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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
   - Specialized Complex Care Leader
   - High-Performance Regional System

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

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

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

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
   - Compete with cost-efficient competitors
   - Streamlined operations between missions
   - Skills like LEAN become essential
   - Commitment to cost reduction key

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

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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<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Joanne Conroy, MD</td>
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</tr>
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</tr>
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<td>Ivy Baer</td>
<td>Senior Director and Regulatory Counsel AAMC</td>
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<tr>
<td>Evan Collins</td>
<td>Health Care Affairs AAMC</td>
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<tr>
<td>Alex Morin</td>
<td>Senior Analyst Manatt Health Solutions</td>
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Questions or Comments? Please contact Tom Enders and Joann Conroy
Profiles in Academic Health System Leadership
Penn Medicine

Profile Takeaways

• Penn has developed a high value system of care which links a destination campus with well distributed IT-connected ambulatory care sites including “Practice of the Future” multi-specialty clinics.
• Its primary care platform, Clinical Care Associates, includes over 175 PCPs and is a rich source for patient centered outcomes research.
• Penn has moved to a sophisticated centralized IT services organization serving both the clinical and research missions, streamlining data needs and providing economies of scale.
• Penn is investing in personalized medicine and translational research capabilities through a variety of avenues, including the recent launch of two Translational Research Centers and a comprehensive research data store.

Interviewees:
• Ralph Muller, CEO
• Kevin Mahoney, Vice Dean for Integrative Services & Chief Administrative Officer
• Beth Johnston, Executive Director, Clinical Practices of the University of Pennsylvania
Mission & Vision

Mission: To advance science through research, provide outstanding patient care and community services, and educate future leaders in medicine.

Vision: Shape the future of medicine through three galvanizing themes - innovation, integration, and impact.

Market Situation

- Three primary systems of care in Philadelphia region: Penn; Temple; and Jefferson Health System
- Penn is reputational but not market share leader
- Penn has been expanding into the 5-county region surrounding Philadelphia in PA and NJ where population is growing, and formalizing an increasingly complete system of care

PENN Medicine Strategic Priorities Are:
1. Lead in Delivering Individualized Medicine
2. Realize Penn Medicine's Potential for Innovation
3. Enrich the Life of Our Faculty through Diversity and Flexibility
4. Impact Health Outcomes Locally and Globally
5. Create Innovative Interdisciplinary Educational Programs
6. Optimize Performance of the Penn Medicine Ecosystem
# Penn Medicine

<table>
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<th>Characteristic</th>
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| Integrated Governance & Management | • PENN Medicine exceeds $4Bn in revenues and has one governing body for both the SOM and the Health System. The PENN Medicine board has responsibility for overseeing the integration/joint activities of the health system and School of Medicine.  
• Clinical services are integrated as the University of Pennsylvania Health System (UPHS), managed under a unified and accountable management structure led by a system Chief Executive. |
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<th>Characteristic</th>
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| **Clinical Strategy: Advanced Medicine** | • Complex medical/surgical care is a strength and priority for PENN Medicine because it is where the integration of research, diagnostics, and therapeutics has the greatest impact on people’s lives. High complexity quaternary care services often bring patients to their first encounter at Penn via referrals to disease-based specialties. The most complex cases currently generate over 50% of the inpatient contribution margin and in the Penn market are those most resistant to pricing pressure and provider competition.  
• PENN Medicine is therefore emphasizing a culture throughout the clinical environment that gives high priority to population management of the complex patient, achieving best outcomes, and minimizing cost of care: linking clinicians with evidence based protocols and with a unified EMR and decision support tools; improving complex care coordination; investing in predictive capabilities; enhancing diagnostics; opening up access; and improving transitions of care. |

**Penn Medicine: Pathways to Clinical Excellence**

1. Provide premier service and enhanced interaction to our patients and families.
2. Provide seamless patient-centered care that increases access, coordination, and communication with referring physicians.
3. Expand current integrated complex care programs, build new ones, and develop innovative leadership and financial models for quaternary inter-disciplinary team-based programs.
4. Become the leader in personalized medicine and provide an advanced diagnostic platform for clinical decision-making and full-spectrum genomic testing.
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| **Role of Chairs**   | • Chairs are responsible for leading both research excellence and clinical development, each within the context of the overall PENN Medicine strategic agenda. Chairs are recruited who exhibit pronounced EQ (Emotional Intelligence), are open to change, and ready to lead faculty for a new future with different requirements.  
• Chairs are responsible for their departmental P&L’s, with limited inter-departmental financial sharing.  
• Faculty Practice organization reports to Health System CEO and has strong physician and administrative leadership, with a robust process for issue resolution and decision making. Strength in both Chairs and Faculty Practice has provided a platform for excellent clinical results.  
• PENN Medicine has evolved its service line structure (Cardiovascular, Cancer, NeuroSciences) and the Chairs work hand-in-hand with senior Health System service line leaders to advance them. |
| **Fiscal Transparency** | • Penn Medicine has financial transparency across all services, especially clinical services.  
• The funds flow model for supporting the academic mission and the clinical departments integrates and aligns incentives across the system. The FPP operates financially as a federated model and managerially as a integrated one, with a strong management team model characterized by effective issue management.  
• Strategic planning and long range financial planning is integrated across PENN Medicine.  
• Recently integrated finance functions across PENN Medicine to facilitate ability to manage enterprise operating and capital budgets. Integrated long range financial and capital planning is in place. |
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| Compensation & Incentives | • Service line incentive plans have been introduced. Incentives for service lines are based on metrics for cost, quality, access, and improved performance. Incentives are returned to service lines both for physician compensation and service line investment.  
  • FPP has strong incentives based on hospital performance which are embedded in the funds flow model.  
  • FPP has general compensation principles: Minimum 20% at risk with base related to productivity or margin. Chairs have discretion on compensation principles, but are moving to a centralized model.  
  • Executive Compensation: Balanced scorecard with goals around clinical quality, financial, education, and research (20-35% of base compensation at risk). |
| Management of Risk      | • Penn has remained largely risk-contract averse, while establishing the capability to accept bundled payments. Through the faculty practice, UPHS funds flow structure, and service lines it has the readiness to accept bundled payments when it deems the market timing to be right. |
| Scale                  | • Over the last decade PENN Medicine has developed its system through an extensive network of ambulatory primary and specialty care centers, including its Practice of the Future sites, strong affiliates, and a joint venture rehabilitation and long term care joint venture. It also invested in its state of the art Perelman Center for Advanced Medicine ambulatory center as a regional destination site for specialty care.  
  • Penn has a high threshold for acquisition of community hospitals, requiring strong market position and a robust balance sheet, avoiding situations which require significant infusions of capital likely to lead to low return on capital. It recently acquired Chester County Hospital, 25 miles south & west of the main campus, a 220 bed hospital which met its criteria. |
Penn Medicine

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<td>Primary Care Network Development</td>
<td>• Over the course of the last decade, Penn has developed Clinical Care Associates, a 501 (c) 3 employed model primary care group serving multiple communities throughout the Philadelphia region.</td>
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• CCA is a distinct operating unit with UPHS; Total net revenue approaches $100M
• 759 full time equivalent employees – 172 physicians, 30 mid-level providers, and 549 additional staff.

• Connects the broad, densely populated suburbs to the central Philadelphia PENN Medicine hospital system and specialist network.
• Established Penn Community “Practices of the Future” which combine primary care clinics with Penn specialty clinics in a unified location with centralized ancillary services.
• Strong and efficient practice management with extensive practice and physician recruitment experience.
• Highly-productive clinical practices that generate complex specialty referrals to UPHS physicians, hospitals, and multispecialty satellites.
• Geographically dispersed network that reduces UPHS’s reliance on and exposure to individual markets and enhances negotiating leverage with insurance plans.
• Supports the School of Medicine educational mission by providing primary care education opportunities in diverse practice settings.

CCA is playing an increasing role in community-based comparative effectiveness research (e.g., lipid management strategies, weight loss outcomes are two recent studies). The EPIC database provides a rich dataset using discrete values and natural language processing tools.
PENN Medicine considers Information to be a strategic asset. Clinical and research missions may differ in scope and purpose but are alike in data infrastructure, data analytics, and data security needs, making a centralized IS function highly valuable in the ability to use information strategically.

PENN Medicine reorganized their enterprise Information Services function across its clinical and research organizations, with extensive investment in creating enhanced capabilities for clinical performance, administrative reporting, and connectivity.

### Organization of Penn Medicine Information Services

- Vice Dean for Integrative Services/Chief Administrative Officer has PENN Medicine IT budget responsibility — and ultimate service delivery responsibility.
- Single CIO with overall service delivery leadership accountability for PENN Medicine.
- Leveraged IT services across PENN Medicine including research computing.
- Enterprise level delivery for emerging technologies.

**PENN Medicine’s re-organized IT governance model is a dual-governance model for academic and clinical, with unified resource management and a reporting structure through a central administrative leader.**
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| Cost Management/Quality of Care   | • PENN Medicine’s clinical enterprise has made significant progress in the areas of mortality and health care acquired infections since the inception of its *Blueprint for Quality* in 2007, a multi-year agenda which establishes priorities for quality improvement. For example, risk adjusted mortality has decreased by 45% over the past five years across the health system and central line catheter blood stream infections have decreased by 95% over a similar time period.  
• PENN Medicine has a multi-part, multi-year approach to driving down unit costs and improving the operating results of the clinical system, characterized by:  
  • *Throughput improvements* centered on a deep institutional commitment to optimal patient flow to free up capacity and enhance the service mix, leveraging the main campus and its two community hospital sites.  
  • Invested significantly to build *unit-based clinical leadership teams* that are testing and implementing data driven innovative approaches to care delivery in both inpatient and ambulatory settings. These groups are led by physicians with dedicated quality managers than span multiple teams. In addition to care innovations on the inpatient side, they are tasked with translating quality of care initiatives into action. All inpatient units have unit based teams.  
  • *Coordination/transitions of care* is the current focal point at Penn with regard to quality and capacity management. Investment in a rehabilitation/LTC provider is facilitating.  
  • *Commitment to employee action* with a highly successful “Your Big Idea” campaign and competition to recognize and implement employee team sponsored initiatives. |
### Penn Medicine

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| **Open Architecture – Engaging with Community Providers** | • Penn’s physician services model is centered on the evolution of the Faculty Practice and the further development of CCA. Both are aligned with referring physicians.  
• Penn has recently formed a significant joint venture with a leading rehabilitation/long term care care provider (Good Shepherd-Penn Partners) through which it is developing its post-acute care services in a partnership model. |
| **Education, Research, and Innovation**     | **Research**: Penn is engaged in a major effort to advance personalized medicine; initiatives include *Pennomics* (a comprehensive research data store to be the engine for personalized medicine); a new Center for Personalized Diagnostics; *Connected Health*, investment in technology & process to improve predictive capabilities; and migration to a single EPIC clinical system platform. Penn has also launched two broad Translational Centers of Excellence to bridge basic science, clinical research, and clinical care in Cancer, Metabolic Disease, and Neurosciences.  
**Education**: Penn is emphasizing team training, collaboration, interdisciplinary and interprofessional activities, online access, new media (e.g., Coursera) and reduced costs and time for training.  
**Innovation**: Penn has established a Penn Medicine Center for Health Care Innovation with an inter-disciplinary team leveraging the Health System, School of Medicine, Wharton, and a Chief Innovation Officer recruited from high technology industry. The emphasis is on creating and testing prototype efforts in three areas: Enabling a Culture of Innovation, Connected Health, and Population Health at PENN Medicine. |
Emory Healthcare

Profile Takeaways

• Emory has developed an approach to their market using a segmentation based on their view of where payment models for types of services will shift and is preparing to accept various types of risk in each. They have designed their overall system strategy, including physician network development around this approach and it acts as the basis on which Emory will focus strategically in the future.
• Emory has a flexible three-pronged physician services strategy that allows them to strategically develop the right networks of primary and specialty physicians for clinical care. The strategy and its related vehicles allow Emory to be opportunistic and nimble in the types of relationships it develops, with a common underpinning of IT connectivity and data exchange for all that benefits all patients across the entire network regardless of the level of physician integration.

Interviewees:
• Wright Caughman, Executive Vice Chancellor for Health Sciences, Emory University, CEO Woodruff Health Sciences Center and Chairman, Emory Healthcare
• John Fox, President & CEO, Emory Healthcare
• Christian Larsen, Dean, Emory School of Medicine and Vice President for Woodruff Health Sciences Center

Profile Completed on November 1, 2013
**Emory Healthcare: Mission and Vision**

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<th><strong>Mission &amp; Vision</strong></th>
<th><strong>Market Situation</strong></th>
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<tr>
<td><strong>Mission</strong>: EHC is an integrated academic healthcare system committed to providing the best care for our patients, educating health professionals and leaders for the future, pursuing discovery research in all of its forms, including basic, clinical, and population-based research, and serving our community.</td>
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<td><strong>Vision</strong>: To be recognized as a leading academic health system, differentiated by discovery, innovation and compassionate, patient- and family-centered care.</td>
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<td><strong>Market Share (FY 2011):</strong></td>
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<td>- PSA: 20%</td>
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<td>- 7 major systems compete with EHC in PSA:</td>
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<td>- Wellstar: 16.7% market share</td>
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<td>- Piedmont: 15% market share</td>
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<td><strong>Market is quite competitive – 85% of EHC services have active competition locally.</strong></td>
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**Emory Healthcare** is the integrated system entity that includes all clinical activities of the hospitals, outpatient clinics, and faculty of the Emory School of Medicine. It contains the Emory Hospitals, Wesley Woods Center, the Emory Clinic (FPP) and two joint ventures. The School of Medicine is governed separately as part of the Woodruff Health Sciences Center (of which Emory Healthcare is a part).

*2011 Inpatient “Wallet Share” (state-wide average charges by DRG)*

**Source:** Official Statement. Private Colleges and Universities Authority. Emory University Revenue Bonds. Series 2013A
### Emory Healthcare

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| Integrated Governance| • All clinical services are organized under Emory Healthcare under the responsibility of the EVP Health Affairs. Emory Healthcare integrates clinical services under a CEO and academic services under the Dean.  
  • Emory utilizes two major groups of leaders for major strategic decision making.  
  • The first, the Executive Leadership Group, is focused on EHC’s organizational view of academic medicine and institutional development.  
  • The second group, “Academic Medical Center Initiatives Group” is focused on implementation of its strategic vision: optimal integration of education, research and healthcare, referred to as “Emory Medicine”. |

### Executive Leadership Group
- Health Sciences Center CEO
- CEO, Health System
- Dean of Medical School
- Emory University Executive VP Business and Administration

### Academic Medical Center Initiatives Group
- Health Sciences Center CEO
- CEO, Health System
- Dean of Medical School
- Health Science Center VP’s of Research, Finance, and Administration
## Emory Healthcare

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| Fiscal Transparency  | • Clinical revenues of the faculty remain managed at the departmental level within the Emory Clinic, although clinical services are integrated within Emory Healthcare (with the hospitals, non-faculty physicians, etc.).  
• There is revenue sharing with the hospital (and the FPP) but funds are mostly used for program development. |
| Compensation & Incentives | • Executive leaders have aligned goals and metrics. Department Chairs have the same institutional goals, with a few local components that can vary.                                                       |
| Access to Capital    | • Emory University owns the system and issues debt on a unified basis. Rating agencies question whether Emory is a University with a Health System, or “a Health System with a University”.        |
| Scale                | • The forces of consolidation are in play in their market. Leadership believes that 1.5 million lives will be necessary to sustain the system and engage the broader community in missions of education and translational research. |
Emory Healthcare

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<tr>
<td>Management of Risk</td>
<td>• Emory views its market in three “tranches” (acute and complex care, chronic disease care, and population management) where payment models for services will vary based on risk assumption by Emory.</td>
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</tbody>
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**Strategy Assessment**

**“No Future in Fee For Service”**
- Providers being pushed to take risk for cost and quality
- Value based payment the future

**Competition**
- 85% of EHC’s services have direct and active competition in the market

**Value Proposition**
- AMC status less of a differentiator with shift to population health management and new reimbursement models
- All three missions cannot be sustained without a shift in clinical strategy

1 – Tertiary/Quaternary Care
- Packaged set of services with bundled pricing that cover an episode of care – emphasis on Emory clinical strengths
- Bundle includes post discharge outcomes up to a year
- Attractive for purchasers including self-insured employers both in and out of the primary service area.
- Example services: Bone Marrow Transplant; Transplant Surgery

2 – Patient Cohorts with Advanced Illness
- Complex patients with conditions that need intense management, reimbursed in a capitated, risk-adjusted rate
- Risk is syndicated out by patient cohort; actuarially determined risk profiles
- Potential to draw patients into EHC market regionally/nationally for these services
- Example services: Post-transplant care management; congestive heart failure; diabetes

3 – General Services with P4P and Risk-Sharing
- The “Big River” of clinical services in the health system
- Embed process and outcome quality measures into general services and develop risk-sharing contracts with payers (Medicare Advantage, Commercial Insurance, Employers)
- Example Services: $500M Blue Cross contract with risk corridors up & down on cost baseline projections
Emory Healthcare

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| Primary Care Network Development                   | • Organized **Emory Clinically Integrated Network (CIN)** which allows them to contract with private community PCPs and specialists (currently 500).  
• While CIN physicians are not employed by Emory, all are on the EHR and Emory HIE.  
• Emory only contracts as a CIN for community, FPP and non-faculty employed physicians.  
• For the payer and patient, the network is the product. This approach allows Emory to offer different “products” to different insurers across 7 hospitals and 2000 docs. |
| Open Architecture – Engaging with community providers | • In addition to the CIN, Emory has a group called **Emory Specialty Associates (ESA)**, which are community physicians who are employed by Emory Healthcare, but are not faculty in the School of Medicine. They are organized by division according to specialty and are managed by Emory as a group practice and have own leadership structure. Fortuitously, the President of ESA is also the director of the Emory Clinic and thus is able to bridge “town-gown” issues. |

**EHC Physician Strategy**

**Emory Clinically Integrated Network**
Non-employed  
Non-faculty  
PCP/Specialists  
~ 500 physicians

**The Emory Clinic (Faculty Practice)**
501(c)3  
Employed  
Faculty  
PCP/Specialists  
~1,149 physicians

**Emory Specialty Associates**
501(c)3  
Employed  
Non-faculty  
PCP/Specialists  
~160 physicians

*Common EMR and HIE connectivity.*
## Emory Healthcare

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| **Data Analytics & Performance Measurement** | • Emory has a data mart that supports decision making based on outcomes. EHC recently hired a new position to build out their analytic infrastructure.  
• They realize a key for the future is to get the right people, looking at the right data, at the right time.                                                                                                                                                          |
| **Cost Management/Quality of Care**  | • Developing multidisciplinary care teams to work on activities with cohorts of patients with advanced illnesses.  
• Emory views these cohorts as a risk pool and is working with actuaries to develop “intelligently defined payments” and then taking data to payers. The Emory Clinic, CIN and non-faculty employed physicians are being organized around these cohorts.  
• The **Emory Clinically Integrated Network** developed a partnership in 2012 with BCBS GA to provide care to BCBS patients – representing a move into risk assumption for cost and quality for patients. $500M contract with risk corridors (up/down) based on baseline projections. |
| **Education, Research, & Innovation** | • Emory has worked to achieve some functional integration across the three missions. For example, the Transplant center operates across disciplines as a clinical service delivery model, education program, and a translational research center.                                                                                   |
Profile Takeaways

• VCUHS is on an institution-wide “journey to high reliability” with three main focus areas: core quality, patient safety, and service excellence. The ultimate goal of this effort is to build a level of institution-wide level of quality that is driven by culture.
• Through its Medicaid managed care product, programs that manage the health of uninsured individuals, and its emerging analytic infrastructure, VCUHS has experience in developing care models to manage the most complex of patients.
• VCUHS executive compensation system holds health system leaders accountable for both the financial performance and the patient quality/outcomes of the entire system. In addition to productivity, the physician compensation system includes a significant portion of compensation tied to ‘Citizenship Metrics’

Interviewees:
• Sheldon Retchin, Senior Vice President for Health Sciences, VCU & CEO, VCU Health System
• John Duval, CEO, Medical College of Virginia Hospitals, VCU Health System
Mission & Vision

**Mission:** VCUHS is established to preserve and restore health for all people, to seek the cause and cure of diseases through innovative research, and to educate those who serve humanity.

**Vision:** VCUHS is committed to excellence in patient care and education as the preeminent AMC in the mid-Atlantic region, dedicated to:

- Demonstrating superior value
- Securing position as a leader in integrated deliver systems
- Fostering contributions of all care team members to patient care
- Educating the next generation in leading edge techniques
- Applying novel research in clinical and basic sciences
- Ensuring sufficient assets to support mission and vision.

Market Situation

Service Area: 22% market share (2010).

- > 50% market share for several T/Q Services (e.g., BMT, Burns, Heart Transplant, Solid Organ Transplant, and Trauma) and plurality share of others.
- Relatively fragmented market
- Major competition:
  - Bon Secours Health System – 4 Hospitals, 200 physician medical group
  - HCA – 6 Hospitals and 1700 providers
- Virginia Medicaid expansion still undecided

**VCU Health System (Authority)** – public corporate body and political subdivision of the Commonwealth of Virginia and operator of Medical College of Virginia Hospitals. System encompasses MCV Hospitals, MCV Associated physicians (FPP), Children’s Hospitals of Richmond at VCU and Virginia Premier Health Plan. The VCU Medical Center encompasses the clinical delivery components of the VCU Health System and academic components of the VCU Health Sciences schools.

VCU Health System Authority is the organizational entity overseeing all clinical activities (MCV Hospitals, MCV Physicians, Virginia Premier Health Plan) as well as collaboration with the SOM. Leadership is aligned around system strategy and environmental changes happening in the market. System leadership “gets it” and realizes the change that is happening is real.

MCV Physician leadership reports up through the Dean to the CEO of the Health System who has responsibility for both clinical and academic responsibilities across VCU.
## VCU Health System

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| **Compensation & Incentives** | • Faculty compensation is currently RVU driven with salaries and bonuses set by the group practice (MCV Physicians). FPP is moving to centralized management such that it will mimic a multi-specialty group practice with a single compensation system for all physicians.  
• Up to 20% of compensation is tied to quality (“Citizenship”) metrics; % will grow over time.  
• Senior leaders have sizable performance incentives: 40% of incentives are tied to major quality metrics, 40% to patient satisfaction and experience, and 20% to margin.  
• Chairs incentives are tied to academic goals, compliance, and quality. |
| **Management of Risk**   | • Population health management in inner-city Richmond exists currently through the Virginia Coordinated Care (VCC) program, though without the development of a formal ACO. VCUHS is very focused on complex care models designed to take care of high-cost patients and are seeking health plan partners.  
• The VCC coordinates providing medical services – hospital and ambulatory – to qualified uninsured individuals in the Richmond area at reduced rates. Averaged 50% cost savings per enrollee after 3 years of continuous enrollment in the program.  
• VCUHS Owns a Medicaid Managed Care Product – Virginia Premier Health Plan which currently covers over 170,000 lives. Recently, the Virginia Premier Health Plan has been awarded a contract, along with two other plans in Virginia, to enroll dual-eligibles. |
## Characteristic

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Features</th>
</tr>
</thead>
</table>
| **Scale**                     | • VCUHS is expanding for specific reasons – to reduce cost of care, support education and research as well as high-quality clinical programming – not just for referrals.  
                                • They do foresee geographic expansion, but not simply through acquisition.                                                             |
| **Data Analytics & Performance Measurement** | • A major focus in the future will be investments in analytic capacity. They view a robust analytic infrastructure as a vital component in their efforts throughout the system to increase quality and reduce costs.  
                                • This increased analytic capacity will also be applied to their HMO product as they focus on the subset of their population that are the “frequent flyers” in the system. |
| **Cost Management/Quality of Care** | • VCU is on what they call a “journey to high reliability” which contains three main focus areas: core quality, patients safety, and service excellence. Through this journey their focus is to build a level of institution-wide quality that is driven by culture.  
                                • Through the RAM-Care program evidence-based protocols, pathways, and guidelines are being established for disease cohorts. 13 diagnostic cohorts are in process to-date and are focused on removing clinical variation.  
                                • The VCU Office of Clinical Transformation is working to develop predictive medicine systems to drive unnecessary costs out of patient care and increase care quality. |
### Characteristic

<table>
<thead>
<tr>
<th>Education, Research, and Innovation</th>
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<tbody>
<tr>
<td><strong>Features</strong></td>
</tr>
<tr>
<td>• VCUHS includes GME as part of their quality incentives for system leaders. Residents are trained using new technologies such as clinical simulation and are eligible for bonuses based on quality metrics.</td>
</tr>
<tr>
<td>• Future GME strategies include aligning with the workforce needs of Virginia and aligning GME with the clinical programs in which they excel. In their eyes, in a time of constrained resources, it may not make sense to try to do everything.</td>
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<tr>
<th>Open Architecture – Engaging with Community Providers</th>
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<tr>
<td><strong>Features</strong></td>
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<tr>
<td>• A purely bricks and mortar strategy is not in VCUHS’ plans. They feel they can take their expertise into surrounding communities to complement existing services already serving the population.</td>
</tr>
</tbody>
</table>
University of Pittsburgh Medical Center
Profile Takeaways

- UPMC’s future strategic direction is centered in large part on its health plan, which is a primary vehicle currently for testing new delivery models and payment models with physicians.
- UPMC’s primary care model drives collaboration between PCPs and specialists, with PCPs operating in shared savings arrangements with the UPMC Health Plan. Specialists are incentivized to adhere to protocols and clinical guidelines that improve quality and lower costs to win PCP referrals.
- UPMC is positioning itself to lead in the area of precision (personalized) medicine and will in the future have as one of its core missions improving the overall health of the population it serves.

Interviewees:
- Steven Shapiro, Executive Vice President, UPMC, Chief Medical and Scientific Officer, and President, Physician Services Division
- Arthur Levine, Senior Vice Chancellor for Health Sciences and John and Gertrude Petersen Dean, School of Medicine
Mission & Vision

**Mission:** To serve our community by providing outstanding patient care and to shape tomorrow’s health system through clinical and technological innovation, research, and education.

**Vision:** UPMC will lead the transformation of health care and be nationally recognized for redefining health care by:

- Putting patients first
- Delivering state-of-the-art care
- Enhancing UP SOM partnership to advance the understanding of disease
- Fueling new business opportunities
- Serving the underserved

Market Situation

- 29 county market of over 4 million, 15% Medicare age; heavy consolidation.
- Market Share:
  - Allegheny County: 60%
  - Southwest PA (10 Cty.): 40.2%*
- Primary competition is Highmark (recent acquisition of West-Penn Allegheny Health System and Jefferson Regional Medical Center). Market share in Southwest PA (10 Cty.): 19%
- Moving into surrounding regions including West Virginia and building an international presence including campuses in Italy and Ireland and joint ventures in Southeast Asia and Kazakhstan

**UPMC is the entity responsible for clinical activities of UPMC facilities and the University of Pittsburgh FPP (University of Pittsburgh Physicians) with an affiliation with the University of Pittsburgh School of Medicine. Both are distinct corporate entities.**

*2012 Q1 Inpatient Market Share, 10 County Western PA Region; based on aggregate discharges
Source: UPMC Website; Official Statement, Monroeville Financing Authority, UPMC Revenue Bonds Series 2012*
University of Pittsburgh Medical Center

**Characteristic** | **Features**
--- | ---
Integrated Governance | • UPMC governs all clinical activities of inpatient and outpatient facilities as well as physicians including employed (Faculty/Non-Faculty) and affiliated physicians.  
• SOM Dean is involved in clinical enterprise strategic decisions, along with Operating Division EVPs (Insurance, Hospital and Community Services, UP Physician Services [FPP]) and the Health System CEO; Dean maintains joint oversight of UP Physicians for academic affairs and compensation.

**Joint Board Appointments**

- Chair of Pitt Board is the Vice Chair of the UPMC Board
- University is allocated 8 of the 24 seats on the UPMC Board

---

**UPMC Board of Directors**
24 Seats

- President & CEO, UPMC
  Jeffrey Romoff

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**University of Pittsburgh Board of Trustees**
36 Voting Members

- Chancellor, University of Pittsburgh
  Mark Nordenberg

---

EVP, UPMC & President, International and Commercial Services Division
Charles Bogosta

EVP, UPMC & President, Hospital and Community Services Division
Elizabeth Concordia

EVP, UPMC & President, UPMC Insurance Division
Diane Holder

EVP and CMSO, UPMC & President, Physician Services Division
Steven Shapiro, MD

University of Pittsburgh Physicians, Clinical Department Chairs

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**Source:** Interview, Steven Shapiro, UPMC. 2013. Levine, Arthur S. et al. “The Relationship Between the University of Pittsburgh School of Medicine and the University of Pittsburgh Medical Center – A Profile in Synergy. Academic Medicine, 83(9): 816-826.

Clinical department chairs and faculty report to UPMC for clinical activities and to the Dean for academic activities. “Receive 2 paychecks.”
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Features</th>
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</table>
| Fiscal Transparency         | • The SOM and Health System are not integrated financially, yet engage in significant cross-institution financial support.  
• UPMC transfers money for academic research and teaching programs, including a transfer based on clinical revenue.                                                                                                                                                               |
| Compensation & Incentives  | • Incentives and goals for the SOM and medical center leadership are aligned, and there are joint performance evaluations across the organization (both Medical Center and SOM)  
• Faculty receive two paychecks – one for clinical services from UP Physicians and one for academic service from the SOM (dual-faculty only).  
• For clinical work, RVUs still drive compensation. Individual departments control compensation plans; 20% of incentive is based on quality.                                                                                      |
<table>
<thead>
<tr>
<th>Characteristic</th>
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<tbody>
<tr>
<td>Access to Capital</td>
<td>• UPMC makes payments through a long-term affiliation agreement to the SOM in the form of discretionary funds to the SVC/Dean for faculty recruitment, innovative research programs, and major equipment purchases ($40M in 2012) in addition to payments for research and teaching (total contribution in 2012 – over $200M).</td>
</tr>
</tbody>
</table>
| Management of Risk                     | • UPMC Health Plan enrolls 2.1 million beneficiaries, including 110,000 MA beneficiaries.  
• MA Plans: UPMC is using MA as a vehicle to move toward greater capitation. Currently there are still non quality-based insurance plans, but UPMC is moving toward greater quality-based payments.  |
| Scale                                  | • UPMC recognizes that despite its current size, it will need fewer hospital beds in particular areas.  
• Expanding in the local/regional market and growing its international business, and its subsidiary enterprises, are seen as critical for UPMC.  |
| Primary Care Network Development       | • UPMC includes Community Medicine, Inc. - a 501(C)3 organization that is a consolidation of 100 community-based practices (mostly primary care). These physicians complement existing UPMC faculty physicians. A common MSO is in place for the FPP and CMI to supply physician services.  |
| Data Analytics & Performance Measurement| • UPMC is developing an enterprise “big data” warehouse with an integration layer, including genomics, that creates a single source of information across systems, allowing for complete integration.  
• Financial and quality performance metrics are transparent across all organizations and shared broadly.  
• Motto – “Smart technology and good science make good patient care.”  |
### Cost Management/Quality of Care

<table>
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<tr>
<th>Characteristic</th>
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<tbody>
<tr>
<td>UPMC Health Plan contracts</td>
<td>• UPMC Health Plan contracts with primary care providers using a PCMH/shared savings arrangement. Specialty physicians are incentivized to develop high quality, lower cost services as PCPs will gravitate toward specialists who are low cost and high-quality.</td>
</tr>
<tr>
<td>UPMC Primary Care Practices</td>
<td>• Specialists are developing clinical pathways and other tools to improve quality and lower costs.</td>
</tr>
<tr>
<td>Referrals to High-Performing</td>
<td>• Specialists are incentivized by referrals; primary care physicians incentivized through shared savings targets.</td>
</tr>
<tr>
<td>Specialists</td>
<td>• Both primary care physicians and health plan benefit financially.</td>
</tr>
</tbody>
</table>

UPMC Primary Care Practices: Supported by the UPMC Health Plan

- Supported By Plan Resources
  - Disease Managers
  - Lifestyle Coaches
  - Behavioral Health
  - Health Plan
  - Disease Registries
  - Care Plans
  - Plan Pharmacists
  - Case Review Committees

- Practice Based
  - Care Manager
    - Goal: Increase practice health care team collaboration.
    - Focus: Assisting practices in meeting target goals for Shared Savings Program

- Supports: Physicians Health Care Team and Members
  - Educates patients on conditions
  - Prepares patients for visits, reviews meds, etc.
  - Devises member self-management plans
  - Informs physician of care gaps, orders needed, important updates

- Referrals to High-Performing Specialists
  - Specialists are developing clinical pathways and other tools to improve quality and lower costs.
  - Specialists are incentivized by referrals; primary care physicians incentivized through shared savings targets.
  - Both primary care physicians and health plan benefit financially.
<table>
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</thead>
</table>
| Education, Research, & Innovation    | • The SOM is beginning to build into the curriculum instruction on efficient models of care and will get cost information into the hands of students.  
• UPMC will focus on Precision (Personalized) Medicine and through its strong partnership with the SOM, UPMC believes that it can move to a prevention/personal and population health management approach to care delivery. A 340,000 square foot Institute for Personalized Medicine is slated for a 2016 opening.  
• UPMC/SOM are discussing scope of practice and have as their focus the creation of inter-professional care teams. |
| Open Architecture – Engaging with community providers | • UPMC employs different contracting vehicles to develop relationships with community providers including primary care/specialty physicians (Community Medicine, Inc.). In addition, UPMC continues to develop and expand on its more than 17 “Community Provider Services” agreements with SNF, home care, and ambulatory rehabilitation providers. |
VUMC Health

Profile Takeaways

- VUMC is developing a system-based approach to care delivery, collaborating with a network of affiliated hospitals and physicians focused on driving patient outcome improvements and overall cost reductions across sites of care.
- VUMC’s excellence, breadth and depth in informatics and information technology provides an integrating information platform for the sharing of data and best practices across participating affiliated institutions.
- VUMC has a common Executive Incentive Plan for ~200 members of leadership across all three missions, with 18 specific measures across the institution’s “Five Pillars of Excellence” that drives all leaders toward a common future state for the enterprise.

Interviewees:
- Jeff Balser, Vice Chancellor for Health Affairs, Dean of the School of Medicine
- Luke Gregory, CEO, Monroe Carell Jr. Children's Hospital at Vanderbilt

Profile Completed on November 1, 2013
**Mission & Goals**

**Mission:** Vanderbilt University Medical Center aspires to shape the future of health and health care.

**Goals:**
- Constantly innovate a healthcare services model that is systems-based and personalized to each individual.
- Create learning systems that produce leaders who learn in ways that match the next generation health care systems and pace of research discoveries.
- Nurture fundamental discovery and create a translational discovery architecture with national and global scale.
- Build and demonstrate a sustainable economic model for health and health care.

**Market Situation**

- VUMC’s primary service area is the 8 counties surrounding Nashville; secondary service area is the entire middle TN region (36 additional counties).
- Primary and Secondary service area inpatient market share: 16.2%.
- **Three** major competitors in service area:
  - Ascension – St. Thomas Midtown Hospital – 8.1%
  - HCA Centennial Medical Center - 7.9%
  - Ascension - St. Thomas West – 7.6%
- Market has several for-profit healthcare companies, many with their national headquarters based in Nashville (e.g., HCA, Community Health Systems, LifePoint)

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**VUMC**, an administrative division of Vanderbilt University, is the integrated entity that includes all clinical activities of the hospitals, outpatient clinics, and faculty practice plan, as well as the Schools of Medicine and Nursing.

*2012 Q1 Inpatient Market Share, Middle Tennessee Region

Source: Vanderbilt Website; Official Statement, Vanderbilt University, Health and Educational Facilities Board of Nashville, Revenue Refunding Bonds.
VUMC Health

### Integrated Governance

- All clinical services are organized under VUMC, as well as the Schools of Medicine and Nursing, reporting up to the Vice Chancellor for Health Affairs.
- Core leadership team meets weekly in a business plan review sessions, and monthly in other settings. Also utilizes quarterly retreats and coaching sessions to maximize collaboration.
- All strategic projects are vetted using a **common** set of metrics, allowing for a transparent decision-making process for major strategic decisions across all missions.
- VUMC has centralized its primary administrative support functions including IT, finance, HR, planning, space management, and supply chain.

### VUMC Governance & Organization Features

#### Core Team

- Deputy Chairs
- Deputy VC for Health Affairs, Adult and Children’s Hospital CEOs
- Associate VC for Administration
- Associate VC for Finance
- Associate VC for Health Science Education
- Associate VCs for Research (Basic, Clinical, Public Health)
- Associate VC for Faculty Affairs/Compliance
- Associate VC for Strategy and Informatics
- Associate VC for Human Resources

---

**Vanderbilt University Board of Trustees**

**VU Chancellor**

*Nicholas S. Zeppos*

**Vice Chancellor for Health Affairs and Dean of Medicine** *(Jeff Balser)*

**Deputy Vice Chancellor for Health Affairs**

*Wright Pinson*

**CEO, Children’s Hospital & Outpatient Clinics**

*Luke Gregory*

**CEO, Adult Hospitals & Outpatient Clinics**

*David Posch*

**Chiefs of Staff (adult, children), Chief Medical Officer, Executive Chief Nursing Officer**

**School of Medicine Departments and Centers**

**School of Medicine UME, GME, CME**

**Administration, Compliance, Strategy and Informatics**

**School of Nursing**
VUMC Health Strategic Plan Framework

VUMC is focused on 4 major areas of change as part of their overall organization strategy:

- **Consolidation and Standardization**: Relentlessly cutting redundancies and other inefficiencies to reduce operating costs
- **Re-Engineering**: Systematically redesigning processes to simplify, reduce waste, and reduce error
- **Scale**: Developing a system that can increase in volume with minimal increase in variable cost
- **System Innovation from Discovery**: Identifying opportunities to increase the measureable quality, while increasing the number of individuals being helped and reducing the unit cost, fed by a research engine

VUMC Health

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Features</th>
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<tbody>
<tr>
<td>Compensation &amp; Incentives</td>
<td>• VUMC has a common Executive Incentive Plan for approximately 200 members of VUMC leadership across all three missions.</td>
</tr>
</tbody>
</table>

Executive Incentive Plan

• Once-per-year bonus for approximately 200 members of VUMC leadership across all three missions
  • Vice Chancellor and his direct reports
  • All Department Chairs
  • Heads of all major operating units, e.g. Hospital & Clinic, School of Medicine

• Incentive plan consists of 18 measures across Five “Pillars of Excellence” that define the institution’s overall mission and direction. Each metric maps to specific strategic goals for the enterprise, detailed in their strategic plan

<table>
<thead>
<tr>
<th>People</th>
<th>Quality</th>
<th>Growth &amp; Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Turnover</td>
<td>• Publication citation count</td>
<td>• Operational revenue</td>
</tr>
<tr>
<td>• Resident pool diversity</td>
<td>• External awards/honorary society</td>
<td>• Expense reduction</td>
</tr>
<tr>
<td>Service</td>
<td>• % new patients seen within 15 days</td>
<td>• Development funds</td>
</tr>
<tr>
<td>• % new patients seen within 15</td>
<td>• Team work</td>
<td>• Sponsored research</td>
</tr>
<tr>
<td>days</td>
<td>• Timely completion of clinical summary</td>
<td>• Prioritize use of restricted funds</td>
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• Metrics are assigned for each with target and “Reach” goals, updated annually. Bonuses paid out across three levels based on base compensation. Plan is not funded until Hospital reaches budgeted margin.
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<th>Characteristic</th>
<th>Features</th>
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</table>
| Fiscal Transparency         | • Hospitals and the clinic send money to the departments through the VUMC funds flow model, allowing for some strategic investments by department chairs.  
• Finances for the entire medical center are structured under a single CFO.  
• VUMC utilizes its “Numbers Day” approach for providing complete operating and financial information to leaders across the institution.                                                                                                                                 |
| Management of Risk          | • The Nashville provider market has very little risk assumption currently.  
• VU Health Plan (47,000 members): Fully self-insured group. Group has active patient management on the pediatric side through a community IPA contracted with the University. This group is modeled after the PCMH and providers are on shared-savings contracts.  
• VUMC plans to offer a product to large employers based on their health plan model and through leveraging their analytics capability.                                                                                                                                 |
| Scale                       | • VUMC defines scale objectives in the following way: If the volume it handles can be increased with minimal increase in variable cost, or, cost per use increases much more slowly than the number of uses.  
• **Vanderbilt Health Affiliated Network**: 7 systems, all with an identified need for a partnership with a T/Q service provider. Vanderbilt is leading the development of this network with the goal of a Clinically Integrated Network in the future, with VUMC as the T/Q provider.                                                                 |
| Cost Management/Quality of Care | • Nashville has a high % of for-profit providers competing for payer preference.  
• VUMC continues to leverage its informatics capabilities to improve care processes, improve patient outcomes, and lower the total cost of care.  
• VUMC measures its ability to control costs and improve care quality annually against the 5 goal categories included in the compensation plan: People, Service, Quality, Growth and Finance, and Innovation.                                                                 |
VUMC Health

<table>
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<tr>
<th>Characteristic</th>
<th>Features</th>
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<tbody>
<tr>
<td>Primary Care Network Development</td>
<td>• Limited primary care capacity currently (adult), but are working through their Vanderbilt Health Affiliated Network to improve capacity.</td>
</tr>
<tr>
<td>Data Analytics &amp; Performance Measurement</td>
<td>• VU has the largest biomedical informatics team in academic medicine (VU Informatics Center), built by physicians with clinically oriented focus areas. Several Medical Center focused projects/initiatives including clinical systems management, educational informatics, enterprise clinical decision support, information systems, and IT integration are underway.</td>
</tr>
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Informatics CENTER

Vision Statement

To create a completely transformed health care system whose information and information resources are completely integrated with a seamless flow of clinical and research information to support education, clinical care and research.

Goals

1. To achieve the maximum beneficial use of information and information technology in support of VUMC’s missions and strategic directions
2. To define and articulate information technology architectures that treat information as a shared resource while permitting distributed processing. (Decrease complexity by ensuring that strategy and the technological architecture are in alignment.)
3. To create a leading edge information technology infrastructure.
4. To enable changes in the practice of patient care, research, and education.
5. Establish Vanderbilt University as one of the best biomedical informatics programs in the U.S, by establishing and growing the biomedical informatics MS/PhD program.

Center Units/Projects

• Dept. of Biomedical Informatics
• Information and Consultation Services
• Support for Medical Center Operations
• Vanderbilt Center for Better Health
## VUMC Health

<table>
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</table>
| **Education, Research, & Innovation**       | • **Education**: SOM has developed “Curriculum 2.0” – a transformed MD curriculum which has a major focus area training in the understanding and utilization of all information resources available to clinicians in daily practice.  
• **Research**: Large number of centrally managed shared resources/core facilities have been developed where there is a need for specialized equipment, centralized services or produced distribution, allowing for lower cost service delivery. These include centrally managed facilities. |
| **Open Architecture – Engaging with community providers** | • The Children’s Hospital is an “Open panel” hospital. 400 community faculty in addition to the university faculty have admitting privileges.  
• **Vanderbilt Health Affiliated Network**: A wholly-owned LLC clinically integrated network of hospitals and physician groups.  
  • Goals: 1) Rationalize sites of care within the network; 2) Make sure patients land at the right sites of care; 3) Share best practices including pathways and other tools.  
  • 18 hospitals from six affiliates with more than 3,000 inpatient beds and 3,000 physicians.  
  • Currently manage the over 70,000 employees of the network members who are self-insured.  
  • Network is offered as an insurance product by Aetna, and the Network is seeking to work directly with large employers on health plan design and provider accountability.  
  • Network is working toward clinical integration over the next 12 months, with shared medical records and shared programs of quality and disease management. |
Develop New Support Methods to Drive Quality and Efficiency

- New organizational forms and governance structures are improving coordination, along with a focus on communication among affiliates
- Single, virtual medical records are in development allowing authorized providers to access patient data regardless of site of care, and drive best practices with guidance toward common quality metrics between all affiliate members

Demonstrate Improvements in Clinical Outputs and Lower Costs

- Affiliates ensure that every provider practices at the top of their license, every provider facility runs at capacity managing the types of conditions to which it is best suited, and every patient receives the best care possible
- Network hopes to demonstrate significant cost and quality improvements over time and develop new network products for purchasers

Develop Relationships

- Focus on complementary hospitals and practitioner communities who are committed to high quality clinical care (currently 18 hospitals from six affiliates)
- Affiliates are given preferred provider status in each other’s health plan’s for employees, and the Network currently manages the self-insured lives of all members
- Plans share infrastructure to drive down administrative costs, and the affiliates work together as a network for other employers

UCLA Health

Profile Takeaways

• The formation of “UCLA Health” has driven health system integration activities, with structural governance and organization that drives integrated strategic decision making around population health, system development, and FPP integration.

• UCLA’s primary care network development strategy is sophisticated, with over 200 clinical FTEs, and a future strategy for growth currently being executed.

• UCLA has over 100,000 patients in some form of risk arrangement, managed through the FPP infrastructure.

Interviewees:

• David Feinberg, President, Health System & CEO, UCLA Hospital System

• Patricia Kapur, Executive Vice President, Health System & CEO, UCLA Medical Group
**UCLA Health Mission & Vision**

**Mission & Vision**

*Our mission is to deliver leading-edge patient care, research, and education.*

*Our vision is to heal humankind, one patient at a time, by improving health, alleviating suffering and delivering acts of kindness.*

The organizational “True North” for UCLA Health, determined by faculty, researchers, staff: deliver Patient Centered Care in all settings. This focus informs and energizes the clinical services, research endeavors, and educational experience.

**Market Situation**

Sprawling urban market of 10M people
- Kaiser only county-wide system
- Strong sub-regional organizations such as Cedars Sinai, USC, & Providence but no county-wide system formation - yet
- Well established IPA physician groups continue to grow rapidly;
- Intensive competition to acquire/employ physicians in the most attractive areas
- Many independent hospitals which are struggling and likely to be consolidated
- UCLA building its network into the South Bay, San Fernando Valley, and downtown LA

Formation of **UCLA HEALTH** as the platform for the development of a region-wide health system, with commitment to implementing population health, engaging with the community, and delivering patient centered care.
**Integrated Governance**
Have established “UCLA Health” with a non-fiduciary Board of Overseers and integrated Health System leadership team accountable to System President. UCLA is recruiting Chairs for the new Vision, committed to population health, large scale system development, and an integrated group practice.

**UCLA Health Governance & Organization Features**

**HSOT Functional Representatives**
- **Health System President**
- **CEO, Faculty Group Practice**
- **Chief Strategy Officer**
- **Dept. Chair Representative**
- **Chief Operating Officer**
- **Chief Quality Officer**
- **Chief Financial Officer**
- **Chief Innovation Officer**
- **SVP, HR/Communications**
- **Population Health Rep.**
- **Chief Information Officer**
- **Chief Legal**

**Health System Board of Overseers**
Overall governance and long-term strategic direction

**Health System Executive Group**
Exec. Leaders responsible for Health System; meets weekly

**Health System Operations Team**
Responsible for executing and implementing the strategy of the UCLA Health System.

**Strategy and Services Council**
Advises the HSOT “All clinical initiatives go through this group”

Includes all Dept Chairs; 9 at large elected, plus the Medical Directors of the three physician networks ex-officio non-voting
UCLA 2013 Management Structure

President University of California

Chancellor UCLA (G. Block)

Vice-Chancellor Health Sciences & Dean SOM (G. Washington)

UCLA Board of Overseers (7 Member Board)

Executive VP & President UCLA Medical Group (P. Kapur)

Chief Innovation Officer (M. Coye)

Enterprise Functions (Legal, IT, HR, Compliance)

“Chair of Chairs” (M. Steinberg)

Executive Vice Dean SOM (J. Mazziotta)

President UCLA Health System (D. Feinberg)

Health System Strategy & Clinical Services Council (Chairs and Administration)

FPG Board

Health System Functions
- Quality
- Strategy/Network Development
- Population Health

UCLA Medical Center Administration

Source: G. Washington, D. Feinberg Interview
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Features</th>
</tr>
</thead>
</table>
| Fiscal Transparency      | Integration is underway but remains limited. Plan is for Health System to be financially integrated in FY2017 including: hospitals, Medical Group, Department clinical services.  
FPG Fees today:  
• Billing & Collections Fee is 6.2%  
• Support Services Fee is 2.4% |
| Compensation & Incentives| • Health System President has incentives for success of Medical Center and Medical Group.  
• Departments retain individualized compensation plans, with some limited coordination developing as integrated practice units.                                                                                                         |
| Access to Capital        | • UCLA is re-directing internal ad-hoc transfers between the Medical Center and Departments. The Practice Group is prioritizing funds which are invested in projects such as integrated practice units based on ranking and competitive evaluation by the Practice Group.                                      |
| Management of Risk       | • Integrated contracting for professional fees and facilities under one team.  
• A unified Health System facilitates partner and affiliation models through single negotiation & one contracting entity  
• UCLA Health has approximately 100,000 patients with some form of risk: ACO, Medicare Advantage, delegated risk, and subcapitation  
• This is managed through the FPG infrastructure with utilization management, prior authorization, etc. A small but effective infrastructure as the contracts have been successful to date. |
<table>
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<tr>
<th>Characteristic</th>
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</thead>
<tbody>
<tr>
<td>Scale</td>
<td>Target is accountability for 2M lives. Will require UCLA Health being a regional system, likely with partners.</td>
</tr>
</tbody>
</table>
| Primary Care Network Development | UCLA has been developing its primary care network for a long time. Includes approximately 200 FTE PCPs. Goal is “every 4 miles 4 PCPs” plus a 50,000 sq ft hub within 15 miles (advanced specialty offices, procedure rooms, imaging, lab services). Locating PCPs in competition with IPA’s and groups that have been referring. Funds for development have come from Medical Center and from the Dept of Medicine, underpinned by oncology network. The portfolio includes:  
• Santa Monica Group  
• CPN – Community Physician Network  
• Dept. of Medicine Primary Care  
• All PCPs are given Asst. Prof appointments in clinical track with teaching expectation. Faculty without step – getting some pushback from Provost.  
• PCPs at 75% of MGMA non-academic productivity. Have been able to make the economics work by improving productivity and increasing rates.  
• Approx. 25 offsite practices are organized distinctly and run with a dedicated management structure, distinct but under the FPG, and paid for by the FPG, with the exception of Dept. of Medicine, which is also distinctly run. These are increasingly becoming integrated. FPG management resources include:  
• 1 leader for ambulatory services  
• 3 practice leads  
• Also beginning to recruit specialists for off-site practices e.g. Neurology, Gynecology, ENT, Podiatry, Gen Surg. Funding for the development is from Health System. |
## UCLA Health

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<th>Characteristic</th>
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| Open Architecture – Engaging with community providers | Have completed initial development work for a clinically integrated network with community based clinicians. Three levels of integration:  
  • Financial – physicians adopt a fee schedule provided by UCLA Health; these are patients enrolled under UCLA Health contracts. The physician may still own their own practice, employ their own staff.  
  • Quality – must agree to participate in UCLA Health quality improvement efforts including protocol roll-out and quality reporting  
  • Information – must be on UCLA EPIC system |
| Data Analytics & Performance Measurement | • Quarterly financial and activity performance report includes hospitals, FPP, and aggregated departmental results. Shared with all Chairs and Health System leaders.  
  • Recruiting Health System Chief Quality Officer and will be integrating quality across all clinical services. |
| Cost Management/Quality of Care         | • Targeting 30% reduction of the total cost of care by attacking excess utilization and using analytics and data to accomplish.  
  • Are focused on service standards. Have recently implemented same day appointments for any patients that want it. Standard greeting is now: “Hello, this is UCLA Health, would you like an appointment today?”. Implementing uniform look and feel at all departmental clinics. Discussing a unified call center. |
| Education, Research, & Innovation      | • Have established Office of Innovation and initiated multiple programs to enhance application and dissemination of best practices and accelerate innovation in the Health System. |
Cleveland Clinic

Profile Takeaways

- The Cleveland Clinic “Institute Model” has driven fiscal integration and unified decision-making by strategic service lines, eliminating many barriers of the traditional department-based model.
- Cleveland Clinic is focused heavily on developing its “Cleveland Clinic Integrated Care Model,” a patient-centered, continuum-based approach that leverages appropriate use criteria, care paths, and evidence-based medicine to treat patients in the right settings with the right treatments by the right providers.
- Cleveland Clinic is leveraging its brand and unique capabilities in a variety of ventures:
  - Offering products to purchasers nationally, acting as a “destination” center for complex, yet relatively routine procedures
  - New strategic sourcing joint venture, Excelerate, with VHA focusing on physician preference items
  - Commercialization infrastructure through Cleveland Clinic Innovations
  - Health system development internationally

Interviewees:
- Ann Huston, Chief Strategy Officer
Mission, Vision & Values

**Mission:** To provide better care of the sick, investigation into their problems, and further education of those who serve.

**Vision:** Striving to be the world’s leader in patient experience, clinical outcomes, research and education.

**Values:** Quality, Innovation, Teamwork, Service, Integrity, Compassion

Unique Model

- Medical group that runs a health system
- Physician leadership
- High degree of physician alignment and strong culture of collaborative practice
- Organized as multi-disciplinary clinical Institutes, e.g., heart & vascular, vs. traditional departments
- Employed and independent physicians
- Staff physicians have a straight salary, one-year contract and an annual professional review

Positioning

- National and international referral center
- Direct care provider and population manager for the communities served
- Innovative academic center
- Clinical integrator
- Consultant and services provider
Overview

- U.S. News & World Report consistently names Cleveland Clinic as one of the nation’s best hospitals.
- Cleveland Clinic Health System has revenues of $6.2 billion, and includes the main campus in Cleveland, eight community hospitals and 18 Family Health Centers in Northeast Ohio, and facilities across the US and abroad.
- Cleveland Clinic employs over 3,000 professional staff.
- 75% of patients generate from NE Ohio, 18% from other states, and 1% from over 100 countries.
- In 2012, Cleveland Clinic provided more than 1 million same-day visits.
- Tuition-free, five-year Cleveland Clinic Lerner College of Medicine focused on training physician investigators.

Current Market Approaches

- Cleveland Clinic has leveraged its core capabilities and brand through a variety of strategic relationships such as:
  - Direct to national employer contracting, offering bundled products as a destination center for complex, yet-relatively routine procedures
  - Cleveland Clinic Innovations, providing commercialization infrastructure
  - Branded clinical affiliations in heart & vascular, neurosciences, cancer
  - Founding member of National Orthopedic & Spine Alliance
  - Quality Alliance, the third largest clinically integrated network in the U.S., extending its clinical integration services to non-Cleveland Clinic providers
  - Excelerate, a strategic sourcing joint venture with VHS, leveraging proven methodology for physician preference items
In 2007, Cleveland Clinic CEO Toby Cosgrove set out to reorganize all services at the main campus into multidisciplinary teams, organized from the patient perspective and defined around disease and organ systems, called Clinical Institutes. Special Enterprise and Expertise Institutes offer centralized services across all Clinical Institutes.

**Clinical Institutes**

- Eye
- Dermatology and Plastic Surgery
- Digestive Disease
- Emergency Services
- Endocrinology and Metabolism
- Urological and Kidney
- Head and Neck
- Heart and Vascular
- Medicine

- Neurological
- OB/Women’s Health
- Respiratory
- Cancer
- Wellness
- Pediatrics and Children’s Hospital
- Orthopedic and Rheumatologic

**Each Institute has defined:**

- Diseases within scope
- Set of shared outcome measures for which the team would be accountable
- Skills needed to be brought together to care for patients with the sets of conditions in the Institute

**Institute Characteristics:**

- Shared physician revenue
- Singular compensation model
- Multidisciplinary centers that address specific conditions within Institutes

**Special Enterprise Institutes:** Laboratory and Pathology, Imaging, Quality and Patient Safety, Nursing, Education, Wellness, and Anesthesiology (with specialized sections)

**Special Expertise Institutes:** Patient Experience, Legal, Finance, Marketing, and Human Resources providing support services to all care delivery institutes

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<tr>
<th>Characteristic</th>
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<tbody>
<tr>
<td>Integrated Governance</td>
<td>• “One Cleveland Clinic” – integrated enterprise-wide governance</td>
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<td></td>
<td>• Physician leadership very prominent in both line operations and key initiatives</td>
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**Cleveland Clinic Governance**

- **Board of Directors**
  - 25-member fiduciary governing body
  - Community leaders selected for needed expertise and experience
  - Four physician members of Professional Staff.

- **CEO Cleveland Clinic**
  - Convenes weekly
  - Key decisions

- **CEO Council**
  - Key decisions
  - CEO
  - Chief of Staff
  - CFO

- **Clinical Enterprise Management**
  - Leaders from all aspects of clinical enterprise
  - Defines and oversee implementation of clinical enterprise strategy

- **Board of Governors/Medical Executive Committee**
  - Responsibility for standards of medical care and overseeing the clinical activities of Cleveland Clinic.
  - Oversees appointment, promotion, and termination of members of professional staff in conjunction with department chairs.

- **Executive Team**
  - Executive leadership
  - Communications vehicle
  - Advisory to CEO

- **Executive Team**
  - Chief Strategy Officer
  - Chief of Operations
  - Chief HR Officer
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| Fiscal Transparency                   | • Single enterprise balance sheet  
• Payer contracting aligned with clinical enterprise |
| Compensation & Incentives             | • 3,000 employed faculty: 1 year salary contract. Reviewed annually (not just by the chair) relative to various categories of performance such as access, physician communication, productivity, citizenship, etc. |
| Management of Risk                    | • Focused intensely on developing its “Cleveland Clinic Integrated Care Model” that yields a comprehensive, continuum-wide system of care. Entails care paths, care coordination model, real-time data, and predictive analytics  
• Now moving into risk-based contracts |
| Scale                                | • Pursues organizational objectives through ownership and strategic partnerships  
• Selective in ownership of hard/physical assets |
| Primary Care Network Development     | • Primary care network growing, but relatively small given historic focus on specialty care  
• All practices certified Patient Centered Medical Homes; practice transformation in process |
| Open Architecture – Engaging with Community Providers | • Cleveland Clinic Integrated Care Model contemplates mature relationships with continuum providers  
• Relative to community partners, most active work relates to post-acute care space |
Cleveland Clinic Network

“One Cleveland Clinic” Principles:
1. Enterprise strategy, unified culture and operating policies and procedures
2. Fully integrated corporate/administrative services, including call center
3. Focus on developing the right sites of care across the service area: most acute care at main campus; distributed and rationalized services among regional hospitals to ensure access, quality and lower cost
4. Consistency and integration of care paths, common EMR, outcomes reporting, medical staff needs planning, and purchasing across the enterprise
5. Local accountability and management for facilities with clear alignment to enterprise strategy and goals

- In the local and regional market, the Clinic is linking with organizations to solidify its standing in the Northern Ohio market.
- Cleveland Clinic Florida: Major operation in Weston, FL
- Lou Ruvo Center for Brain Health in Las Vegas – research and treatment
- Expanding its affiliate programs in heart & vascular, orthopaedics & spine, neurosciences and cancer with institutions and physician groups across the country
- Also expanding its “Destination program” offerings to purchasers to treat discrete T/Q conditions
- Expanding its national telemedicine offerings including on-line second opinion services called MyConsult.
- Executive health and wellness service in Toronto, Canada.
- Manages 750-bed hospital, Sheikh Khalifa Medical City
- Under construction: Cleveland Clinic Abu Dhabi – a 360-bed hospital and outpatient clinic that is being built as true Cleveland Clinic model
- Contact centers in various countries

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| Data Analytics & Performance Measurement | • Cleveland Clinic Integrated Care Model: Apply data to practice to reduce clinical variation and cost; includes evidence/experience-based care paths with emphasis on appropriateness criteria where relevant  
• Integrated medical record with a single common data warehouse organized longitudinally by patient |
| Cost Management/Quality of Care      | • Transparency at the physician, Institute, and the overall enterprise level  
• Recently announced multi-year, $330 million cost reduction target based on long-term financial forecast. Cost repositioning initiative one of eight initiatives in strategic plan. Examines all aspects of the cost structure.  
• “State of the Clinic” annual reports detail medical outcomes for the established institutes.  
  • Each institute charged with defining “good care” in their institute and what outcomes measures could be measured to show quality and a high-level patient experience.  
• Cost analyses are continuous, supported by data on process standardization, patient experience, clinical outcomes, safety, and access that enables data-driven discussions.  
  • Clinic leaders meet with institute staff to share information about the costs of supplies and services. Armed with this information, institute managers can make informed decisions and standardize the use of equipment and other elements across the institute to drive down costs.  
• Excelerate: new strategic sourcing (supply chain) joint venture with VHA leveraging successful methodology in physician preference items |
| Education, Research, & Innovation    | • Strong academic brand absent traditional university infrastructure and dynamics  
• Strong history and capability in innovation and commercialization. Cleveland Clinic Innovations hold over 525 patents and nearly 70 spin off companies |
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 managing 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
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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<tr>
<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

Senior Vice President, Network Development

Senior Vice President and Chief HR Officer

Senior Vice President and CMO

Senior Vice President, Operations

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

Department Chairs

VP, Strategic Planning
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## Montefiore

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<th>Characteristic</th>
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<tr>
<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>
</tr>
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</table>
| 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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<tr>
<td><strong>Scale</strong></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 the larger health system financial report.</td>
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</tbody>
</table>
| **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. |
<p>| <strong>Provider Network</strong>           | 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. |
| <strong>Access to Capital</strong>          | Critical for growth but anticipate that there will be limits as determined by the success of systems operations. |</p>
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| Health Information Technology      | • Montefiore spearheaded efforts to collaborate with other health systems in the Bronx around data-sharing.  
• 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. |
| Architecture                        |                                                                                                                                                                                                                                                                                                                                            |
| Data Analytics & Performance        | • 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.  
• 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. |
| Measurement                         |                                                                                                                                                                                                                                                                                                                                            |
| 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.                                                                                                                                                     |
UAB Health System

Profile Takeaways

• UAB has developed a funds flow model that distributes clinical revenue from the hospital and the FPP through a centralized leadership group, setting a portion aside for a strategic growth fund with a centralized governing body responsible for overseeing and administering the funds flow model.
• UAB is a data-drive organization with physicians seeing all data at the department-level. Quality and patient satisfaction data are shared broadly and departments are scored on specified metrics that drive accountability and best practice adoption across the enterprise.
• Given its status in AL as the singular major complex care provider and trauma center, UAB is partnering with local hospitals to assist in improving quality, efficiency, and operations, and are focused on targeted network development in specific service lines extending into other states.

Interviewees:
• Anupam Agarwal, Senior Vice President for Medicine and Dean, School of Medicine
• Jim Bonner, President, University of Alabama Health Services Foundation
UAB Health System

Mission & Vision

Mission: To improve the health and well-being of society, particularly the citizens of Alabama, by providing innovative health services of exceptional value that are patient- and family-centered, a superior environment for the education of health professionals, and support for research that advances medical science.

Vision: We will create highly innovative, well-coordinated interdisciplinary services and partnering relationships that serve as a model for health education and service delivery.

Market Situation

- UAB is in an advantageous position as the only level 1 trauma center in Alabama, drawing patients from bordering states and the only comprehensive cancer center in the region.
- UAB recently opened a new cancer center facility and has cancer affiliates in GA, FL, and AL.
- UAB has partnered with local hospitals in other areas to assist in improving quality, efficiency, operations as Affiliates and Associates in broad and specialty specific areas.

Formation of UAB Medicine recognizes that the future of academic medicine and the focus of UAB has to be on survival in value-based care delivery and value based reimbursement. The Health System, Faculty Practice, and SOM are all thinking about what that means to them collectively, under “UAB Medicine”
UAB Health System

UAB’s strategic plan, “AMC21” details how UAB will position itself for success in the 21st Century healthcare and academic world:

**AMC21**
Create the Preferred Academic Medical Center of the 21st Century

**Preferred For:**
- Delivery of Outstanding Patient Care
- Scientific Discovery & Biomedical Research
- Teaching & Training Professionals

**ALIGNMENT AND INTEGRATION**
- Implement enterprise-wide funding
- Improve internal communication
- Promote leadership development
- Align support functions
- Expand centers and institutes
- Expand enterprise-wide collaboration
- Advance signature programs & cross cutting platforms

**INNOVATION**
- Promote a culture of innovation
- Fund pilot projects through the Innovation Board
- Develop innovation in translational science
- Implement Innovation curriculum
- Pilot projects for highly innovative science

**REACHING FOR EXCELLENCE**
- Implement organizational evaluation system
- Develop skills and leadership competency
- Utilize engagement tools to foster improvement
- Hire and retain top performers
- Standards and processes
- Align every level to mutual goals

**SATISFACTION**
- Build a service-oriented culture
- Build and reward teaching and research excellence
- Improve and expand access
- Enhance communication among faculty, staff, and patients
- Assess curricula and expand training programs
- Create a workplace that promotes communication, recognition and empowerment

**QUALITY**
- Provide care that is accessible, timely, and coordinated
- Recruit high caliber trainees
- Coordinate care delivery- engaging faculty, staff, patients and families
- Enhance skills training for students and residents
- Provide effective care that adheres to science-driven, evidence-based guidelines

**FINANCIAL**
- Recruit and retain faculty to support signature programs
- Expand philanthropic funding and investment
- Meet or exceed financial targets
- Achieve strategic growth goals
- Expand value-added partnerships and build sustainability
- Increase and diversify research funding

**ADVANCEMENT OF KNOWLEDGE**
- Enhance the integration and transfer of knowledge
- Expand collaborative research and education models
- Support and expand teaching and research infrastructure
- Develop new capacities in translational science and experimental therapeutics
- Integrate new, emerging disciplines into curricula
## UAB Health System

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| Integrated Governance   | • The UAB Health System is the entity created to jointly manage UAB Hospital and health system, University of Alabama Health Services Foundation, but not the SOM. The SOM and the UAB hospital are members of the UA System (University).  
• Joint Operating Leadership: Governance of three entities and decision making processes has been critical to the ability of UAB to be nimble, supportive of each other, and in developing world class clinical care, teaching, and research. Unified decision-making strongly facilitates collaboration among the components of UAB Medicine.  
• A new COO position has been created that will oversee all clinical services – ambulatory and hospital. Will be filled by an existing VP who is liked and respected by physicians. This is seen as being instrumental to getting folks on board with integration across the two entities.  |

### Joint Operating Leadership.
- CEO Health System
- Practice Plan President
- Dean of Medical School
- All have equal powers involving decisions that affect each. All major decisions are made by the Joint Operating Leadership

Ex Officio Members
- Chancellor of UA System
- Vice Chancellor Fin. Affairs
- President of UAB
- Dean of the School of Medicine

![Diagram of UAB Health System ](attachment:diagram.png)
UAB Health System

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<td>Fiscal Transparency</td>
<td>• Currently in the clinics, physicians pay for the cost of running their clinics. A new funds flow process is being implemented (below). All collections from the FPP and hospital will be combined and then will be reimbursed for faculty based on an RVU driven model and meeting quality and efficiency metrics. All direct and indirect expenses will be paid centrally. There is also a sharing-in-success component on the operating margin. Chairs will then distribute throughout their departments. A Separate committee at UAB will monitor the funds flow model.</td>
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**UAB Medicine Clinical Revenue**

- Direct clinical hospital and ambulatory expenses (with the exception of expenses covered by service agreements or contracts)
- Indirect expenses

**Monitored by Funds Flow Oversight Committee (FFOC)**

- Joint Operating Leadership
- CFO of UAB Health System
- CEO of UAB Hospital
- Executive Vice President of HSF
- Senior Associate Dean for Administration and Finance of SOM
- 4 Clinical Chairs selected by HSF Executive Committee
- 2 Non-voting Faculty Members

**Clinical Revenue**

- Payments to each Department based on work RVUs (70 percent of MGMA national median), with limited exceptions
  - Departmental compensation plans subject to FFOC approval
  - FFS RVU model. Risk determined by individual contracts
  - Direct clinic expenses (with savings targets and incentives built into budgets)
  - Physician benefit costs related to clinical activity
  - Malpractice insurance expenses
  - Indirect expenses

**University of Alabama HSF**

- % of Revenue
- % of RVU payments

**Triton/VIVA**

- % of Funding

**School of Medicine**

- % of State Allocation

**Strategic Growth Fund**

- % of Revenue
- % of RVU payments

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</table>
| **Compensation & Incentives** | Incentive compensation for chairs and all UAB Medicine leadership helps to drive organizational unity and shared-goals is in place. The at-risk compensation plan is up-side only.  
- 10% at risk for chairs, if they meet certain benchmarks tied to the system and the school.  
- 50% of goals are aligned between the school and the health system. Both are reliant on each other. For each department chair, they have metrics that tie to all three missions  

Faculty compensation is aligned with health system: Clinical activity is 60-70%, research is 15%. Some departments are seeing a decline in revenue and are having total compensation discussions that may affect raises. UAB believes they need to have frank conversations about adequate and comparable compensation. A committee has been established to set compensation plan principles and approve all compensation plans.  

A new chair evaluation system has performed well, with evaluations done with the input of the Health System, UAB, the SOM, and the JOL. |
| **Scale**                     |  
- UAB is the only major medical center and Level 1 trauma center in the state. They don’t have much competition for complex comprehensive care and are at capacity.  
- Rather than focusing internally, UAB is partnering with local hospitals to assist in improving quality, efficiency, and operations, and are focused on targeted network development in specific service lines (Cancer) extending into other states (AL, GA, MS). |
| **Open Architecture – Engaging with community providers** |  
- Community practice model currently being employed regionally as well as an associates model.  
- Joint Venture at Russell currently underway for Radiation Oncology Services. |
## UAB Health System

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<tr>
<td>Data Analytics &amp; Performance Measurement</td>
<td><strong>Quality Data:</strong></td>
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<td>• All physicians see all data – on a departmental level. In the future, data on the individual level will also be made available.</td>
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<td>• The system shares quality and patient satisfaction at various levels, allowing for course correction at the department and individual physician level, with support.</td>
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<td>• Departments get scores for their physicians and can see individual level reports. Non-identified at the individual level, but individual faculty can see their own data.</td>
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<td>• Leadership in the difference departments can look at individuals to see where there are gaps and to help course correct.</td>
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<tr>
<td>Cost Management /Quality of Care</td>
<td>• UAB is focusing efforts on reducing waste in targeted areas such as the catheterization lab and in interventional radiology – a source of unnecessary cost.</td>
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<td>• They are in diversion constantly and thus must increase inpatient and outpatient efficiency.</td>
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<td>• Engaged in ambulatory practice and inpatient throughput redesign, utilizing patient focus groups to help design clinic and inpatient operations (transplant is one example).</td>
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<tr>
<td>Education, Research, &amp; Innovation</td>
<td><strong>Research:</strong> UAB has an effective strategy in place for research recruitments, using central Impact funds to help departments develop packages for research and draw down federal NIH dollars.</td>
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<td><strong>Education:</strong> UAB has a clinician-educator track, and support for faculty at various level that recognizes teaching as critical (in terms of promotion/tenure). A new department of Medical Education in the School of Medicine has been important with a Senior Associate Dean as it’s leader.</td>
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University of New Mexico Health System
Profile Takeaways

- UNM has consolidated administrative functions for all clinical departments leading to significant cost savings and efficiencies in clinical program management.
- UNM is aggressively involved with its community partners, feeling it is responsible to lead state-wide efforts to provide care for the whole state as the singular T/Q provider and an organization capable of large-scale geographically dispersed population health management.
- UNM believes that it must have physician-led clinical transformation and integration efforts from the top down, and has a designated executive leadership role, “Health System Executive Physician in Chief” responsible for execution.

Interviewees:
- Paul Roth, Chancellor for the Health Sciences, CEO, UNM Health System and Dean, School of Medicine
- Anthony Masciotra, CEO, UNM Medical Group, Inc.
University of New Mexico Health System

Mission & Vision

Mission:
Our Mission is to provide an opportunity for all New Mexicans to obtain an excellent education in the health sciences. We will advance health sciences in the most important areas of human health with a focus on the priority health needs of our communities. We will ensure that all populations in New Mexico have access to the highest quality health care.

Vision:
UNM Health System helps New Mexico make more progress in health and health equity than any other state. New Mexicans will choose UNM Health System as their gateway to advancing patient care, clinical innovation, and continuous healthy living.

Market Situation

UNM is the state’s only academic health center, only Level 1 trauma center and serves as the safety net hospital for all of New Mexico.

Being the only major T/Q provider in the region and the only institution capable of providing population health tools forces them to wear two hats.

UNM faces a challenging payer mix; 26% Medicaid and 20% total uncompensated care.

UNM faces competition from two integrated delivery systems, each with large health plans. UNMs lack of a health plan will force it pursue future partnerships with other large health plans.

UNM Health System formed in 2011 to assure balance between the Health Science Center’s academic and clinical missions.
### University of New Mexico Health System

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Features</th>
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| Integrated Governance   | • CEO of the Health System is also the Dean of the SOM. Clinical and academic activities report up through this role (Chancellor for Health Sciences) who reports to the Health Sciences Center Board of Directors.  
• Other institutional leaders also participate. Core Leadership and HS Operation teams meet weekly with focus on integrated HS strategy and operations. Contracting and quality are consolidated at the HS level.  
• Any strategic issue relating to clinical enterprise is brought before committee of chairs. Big decisions are brought to them early on for reactions and feedback. They implement executive decisions. |

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### Core decision making group

#### Consolidated Virtual Health System Leadership Team
- Chancellor, Health Sciences Center
- Vice Chancellor for Research
- HS COO
- HS Executive Physician In Chief
- Executive Vice Dean SOM
- CEO, Hospital
- CEO, FPP
- Deans Colleges of Nursing and Pharmacy.
- CFO, HSC
# University of New Mexico Health System

<table>
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<tr>
<th>Characteristic</th>
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| Fiscal Transparency      | • FPP has consolidated administrative functions (billing and collections; coding, quality reporting; consulting engagements for some operational performance improvement; and some centralized clinical site costs) for all departments of the SOM.  
• FPP manages clinical contracting for the HS and contracts under a single UNM HS boilerplate.  
• Currently developing funds flow alignment with governance committee overseeing all HS capital (Hospitals, SOM and FPP). Governance committee commenced in October, 2013.  
• Health system created 2 years ago—consolidation of 7 hospitals, practice plan and outpatient facilities, colleges of nursing and pharmacy. |
| Compensation & Incentives| • XYZ compensation plan now. Thinking about how to embed quality metrics. Working to align metrics of hospital management team with those at the School of Medicine.  
• Goal: eventually every faculty member will have some portion of salary tied to frontline hospital and faculty clinical performance.  
• All chairs share 5 goals: increase ambulatory care volume by 5%; reduce LOS by 0.5 days; increase surgical volume by 5%; increase revenue per unit by 2%; align IT use to business capability/strategy across system. |
## University of New Mexico Health System

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| **Access to Capital**   | • Health System keeps all of its balances (although housed within each of the clinical departments, hospitals and FPP). The HS is run as a separate enterprise, even though is part of a university and reports to University Board.  
  • Recently approved funds flow change will create a “Consolidated Service Fund” to be funded by all the revenues of the Hospitals, FPP and SOM. Hospital, clinical departments and FPP will get annual budgeted funding and will be cost centers in the future. Funds will be set aside from the CSF for strategic planning. Oversight and governance of this fund will include HSC Chancellor, HS COO, EPIC, EVD SOM, Clinical Chairs, Hospital and FPP CEO and HSC CFO. Committee commenced operations in October, 2013.  
  • Phase one, beginning now, is to manage as a virtual CSF and funds will move beginning in FY 15 budget cycle.  
  • FPP and Hospital jointly funded development of a UNM HS owned community hospital with open medical staff. |
| **Management of Risk**  | • Facing mixed reimbursement model in next few years where there is some capitated reimbursement, meaning they have to assume risk. Need to figure out how to thrive when some clinical revenue is fee-for-service and some is risk-based.  
  • Currently responsible for approximately 40,000 lives through UNM Care Program (designed for poorest patients) and the state program – State Coverage Insurance (SCI) – for patients who just miss qualifying for Medicaid. SCI reimburses on a capitated basis.  
  • Will establish an entity responsible for accepting risk-based payments. |
| **Scale**               | • FPP has financially supported expansion of 10 clinics into new markets.  
  • Focus is not on size of the clinical enterprise but on their core missions. UMN “owns” population health in New Mexico. |
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| **Primary Care Network Development**   | • All ambulatory clinics to be consolidated into a virtual, consolidated entity responsible for billing, staffing, operating ambulatory clinic platform to be led by a physician executive. Licensure will maximize revenue but governance and oversight will be consolidated.  
• Partnerships being explored with providers including large multispecialty for-profit practice, FQHC’s and post acute (rehab and home health) with additional integration of health insurers into mix (BCBS, Molina, United) |
| **Open Architecture – Engaging with community providers** | • UNM is aggressively involved with community partners. Its vision “... to improve the health and health equity of New Mexicans greater than any other state by 2020...” has driven this initiative.  
• Strategies include:  
  • HERO’s (Health Education Resource Officers) serves all of rural NM, divided into 5 regions, to create partnerships with community care agencies and bring clinical care as need to those communities  
  • Project ECHO provides outreach education and a clinical care platform funded by RWJ, CMS CMMI and other private funds. Currently being reviewed by CMS as a national model to provide care and education to rural underserved communities. |
| **Data Analytics & Performance Measurement** | • The HS has a centralized data warehouse housing hospital, FPP billing data, quality and care extracts from the EMR, cost data and 10 years of ETG data (Delta Group). Still working on top end tools for more timely transformation from data to information to impact clinical practice outcomes. |
## University of New Mexico Health System

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| **Cost Management/Quality of Care** | • Financial data, productivity data, and quality metrics available across organization through internal website.  
• UNM participates in RWJ Foundation Aligning Forces for Quality (AF4Q) community.                                                   |
| **Education, Research, & Innovation** | • Designated as a CTSA in 2010 which provides umbrella for research and educational activity for entire HSC. Research landscape transformed to considerably more clinical, community, and population-based research that is more closely integrated with clinical activities. HEROs also provide Academic Extension Hubs that allow UNM to connect with community hospitals, FQHCs, community colleges, and others, all of whom feel they are strengthened by a UNM affiliation- This involves all mission areas. |
University of New Mexico Health System

University of New Mexico has a “Health System Executive Physician in Chief” that reports directly to the Chancellor, and supervises the Chief Medical Officer and the individual component unit chief medical officers.

Responsibilities

• Leader and architect of the strategic operating plans for the UNM Health System, leading the implementation of both the UNM strategic plan and operating plan, assuring consistency in approach by all health system component units.
• Responsible for fostering effective collaboration, alignment and integration between components of UNM Health System.
• Internal expert in best practices at a local and national level, and external representative in national endeavors in health reform.
• Supports Health System CMO and unit CMOs in quality improvement and safety initiatives, medical staff affairs, and lean management systems.
• EPIC: Drives external partnerships and relationships.
A founding member of the University of Iowa Health Alliance (UIHA) which provides a vehicle for collaboration on statewide efforts to share best practices, reduce variations in care, and ensure Iowans have access to a “medical home”.

Through the UIHA, Iowa will extend its reach throughout the state by offering an insurance product on the state exchange.

Cohesive and aligned leadership, with shared incentives, have enabled Iowa to implement cost reduction strategies such as the development of enterprise wide, centralized support functions.

Interviewees:
• Mark Hingtgen, Assistant Vice President for Finance, Iowa Healthcare
• Debra Schwinn, Dean, Roy J. and Lucille A. Carver College of Medicine

Profile Completed on November 1, 2013
University of Iowa

**Mission & Vision**

*Mission:* Changing medicine through pioneering discovery, innovative inter-professional education, delivery of superb clinical care and an extraordinary patient experience in a multidisciplinary, collaborative, team-based environment; and changing lives by preventing and curing disease, improving health and well-being and assuring access to care for people in Iowa and throughout the world.

*Vision:* World class people creating a new standard of excellence in integrated patient care, research, and education, making a difference in quality of life for generations to come.

**Market Situation**

UIHC Serves patients throughout Iowa and other states; especially western and central Illinois. They define their geographic service areas by 30 mile increments.

- 59% of all patients come from within 30 miles of the main Iowa City campus.
- 82% from within 60 miles

UIHC ranked in top of state total hospital discharges

- Hospital is statewide inpatient market share leader in 22 of 33 services lines
- In primary service area, they have highest market share in 24 of 33 services lines (10 surrounding counties)

University of Iowa Hospitals and Clinics (UI Health Care) constitutes the clinical practices of the University System including University of Iowa Physicians (UIP). The College of Medicine operates as an integrated organization with UIHC as well as the overall University of Iowa System.
### University of Iowa

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<tr>
<th>Characteristic</th>
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<tbody>
<tr>
<td>Integrated Governance</td>
<td>• All clinical services report up through an integrated organizational structure including the clinical activities of the UIP.</td>
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<td>• Leadership team (VP of Medical Affairs, Jean Robillard; Dean Debra Schwinn; and CEO of UIHC, Ken Kates) bridge many issues. Leadership team shares incentives. All goals support the pillars in the strategic plan; there is some cascading down to next level of management.</td>
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### VPMA CABINET *

- Board of Regents, State of Iowa
- President, University of Iowa
  - Sally Mason, PhD
- Vice President for Medical Affairs
  - Jean Robillard, MD
- UI Health Care Board of Advisors

#### UI HEALTH CARE SHARED SERVICES
- Human Resources
  - Jana Wescott
- Information Technology
  - Lee Cameron
- Operations Excellence
  - Sabi Singh
- Compliance
  - Deborah Thoman
- Strategic Planning
  - Christine Miller
- Marketing & Communications
  - Ellen Barron

*2 rotating MD department chairs added to cabinet in 2013*
### University of Iowa

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<tr>
<th>Characteristic</th>
<th>Features</th>
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<tr>
<td>Fiscal Transparency</td>
<td>• The hospital must produce a separate, audited, balance sheet because hospital issues its own revenue bonds.</td>
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<td>• However, the UI Health Care enterprise can produce a combined income statement and balance sheet through the use of a unified financial reporting system.</td>
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<td>• Many support functions, such as finance, human resources, information systems, patient fiscal services and marketing support the entire UI Health Care enterprise (See Org chart on previous slide for UI Shared Services)</td>
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<td>Compensation &amp; Incentives</td>
<td>• Compensation plans are specialty-specific but have common elements (e.g., time to schedule an appointment; not bumping clinics; timely and accurate documentation; patient satisfaction).</td>
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<td>• Leadership (VP for Medical Affairs, Dean, and Hospital CEO, etc.) share goals and incentives for successfully meeting them.</td>
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<tr>
<td>Access to Capital</td>
<td>• Access to capital for the clinical enterprise is available through cash reserves or the issue of revenue bonds by the hospital.</td>
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<td>• Access to capital for the academic enterprise is through collegiate cash reserves or the central University.</td>
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</table>
### University of Iowa

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<tr>
<th>Characteristic</th>
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</table>
| **Management of Risk**         | • UIHC has a Medicare ACO with Cedar Rapids Mercy and has partnered with community providers in a commercial ACO.  
                                | • Formed the University of Iowa Health Alliance (UIHA) to serve as an umbrella for numerous initiatives to employ and share best practices within the network, which has state-wide reach, and to share potential costs related to population health management.  
                                | • The Alliance participants have also partnered to offer an insurance product on the State health exchange starting October 2013. |
| **Scale**                      | • UIHA extends throughout the state of Iowa. The UIHA has the potential to meet the health care needs of approximately 2,000,000 covered lives within the next three years by partnering around the Medicaid expansion and the health insurance exchanges. |
| **Primary Care Network Development** | • UIHA will increase access and strengthen primary care to provide Iowans with a medical home and allow for continuity of care from the community to the specialty providers through the use of care coordinators, tele-health and electronic health records.  
                                | • Next step is UIHA to move toward clinical integration of primary care.                                                                 |
| **Data Analytics & Performance Measurement** | • EPIC clinical information enables access to robust datasets that are, or can be, utilized to understand care and its costs across the continuum internally, and as the UIHA develops perhaps externally. This is enhanced by academic predictive analytics research via CCOM.  
                                | • UIHA will allow for sharing of costs of information systems and expertise. The data from the clinical information system has already allowed for development of scorecards and metrics around quality, safety and satisfaction data. |
### University of Iowa

<table>
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<tr>
<th>Characteristic</th>
<th>Features</th>
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</table>
| **Cost Management/Quality of Care** | • Setting up relationships with long term care organizations as a way to lower costs. Trying to learn about cost of care and how to manage that cost.  
• The Clinical Quality Group leads efforts to improve care across the organization.  
• Need physicians to understand the importance of managing costs; this is not yet consistent across the physician organization, however is rapidly moving forward. |
| **Education, Research, & Innovation** | • As in most academic organizations, the economics of health care reimbursement are making it more difficult to support academic costs out of declining clinical revenues.  
• The enterprise is focused on identifying opportunities to eliminate redundant services and related costs, both in support of the academic and clinical enterprise. Investigating opportunities to fund research beyond traditional grants or clinical and translational grants, perhaps through commercial partnerships.  
• Undergraduate medical students are introduced to the EPIC EMR system early on and become highly proficient users of clinical information and data. Educational material is presented now in EPIC playground modules so students access data for class as they will when interacting with patients. |
Iowa Chair Workgroups

Four department chair workgroups were established in the last year to ensure physician leaders have a voice in leading the organization. Groups coalesce around a vision for the future of medicine in a time frame of 5-10 years. This facilitates development of ideas to help the organization succeed in this future state and drive needed change. All groups examine their focus area through the lenses of patient care, education and research. Recent work products include innovative residency pathways, leadership for facilitating more accurate coding of patient characteristics, etc.

ACO and Outpatient Group
Focus: Issues related to ambulatory care and alternative payment and delivery models while supporting research

ICU and Inpatient Group
Focus: Inpatient clinical quality, outcomes and operations, and hospice care, and bridging with basic science for enhanced

Basic Sciences
Focus: Decreasing cost of research, stretching research dollars, supporting faculty in adding informatics, and preserving tenure through innovative recommendations

Diagnostic and Molecular Therapeutics
Focus: Development of innovative residencies to drive the merged field of Diagnostic and Molecular Therapeutics

Preparing for the Future of Health Care
Iowa Healthcare – *Networked AMC System*

- Established June, 2012 and includes 54 hospitals, >160 physician clinics, and 2,300 physicians. Each organization will maintain its independence and focus on local missions and governance while also participating in statewide efforts to lead and improve the health care system.

**Examples of Activities include:**

- Member-assisted development of performance metrics and comparative data reporting to identify best practices.
- Cost sharing for IT systems and resources needed to analyze clinical data and make it available and useful for physicians.
- Collaborative research initiatives (ICORE = Iowa Center for Outcomes Research).

**Founding Members**
- University of Iowa Health Care
- Mercy Health Network
- Mercy – Cedar Rapids
- Genesis Health System
Profile Takeaways

- Although operating as two separate entities, Yale University School of Medicine and Yale New Haven Health System share an objective of making high value care available and continuing to offer the “destination” services of an academic medical center. The Yale School of Medicine is also the architect of its research and teaching missions.
- The Yale Medical Group (faculty practice plan) is working to develop its infrastructure to support clinical practice growth in a cost effective and efficient manner.
- Both organizations are collaborating on a number of key initiatives including clinical integration, primary care network development, Epic optimization and data analytics.

Interviewees:
- Paul Taheri, M.D., Chief Executive Officer Yale Medical Group
- Christopher O’Connor, Chief Operating Officer Yale New Haven Health System
### Yale University School of Medicine Overview

**Characteristics** | **Features**
--- | ---
**Size** | • 1,161 students (all programs)  
• 2,447 full-time faculty members  
• 3,314 staff members  
• $1.3B operating budget

**Research** | • 1,815 awards totaling $510.4 million  
• 5\textsuperscript{th} for NIH funding among medical schools  
• 3\textsuperscript{rd} for NIH funding per faculty member

**Yale Medical Group (Faculty Practice Plan)** | • One of the largest academic multi-specialty group practices in the United States  
• 1,081 faculty members (full-time and part time)  
• Over 100 specialties and subspecialties  
• Over 135 programs, services and centers  
• $526M clinical income
## Yale New Haven Health System Overview

<table>
<thead>
<tr>
<th></th>
<th>Yale-New Haven Hospital</th>
<th>Bridgeport Hospital</th>
<th>Greenwich Hospital</th>
<th>Northeast Medical Group</th>
<th>System Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td>4,138</td>
<td>825</td>
<td>545</td>
<td>552</td>
<td>6,060</td>
</tr>
<tr>
<td>Employees</td>
<td>11,436</td>
<td>2,512</td>
<td>1,754</td>
<td>1,091</td>
<td>18,529</td>
</tr>
<tr>
<td>Total Licensed Beds</td>
<td>1,541</td>
<td>383</td>
<td>206</td>
<td>-</td>
<td>2,130</td>
</tr>
<tr>
<td>Inpatient Discharges</td>
<td>80,647</td>
<td>18,469</td>
<td>12,564</td>
<td>-</td>
<td>111,680</td>
</tr>
<tr>
<td>Outpatient Encounters</td>
<td>1,078,194</td>
<td>237,520</td>
<td>297,888</td>
<td>-</td>
<td>1,612,602</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$2,314,000</td>
<td>$463,853</td>
<td>$368,581</td>
<td>$105,127</td>
<td>$3,497,625</td>
</tr>
</tbody>
</table>

Note: FY 2013 Forecasted Data
Yale New Haven Health System Structure

Yale University

Yale-New Haven Delivery Network
- Yale-New Haven Hospital
- Yale-New Haven Children's Hospital
- Yale-New Haven Psychiatric Hospital
- Smilow Cancer Hospital, Care Centers and Boutique

Bridgeport Delivery Network
- Bridgeport Hospital
- Bridgeport Hospital Foundation

Greenwich Delivery Network
- Greenwich Hospital
- Greenwich Health Services, Inc.
- Greenwich Hospital Home Care & Hospice

Northeast Medical Group
- Hospital physicians
- Community physicians

Yale New Haven Health System Infrastructure

Corporate Services
- Budgeting
- Call Center
- Corporate Compliance
- Corporate Finance
- Decision Support
- Treasury
- Financial Planning
- Government Affairs
- Human Resources
- Workers' Compensation
- Health Benefits/Admin
- Compensation & Benefits
- Information Technology
- Internal Audit
- Institute for Excellence
- Legal Services
- Managed Care
- Marketing
- Materials Management
- Office of Emergency Preparedness
- Performance Management
- Planning & Business Development
- Reimbursement
- System Business Office
Yale University School of Medicine and Yale New Haven Health System Governance Relationships

Legend

- Yale University President nominates 3 Yale New Haven Health System Directors
- Yale University President nominates 4-5 Yale-New Haven Hospital Trustees
- Yale-New Haven President and COO as well and the Chief Medical Officer are members of the Yale Medical Group Board
- 20% Northeast Medical Group Board comprised of Yale Medical Group physicians
### Yale Medical Group Structure and Fiscal Transparency

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<tr>
<th>Characteristic</th>
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<tr>
<td>Role of Chairs</td>
<td>• Yale Medical Group includes 19 department Chairs who are moving towards functioning as a multispecialty group. Although each department is autonomous and has its own bottom line, departmental losses are absorbed within Yale Medical Group.</td>
</tr>
</tbody>
</table>
| Practice Infrastructure | • Yale Medical Group charges a tax on revenue for operations that support their back office functions that are essentially billing, collecting and the compliance infrastructure.  
• Yale Medical Group performs the billing function for Northeast Medical Group.  
• Yale Medical Group wants to evolve into a more robust organization capable of supporting community physician group integration and is working toward that end. |
| Fiscal Transparency    | • Yale-New Haven Hospital transfers over $190M to Yale Medical School for clinical program support/services.  
• Within Yale Medical Group, losses are shared and covered by the other departments. |
| Compensation & Incentives | • Faculty incentives are driven at the department level (often a combination of RVUs and citizenship metrics). Quality incentives are included in the citizenship portion of incentive compensation, but are minimal. |
| Management of Risk     | • No risk-based contracting currently, but are investigating using bundled payments as an approach to test quality based payments with physicians and are set to participate in the CMMIT BPCI program. |
Yale University School of Medicine and Yale New Haven Health System Collaboration

- Long standing collaboration for clinical care, teaching and research
  - Yale University affiliation with Yale-New Haven Hospital updated in 1965
  - Yale University affiliation with Yale New Haven Health System since 1999

- Clinical services/service line planning

- Enterprise-wide Epic implementation

- Specialty referrals/inter-hospital transfers (Y-Access)
### Clinical Integration Activities

- Common information technology platform (Epic)
- Common clinical protocols and clinical redesign underway across the enterprise
- Establishment of medical home pilots in two Northeast Medical Group primary care practices
- Establishment of quality metrics in select specialties to measure and improve care delivered
- Centers for Medicare & Medicaid Services bundled payments and readmissions reduction grants

### Ongoing and Future Collaborations

- Primary care network development
- Clinical trials
- Epic optimization
- Data analytics
Partners HealthCare System/Massachusetts General Hospital

Profile Takeaways

• MGH is one component of Partners Healthcare, an integrated delivery system.
• Partners Healthcare has developed expertise in complex care management through its experience in an MGH led Medicare demonstration project that started in 2006.
• Assuming risk for 600,000 lives in both commercial contracts and Medicare population as a Pioneer ACOs is a central part of the Partner Population Management Strategy.
• The system has achieved a strategic goal to reduce costs by $300 Million by the end of 2013. Initiatives supporting this goal include traditional budget controls as well as patient affordability and care redesign initiatives developed to create efficiencies in care delivery and improve outcomes.
• Partners launched an “Innovation Fund” in 2007 that supports/invests in the commercialization of research activities with all gains reinvested back into the fund.

Interviewees:
• David Torchiana, Chairman and Chief Executive Officer, Massachusetts General Physicians Organization
• Greg Pauly, Chief Operating Officer, Massachusetts General Physicians Organization and Senior Vice President, Massachusetts General Hospital.
Partners HealthCare/Massachusetts General Hospital

**Mission:** Partners is committed to serving the community. We are dedicated to enhancing patient care, teaching and research, and to take a leadership role as an integrated health care system. We recognize that increasing value and continuously improving quality are essential to maintaining excellence.

**Vision:** To Dedicate ourselves to the delivery of superior care; To provide a coordinated, cost-efficient, and transparent care model; To touch the communities we serve, local or global; To lead in research that fosters collaboration, bringing discovery to patients bedside; To invest in education and training to nurture next generation of leaders; To promote the development of our workforce by creating opportunities for achievement and advancement; To seek ways to deliver the highest quality healthcare to all.

**Market Situation**

- Primary service area has a population of about 5 million people
- Partners currently serves ~23% of eastern Massachusetts Market.
- Largest healthcare delivery system in eastern Massachusetts
  - 2 AMCs – Massachusetts General and Brigham and Women's Hospital.
  - 6 acute care community Hospitals
  - Post acute and home care
- PHS contracts for the hospitals and their associated physicians, more than 6,000 in aggregate
- Unique state law passed in August 2012 requires that annual state health care spending grow no faster than the rate of growth of the state’s economy until 2017 and then must be 0.5% lower until 2022.

Founded in 1994 by Brigham and Women's Hospital and Massachusetts General Hospital as a response to the growing presence of capitation and managed care.
Partners HealthCare System/Massachusetts General Hospital

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| Integrated Governance & Management | - The Board of the Partners Healthcare system is the sole member of all PHS entities  
- MGH physicians are members of the faculty of Harvard medical school.  
- The Massachusetts General Physicians Organization and Massachusetts General Hospital are separate first tier PHS entities joined by a single board, the 1811 Corporation  
- The leadership of Partners Healthcare System, which includes entity executives, meet weekly to focus on joint strategy and decisions to be made at the system level. |
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<td><strong>Compensation &amp; Incentives at</strong></td>
<td>• Clinical department chairs and vice presidents have up to 10% of base salary eligible for an incentive based bonus. Bonus is comprised of two components: individual performance against individual goals and institutional/budget goals.</td>
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<tr>
<td><strong>MGH</strong></td>
<td>• Chiefs and Senior Executives can qualify for an additional 5% bonus based on quality and safety metrics for each department.</td>
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<td>• MGPO has a quality incentive plan in place for individual physicians based around 3 quality metrics. If physicians meet all three metrics they receive a bonus every 6 months.</td>
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<tr>
<td><strong>Access to Capital</strong></td>
<td>• Major capital allocation decisions are made by a central PHS finance committee under a five year financial framework</td>
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<td>• MGH Departments have separate budgets within the MGPO but are aligned around institutional goals. The MGPO supports multiple administrative functions on behalf of all departments.</td>
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<td>• System goals drive organizational investments and priorities.</td>
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<tr>
<td><strong>Management of Risk</strong></td>
<td>• Network is responsible for financial risk on 600,000 lives through Partners Population Health Management and Medicare Pioneer ACO.</td>
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<td>• All commercial HMO plans are in an at-risk, capitated model.</td>
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<td><strong>Scale</strong></td>
<td>• System currently has about 23% of the eastern Massachusetts Market.</td>
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<td>• Partners Healthcare International (PHI) markets and provides clinical services via the AMC’s to patients in the Middle east, southern Europe, India, Bermuda and South America.</td>
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<td>• PHI also provides advisory services to international hospitals and health systems.</td>
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<tr>
<td>Characteristic</td>
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<tr>
<td><strong>Primary Care Network Development</strong></td>
<td>• Partners community network currently has approximately 1000 PCP FTE’s. The system is evolving to become more tightly aligned and clinically integrated with our community hospitals and their physicians.</td>
</tr>
<tr>
<td><strong>Data Analytics &amp; Performance Measurement</strong></td>
<td>• On a semi-annual basis, Partners releases (internally and externally) its Quality dashboard which contains over 200 data points benchmarked against competitors.  \</td>
</tr>
<tr>
<td></td>
<td>• A population registry has been established for patients in the ACO and Partners Population Health PCMH. \</td>
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<td></td>
<td>• An enterprise data warehouse is being launched with a development partner</td>
</tr>
<tr>
<td><strong>Education, Research, and Innovation</strong></td>
<td>• The Partners Innovation Fund was launched in 2007 to support commercialization of medical systems, pharmaceuticals and medical devices. Gains from investments are reinvested in the fund. \</td>
</tr>
<tr>
<td></td>
<td>• Resident and fellowship training programs are a vital pipeline for our research and clinical programs.</td>
</tr>
<tr>
<td><strong>Open Architecture – Engaging with Community Providers</strong></td>
<td>• Partners has used a variety of models to forge relationships with community providers: employed community physicians, affiliated practices, and hybrid models. \</td>
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<tr>
<td></td>
<td>• PHS is on the threshold of a four year process to install the EPIC clinical and financial systems across its entire physician and hospital network \</td>
</tr>
<tr>
<td></td>
<td>• Massachusetts is taking regulatory actions aimed to slow the growth of medical costs.</td>
</tr>
</tbody>
</table>

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**Partners HealthCare System/Massachusetts General Hospital**
### Cost Management/Quality of Care

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Features</th>
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<tbody>
<tr>
<td></td>
<td>• Each clinical department has a dashboard that shows clinical quality performance against their peers. Peer benchmarking drives physician compliance around quality metrics.</td>
</tr>
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<td></td>
<td>• Partners Healthcare Report Card publicly reports system performance against national benchmarks around the areas of: IT adoption, Patient Safety, Clinical Quality, Prevention and chronic disease management, efficiency, and the patient experience.</td>
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<td></td>
<td>• Partners has undertaken a successful effort to reduce costs by $300 Million by the end of 2013.</td>
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<td>• Multi-disciplinary care teams were created to create efficiencies and improve outcomes in multiple conditions including stroke, AMI, and diabetes. Teams make recommendations which are then spread across Partners system, multiple teams are also active at the entity level.</td>
</tr>
</tbody>
</table>
Partners HealthCare System/Massachusetts General Hospital

Measure Domains

- HIT Adoption
- Patient Safety
- Clinical Quality
- Prevention and Chronic Disease Management
- Efficiency
- Patient Experience

Publicly Reported Dashboards

<table>
<thead>
<tr>
<th>Report Card</th>
<th>Our Current Performance</th>
<th>Reference Point</th>
<th>How We're Doing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Blocked Arteries Within 90 Minutes</td>
<td>87%</td>
<td>93%</td>
<td>✔</td>
</tr>
<tr>
<td>Delivering Recommended Care for Patients with Heart Attack</td>
<td>99%</td>
<td>99%</td>
<td>✔</td>
</tr>
<tr>
<td>Delivering Recommended Care for Patients with Pneumonia</td>
<td>96%</td>
<td>96%</td>
<td>✔</td>
</tr>
<tr>
<td>Delivering Recommended Care for Patients with Heart Failure</td>
<td>96%</td>
<td>97%</td>
<td>✔</td>
</tr>
<tr>
<td>Delivering Recommended Care to Prevent Surgical Infections</td>
<td>96%</td>
<td>96%</td>
<td>✔</td>
</tr>
<tr>
<td>Helping Tobacco Users Quit</td>
<td>99%</td>
<td>99%</td>
<td>✔</td>
</tr>
<tr>
<td>Delivering Recommended Care to Prevent Blood Clots in Surgical Patients</td>
<td>97% Treatment Ordered; 96% Treatment Received</td>
<td>97% Treatment Ordered; 95% Treatment Received</td>
<td>✔</td>
</tr>
</tbody>
</table>

Bar chart showing performance metrics for Partners HealthCare compared to reference point.
Appendix
### Advancing the Academic Health System for the Future - Advisory Panel Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Anastos</td>
<td>Executive Vice President, Clinical Practice and Business Development</td>
<td>University of Chicago Medical Center</td>
</tr>
<tr>
<td>Anthony R. Masciotra, Jr. CPA, MBA</td>
<td>Chief Executive Officer</td>
<td>UNM Medical Group, Inc.</td>
</tr>
<tr>
<td>Benjamin P. Sachs, M.B., B.S., D.P.H., FACOG</td>
<td>Senior Vice President &amp; Dean</td>
<td>Tulane University School of Medicine</td>
</tr>
<tr>
<td>Jeffrey R. Balser, M.D., Ph.D. (2012-2013 Chair)</td>
<td>Vice Chancellor for Health Affairs</td>
<td>Dean, School of Medicine Vanderbilt Medical Center</td>
</tr>
<tr>
<td>J. Lloyd Michener, M.D.</td>
<td>Chairman, Department of Family and Community Medicine</td>
<td>Duke University School of Medicine</td>
</tr>
<tr>
<td>Debra A. Schwinn, M.D.</td>
<td>Dean, Roy J. and Lucille A. Carver College of Medicine</td>
<td>The University of Iowa</td>
</tr>
<tr>
<td>Dayle Benson, MHA</td>
<td>Executive Director</td>
<td>University of Utah School of Medicine University of Utah Medical Group</td>
</tr>
<tr>
<td>Christopher T. Olivia, M.D.</td>
<td>Executive President</td>
<td>Continuum Health Alliance</td>
</tr>
<tr>
<td>Cory D. Shaw</td>
<td>Chief Executive Officer</td>
<td>UNMC Physicians University of Nebraska, College of Medicine</td>
</tr>
<tr>
<td>Dr. S. Wright Caughman</td>
<td>Executive Vice President for Health Affairs, Emory University CEO, Woodruff Health Sciences Center Chair, Emory Healthcare</td>
<td></td>
</tr>
<tr>
<td>Greg Pauly</td>
<td>COO, Massachusetts General Physicians Organization &amp; Senior Vice President, Massachusetts General Hospital</td>
<td></td>
</tr>
<tr>
<td>Craig Henry Syrop, M.D.</td>
<td>Associate Dean for Clinical Affairs</td>
<td>University of Iowa Roy J. and Lucille A. Carver College of Medicine</td>
</tr>
<tr>
<td>Steven Corwin, M.D.</td>
<td>Chief Executive Officer</td>
<td>NewYork-Presbyterian Hospital The University Hospital of Columbia and Cornell</td>
</tr>
<tr>
<td>Thomas M. Priselac</td>
<td>President and CEO</td>
<td>Cedars-Sinai Health System</td>
</tr>
<tr>
<td>Paul A. Taheri, MD</td>
<td>Deputy Dean and CEO, Yale Medical Group</td>
<td>Yale University School of Medicine</td>
</tr>
<tr>
<td>Patricia Currie</td>
<td>Chief of Hospital Services</td>
<td>Scott and White Memorial Hospital</td>
</tr>
<tr>
<td>Denise V. Rodgers, M.D</td>
<td>Interim President</td>
<td>University of Medicine &amp; Dentistry of New Jersey</td>
</tr>
<tr>
<td>Warner Thomas, MBA</td>
<td>President and Chief Operating Officer</td>
<td>Ochsner Health System</td>
</tr>
<tr>
<td>Steve Lipstein</td>
<td>President/CEO</td>
<td>BJC Healthcare</td>
</tr>
<tr>
<td>Paul Bennett Rothman, MD</td>
<td>Dean of Medical Faculty, CEO Johns Hopkins Medicine Johns Hopkins University School of Medicine</td>
<td></td>
</tr>
<tr>
<td>Project Team:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joanne Conroy, Chief Health Care Officer, AAMC</td>
<td>Ivy Baer, Senior Director and Regulatory Counsel, AAMC</td>
<td>Evan Collins, Health Care Affairs, AAMC</td>
</tr>
<tr>
<td>Lilly Marks</td>
<td>Executive Vice Chancellor Anschutz Medical Campus and Vice President for Health Affairs</td>
<td>University of Colorado at Denver</td>
</tr>
<tr>
<td>Fred Craig Rothstein, MD</td>
<td>President</td>
<td>University Hospitals Case Medical Center</td>
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