Advisory Panel for Health Care

Advancing the Academic Health System for the Future:

Profiles in Academic Health System Leadership

November, 2013
## Project Focus and Methodology

### Project Focus

This project is focused on developing a blueprint of best practices/principles for leadership that will help AMCs move to a sustainable model in the future.

Our Report, based in part on the profiles contained here, begins with premise that AMCs are distinguished as institutions that support opportunities for translational research, testing innovative models of care, and education.

With those foundational commitments, AMCs must learn to decrease cost, increase integration, and right-size in this new era. The generational shift away from hospital-based care must be recognized and addressed.

### Our Methodology

The following are institutional profiles that summarize emerging strategies and highlight innovative approaches to system development and other AMC transformation activities from across the county. These institutions were selected specifically by the Advisory Panel for Health Care at the AAMC as institutions that are engaged in specific activities that can teach other AMCs.

These profiles were built through extensive primary interviews with executives, as well as secondary research using a variety of sources. All profiles completed on Nov. 1, 2013.
Drivers of Academic Health System Formation

- Movement from fee-for-service payment toward value based payment
- Need to achieve order of magnitude reductions in cost structures (of clinical and academic enterprises)
- Need to participate in consolidating markets and not be marginalized
- Need to continue to support teaching and research missions
- Need to manage population health, and
- Need to focus on the overall patient experience and overall societal health
Major Themes – Advancing the Academic Health System for the Future

1. Future will be System-Based
   - Population Health Manager
   - Public Entity Statewide Hub
   - High-Performance Regional Systems
   - Merge or Affiliate with Mega systems
   - Specialized/Complex Care Leaders

2. Strong, Aligned Governance, Organization & Management Systems
   - Leadership strategically/structurally aligned
   - Aligned and effective decision-making
   - Multi-systems up to the task
   - Trust among resource allocation and performance

3. University Relationships Challenged to Evolve
   - Compelling new opportunities
   - Political and strategic challenges
   - Fair market values, services, transparency
   - Updated/university policies and procedures

4. New Physician Leadership and Evolution of Practice
   - Chair roles focused on leadership framework
   - Community-based physician expansion
   - Economic and admin. integration
   - New roles for physicians, executives

5. Transparency in Quality, Performance, Financial Data
   - True understanding of complete cost structure
   - Measures to demonstrate value to purchasers
   - Quality reporting and outcomes critical to brand

6. More Efficient Operating Models to Bend the Cost Curve
   - Commitment to cost reduction key
   - Streamlined operations between missions
   - Skills that can become essential
   - Compete with cost-efficient competitors

7. Time to Lead on Population Health is Now
   - Pop. Health capabilities needed to assume risk
   - Post-acute services become critical success factor
   - Successful AMCs leveraging branded health plans

8. Candid Assessment of Strengths and Weaknesses Essential
   - Market and policy dynamics forcing current state evaluation
   - Candid leadership conversations about organization’s “hand”
Acknowledgements

The AAMC research team would like to acknowledge the AAMC Advisory Panel for Health Care that provided significant direction on the development of the overall project report and the case study profiles included here. A complete list of the panel participants is in the Appendix.

The research team would also like to thank the institutional leaders who generously gave of their time to help build these profiles, and who offered materials to support our understanding various aspects of their respective institutional strategies. We list the participants at the beginning of each profile throughout and we thank them for their generosity.

Project Team

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Montefiore Medical Center

Profile Takeaways

• Montefiore leadership is aligned structurally and through compensation metrics focused around system performance and quality.
• Montefiore is heavily involved in alternative payment models. They are currently manage over 500,000 lives with 50 percent of total revenue at risk through various ACO and shared savings/risk arrangements, including the Pioneer ACO program.
• Montefiore has invested heavily in its community by aligning the medical center with community physicians, investing in primary care and developing a regional health information organization.

Interviewees:
• Lynn Richmond, Senior Vice President and Chief of Staff

Profile Completed on November 1, 2013
Mission & Vision

Mission: To heal, to teach, to discover and to advance the health of the communities we serve. Montefiore builds upon a rich history of medical innovation and community service to improve the lives of those in our care.

Vision: To be a premier academic medical center that transforms health and enriches lives. Through our enduring partnership with Albert Einstein College of Medicine, we combine clinical care with research to offer innovative treatments and therapies to our patients. Together, with state-of-the-art treatment and facilities and the highest ethical standards, we are challenging the limits of medicine.

Market Situation

Montefiore includes six hospitals, with a total of 1,900 plus beds. In 2012, Montefiore had 86,500 inpatient discharges, 301,000 emergency department visits, and 7,100 births annually. Montefiore has nearly 140 community-based sites including 21 primary care clinics (including five federally qualified health centers) that are located throughout the Bronx and lower Westchester and provide 830,000 visits annually; 17 school-based clinics that provide medical, mental health, and dental services, with a total of 65,000 annual visits to 40 schools (many schools, particularly high schools, are clustered at the same site); an integrated provider association and a care management organization with 150,000 enrollees in capitated contracts that provide a fixed payment per enrollee.

Although close to 80 percent of its payer mix is Medicaid and Medicare, Montefiore has been able to achieve financial and organizational sustainability. As CEO, Dr. Steve Safyer launched a strategic planning process that included strengthening the partnership with Albert Einstein School of Medicine. Dr. Safyer has set a vision for a new care model and driven that forward with rigor. Factors that contribute to this success include: care management that allows for integration across the system; building patient-centered primary care that combines traditional and new models; and medical systems that focus on population health and community accountability.
### Montefiore Governance & Organization Features

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<th>Characteristic</th>
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<td>Integrated Governance</td>
<td>• Montefiore reorganized each campus under an executive director/medical director dyad. Each campus site has taken on more accountability; moving from less service line oversight to more local responsibility, authority, ownership and ability to respond to patient needs.</td>
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**Montefiore Medical Center Board of Trustees**

- President and CEO

**Executive Vice President and COO**

- Senior Vice President, Network Development
- Senior Vice President and General Counsel

**Executive Vice President, Finance**

- VP Finance, Accounting and Reporting
- VP Finance
- VP-BS & Information Systems
- VP Finance, Physician Revenue Cycle Services

**Senior Vice President and Chief of Staff**

- VP, Strategic Planning

**Department Chairs**

- VP, Strategic Planning
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<td>Fiscal Transparency</td>
<td>• Montefiore has one single balance sheet. The CMO is a wholly owned subsidiary and Montefiore IPA is a joint venture. As they become a larger system, each institution will have their own balance sheet within an integrated system financial report.</td>
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| Compensation & Incentives | • Majority of physicians are employed. In process of tying quality to compensation.  
• Implementing, unit-based incentive programs with inpatient focused metrics - all will do well, if the team does well.  
• Executives and management have compensation tied to various quality metrics (i.e. patient experience).  
• Working towards the ability to measure “efficiency” and tie compensation to it. |
| Management of Risk   | • There has been exponential growth in alternative payment models. After almost two decades of incremental assumption of risk, Montefiore is working towards full commitment. Currently, 50% of total revenue is at-risk, 50% is FFS. The goal is to quadruple the number of covered lives...to jump the line. Montefiore is operating at capacity and a decrease in LOS and readmissions mitigates capacity issues.  
• Montefiore manages the care for 250K lives, 23K of them in the Pioneer ACO. The Montefiore IPA assumes downside risk from payers. If it brings in money, money flows back to IPA physicians.  
• In 1996, Montefiore established CMO, The Care Management Company as a wholly owned subsidiary. CMO manages the risk for the IPA and the medical center.  
• The CMO has responsibility for care management delegated by health plans as well as administrative functions of claims payment and credentialing.  
• As Montefiore grows, these functions may well migrate to the system level to leverage knowledge and infrastructure. |
Montefiore

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<td>Scale</td>
<td>• Recently acquired two additional acute care facilities in lower Westchester. There will be migration of some activities to the system level. Each facility will have its own balance sheet within in the larger health system financial report.</td>
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| Primary Care Network Development | • Montefiore's primary care network has grown exponentially over the past two decades to meet the demand for community-based, comprehensive, patient-centered care.  
  • After a significant investment in primary care by Montefiore, the Bronx now has 106 primary care physicians per 100,000 population, which, although below the New York State rate of 148 per 100,000 population. Since 1999 the rate has increased 15 percent.  
  • Montefiore has also grown its specialty services to meet the needs of the community. They have entered into various arrangements with volunteer physician community to ensure comprehensive care in which information follows the patient from setting to setting. |
| Provider Network               | • In 1995, Montefiore worked with its employed and voluntary physicians to establish an integrated provider association (IPA) to align the medical center and its physicians around assumption of financial risk and improvement of care delivery. The IPA board includes hospital and physician representation, with the latter including employed, voluntary, primary care, and specialty physicians. |
| Access to Capital              | • Critical for growth but anticipate that there will be limits as determined by the success of systems operations.                         |
### Montefiore

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<td><strong>Health Information Technology</strong></td>
<td>• Montefiore spearheaded efforts to collaborate with other health systems in the Bronx around data-sharing.</td>
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<td><strong>Architecture</strong></td>
<td>• In 2005, Montefiore launched the Bronx Regional Health Information Organization (RHIO), the vehicle for a Bronx-wide electronic exchange of health care information. There is widespread participation in the RHIO, including most of the borough’s hospitals, federally qualified health centers, ambulatory health centers, home care agencies, nursing homes, and community-based organizations. Every provider organization has one vote regardless of size, a strategy intended to put every organization on equal footing as well as to foster consensus and shared leadership.</td>
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<td><strong>Data Analytics &amp; Performance</strong></td>
<td>• Montefiore began developing its health information technology (HIT) system in 1995. Since then, it has invested close to $300 million to create a system that extends throughout its delivery network.</td>
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<td><strong>Measurement</strong></td>
<td>• To make better use of clinical data, Montefiore developed a data warehouse, Clinical Looking Glass (CLG), in 2000. CLG allows aggregate data searches based on Montefiore’s patient population and provides support for clinical research. With more than 700 staff trained, including all internal medicine residents, CLG provides assessment by physician, department or site of care.</td>
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| **Education, Research, & Innovation** | • There are many community efforts that integrate educational research.  
• Under the partnership with Albert Einstein, research is growing with over 450 clinical trails currently underway. Resident and students are integrated into the care team and involved in “value” effort. |