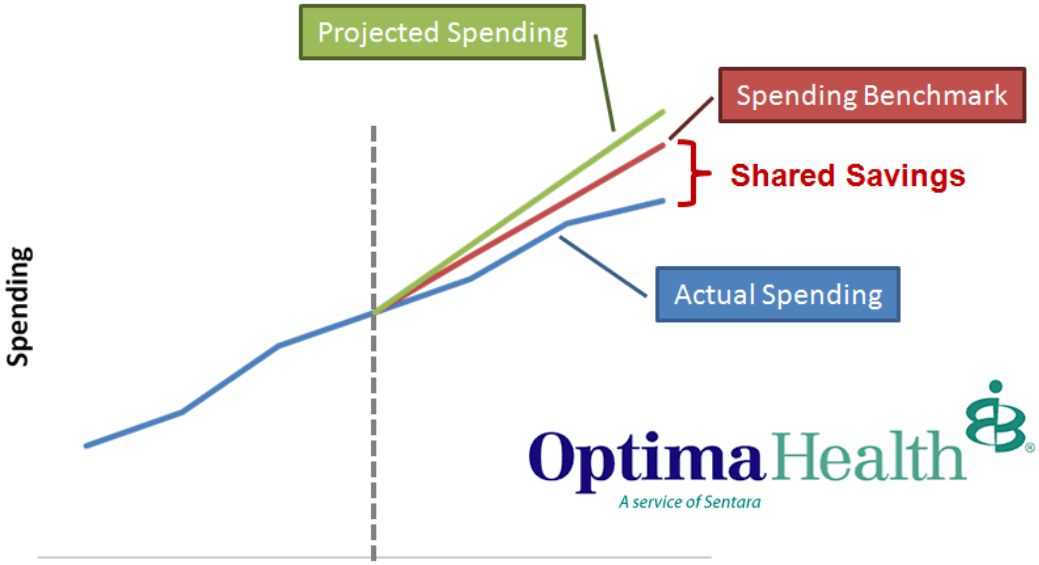
- **CARE PROCESS**
- **QUALITY OUTCOMES**
- **REIMBURSEMENT**

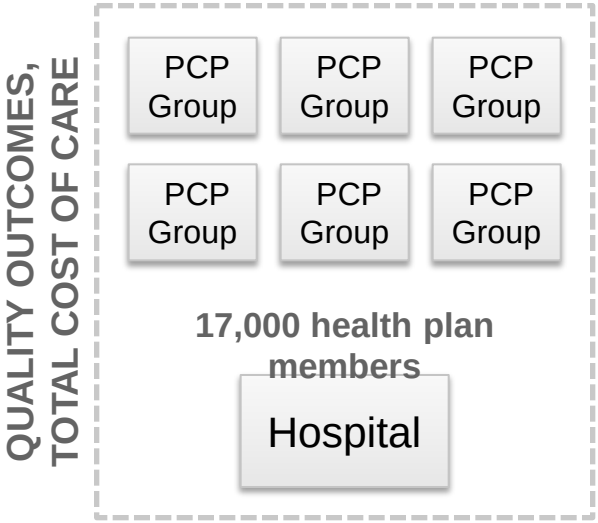
Accountable Care Organization

- Primary care groups and hospital willing to accept accountability for clinical and financial outcomes for a defined group of patients

Bundled Payments

- Bundling of physician and hospital payments
- Select cardiac and orthopedic procedures





From fee-for-service to bundled payments and shared savings

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