MetroHealth

ACO CASE STUDY

METRO HEALTH: *GRAND RAPIDS, MICHIGAN*

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Metro Health is a diversified health system, including a 208-bed hospital, that is positioning itself for delivery of accountable care. The system has developed its own primary care and ambulatory facilities with geographically distributed practices and has a 50 percent share in a physician hospital organization (PHO) that represents both its employed physicians and most other members of its medical staff. It is gaining experience with its 12 patient-centered medical homes and four pay-for-performance contracts. It has linked its primary care practices, some specialists and its hospital with a common electronic health record (EHR) (Epic).

This is one of four case studies of organizations that are relatively far along in preparing for population health management and value-based reimbursement.

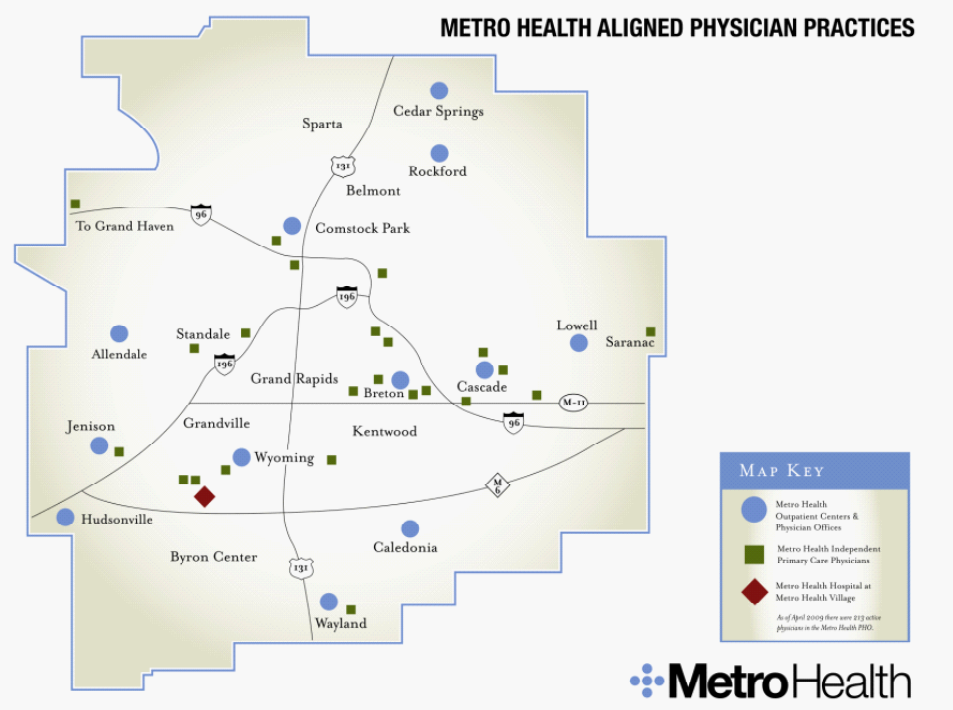
The case studies have been prepared by McManis Consulting, under the sponsorship of the American Hospital Association (AHA).[1]

Metro Health was selected as a case study in part because it highlights the unique challenges facing a single-hospital system in a competitive market – including challenges in realizing economies of scale, accessing capital and becoming accountable for care across the continuum.

The system's aligned physician practices, including primary care, are shown in Exhibit 1.

[1]Two white papers based on this case study, and the other case studies, are available at www.aha.org/ACOcasestudies.

1 METRO HEALTH'S PRIMARY SERVICE AREA AND CARE NETWORK



KEY ELEMENTS

Several features of Metro Health's strategy and care delivery approach are seen as key to its past and future success. These include:

- A geographically distributed and aligned network of primary care offices;
- Achieving scale through strategic alliances;
- An integrated information technology (IT) strategy built on a single ambulatory and inpatient EHR;
- Collaboration with other health systems to spread IT costs;
- Initiatives to improve quality and care management; and
- Adequate capital to transform the system and take advantage of strategic opportunities.

These are discussed in more detail below.

A geographically distributed and aligned network of primary care offices. Beginning in 1994, Metro embarked on strategies relating to becoming a closely integrated delivery system with carefully selected ambulatory locations.

Through Metro Enterprises, a for-profit subsidiary, Metro owns and operates 12 ambulatory care facilities – neighborhood outpatient centers with a total of 60 primary care providers – geographically distributed across its service area. Ten of these sites are staffed by physicians employed by Metro Enterprises.

Metro PHO includes the 208 physicians (85 employed and 123 in private practice) who make up its medical staff. Because of its history, Metro Health has an unusually close relationship with its medical staff.

Metro's overall philosophy is to work with the best physicians it can attract, and achieve the maximum feasible integration of practice approaches, cultures and financial incentives without predetermining the economic model.

Early success with pay-for-performance (P4P) contracting has played a valuable role in continuing to foster alignment. Metro Health's PHO (including the

METRO HEALTH

HISTORY AND EVOLUTION

Metro Health began as the 28-bed Grand Rapids Osteopathic Hospital in 1942. The initial hospital was organized and financed by a group of osteopathic physicians. By 1985, when it was renamed Metropolitan Hospital, it had more than 200 beds and its medical staff was a mix of DOs and MDs. Metro has continued to host one of the nation's largest osteopathic residency programs, and benefits from a close relationship between physicians and hospital administrators.

Metro's replacement hospital opened in 2007 on a new campus in Wyoming, MI, a suburb of Grand Rapids. Metro is the third largest system in Grand Rapids with a 12 percent market share (up 3 percent since the opening of its new campus.)

Metro's major competitors (and also occasional collaborators) are Spectrum Health (59 percent market share) with two hospitals, and St. Mary's Health System (20 percent market share), part of Trinity Health, a large national multi-hospital system.

Priority Health (a Spectrum subsidiary) had a 53 percent share of the commercial health plan market, and was also the market leader in both Medicare and Medicaid managed care products. Blue Cross Blue Shield of Michigan was in second position in the commercial and managed Medicare markets.

"Around 15-16% of a primary care physician's pay can be impacted by pay-for-performance contracts, which is significant. It would be even better if it were 20-25%. This is invaluable experience in learning how to function as an accountable care organization."

– Frank Belsito, DO, EVP, Metro Health Physician Network, CEO

Metro Enterprises physicians) has four P4P contracts – Blue Cross Blue Shield (BCBS), Priority Health, Molina (Medicaid HMO) and the Blues' HMO. These are not insurance risk contracts; they all use some variation of the HEDIS benchmarks to hold Metro Health responsible for performance risk. Together, these contracts include 65,000-75,000 covered lives.

Achieving scale through strategic alliances. Metro has consistently pursued alliances with other hospitals and with medical practices to form larger groups that can manage the care of larger, more geographically dispersed populations, and to achieve economies of scale.

In late 2010, Metro Health, Trinity Health and the University of Michigan announced that they have each become founding members, and one-third owners, of Pennant Health Alliance. Metro's CEO, Mike Faas, also became CEO of Pennant. Pennant Health Alliance has the potential to bring significant benefits to all three sponsoring organizations, and to be a significant organizing force for accountable care networks in western Michigan.

Pennant is expected to provide:

- A critical mass of high-quality physician groups across the continuum of care;
- A dynamic support environment for quality and cost improvements;
- A bigger base of primary care support to recruit new specialties and add new programs;
- A more favorable cost structure for independent medical practices and small hospitals; and
- An effective platform for accountable care organization (ACO) development.

Pennant's plan is that Trinity Health's supply chain and support network will provide the base for the more favorable cost structure for independent medical practices and small hospitals. In addition, Pennant's combination of hospitals and medical groups is intended to serve as the base for a regional ACO.

An integrated IT strategy built on a single ambulatory and inpatient EHR. In 2003, Metro selected Epic as the organization's primary IT platform for both inpatient and ambulatory care. Metro elected to install Epic first at its ambulatory sites (including Metro Enterprises' physician offices). Twenty non-Metro Enterprises primary care physicians are also now on Epic. Epic is now installed for inpatient services as well. The next step will be to add other physicians' offices (e.g., key specialists).

Metro has begun to leverage its integrated inpatient/ambulatory EHR. For example, MetroConnect allows a patient to access his/her EHR via the Internet. This has produced an immediate impact on patient satisfaction.

> *"We received a strong positive reception, almost overnight, when MetroConnect went up on the Internet."*
>
> ***– Laura Staskiewicz, EVP of Foundation & Community Development***

Metro also uses Crimson, an analytical support software system, to drill down into its claims data and identify patterns of care and costs. Crimson, supplied by the Advisory Board, costs $90,000 per year. Epic will have similar functionality, but it is at least two years away.

Collaboration with other health systems to spread IT costs. Metro's approach to IT involved substantial up-front investments and substantial operating costs. This established an excellent foundation to support Metro's population health management initiatives; however, it also posed significant cost problems. First, IT costs as a percentage of Metro's total operating budget were unacceptably high. Second, insufficient dollars were available to support staff dedicated to mining the EHR data and supporting quality and chronic disease care management initiatives.

Looking to cut costs, and noting that other nearby hospitals were choosing the same IT platform, Metro's chief information officer (CIO) proposed the establishment of a regional Epic service center. The Epic organization and other systems with Epic have responded positively.

Metro also uses a collaborative approach to spread the costs of a health information exchange. The three Grand Rapids health systems – Spectrum, Trinity (including St. Mary's) and Metro – are among the five

"This (Epic service center) in no way replaces IT decision-making at our individual hospitals. However, it does have the potential to cut all of our IT costs substantially. For example, we only need one 24/7 help desk. Also, we have the potential to attract high-quality, experienced Epic talent."

– Bill Lewkowski, EVP and CIO

sponsors of Michigan Health Connect, which is working to create shared electronic access across different IT platforms to clinical and patient information among 13 western Michigan counties. Michigan Health Connect has been operational for more than a year, and continues to grow. Metro's Epic system is interfaced with it; it is the hub where Metro physicians are able to receive patient information from other health systems.

Initiatives to improve quality and care management. A number of quality and care management initiatives are underway at Metro Hospital, Metro Enterprises (primary care group) and Metro PHO.

In 2009-2010, Metro made a major push to take its inpatient experience scores to a higher level. Metro worked closely with Studer Group, a firm that partners with health care organizations to create an employee and physician culture that promotes higher levels of quality and service. They made several basic changes that had a significant impact on patient perceptions of care. These included: (1) simple scripting, such as AIDET (Acknowledge, Introduce, Duration, Expectations, Thank you); (2) rounding by nurse leaders on every patient; and (3) follow-up calls to patients by emergency department staff.

Inpatient initiatives recently focused on congestive heart failure, particularly on reducing readmissions. As with other organizations, Metro has identified: (1) communication with the patient and family members at the time of discharge; (2) intervention at home (including monitoring adherence to drug regimens); and (3) coordination with primary care (including scheduling the first post-discharge office visit) as important steps in improving care.

Metro established registries for chronic disease well before it installed Epic. However, the common EHR now facilitates special studies on how physicians and their patients are managing chronic diseases like diabetes and congestive heart failure.

The care management infrastructure is largely in place. However, Metro recognizes it still has substantial work ahead in taking advantage of these assets and achieving care improvement in specific areas. One of Metro's biggest opportunities is working on relationships – for example, on the points of handoff between specialists and primary care. Metro would also like to develop care coordinators (nurses) at the practice level, but has not been able to find funding to pay for it.

Metro Health has narrowed a list of more than 100 home health agencies to four preferred providers and is engaged in a pilot project with the four – closely monitoring readmissions and mortality rates. Metro is meeting with its high-volume nursing homes to discuss how to collaborate and reduce readmissions. And, the system is working with a hospice provider to start a palliative care program in the hospital.

The medical home model is being used to facilitate further development of a common culture across primary care practices that fosters patient-centered coordinated care. All Metro Enterprises practices are certified by the National Committee on Quality Assurance (NCQA) as Level 1 Patient-Centered Medical Homes. In the future, Metro Enterprises anticipates these practices moving to Level III medical homes. Once this is achieved, BCBS will reimburse

"Our performance under our P4P contracts is evidence that these quality efforts are paying off in terms of more appropriate utilization and lower costs."

– Frank Belsito, DO, EVP, Metro Health Physician Network

primary care physicians 10 percent more, and there will be a $3 per member per month payment. These payments equate to about $400,000 a year.

Adequate capital to transform the system and take advantage of strategic opportunities. Metro Health has, over the past decade, invested heavily in developing its network of primary care sites, integrating physicians, implementing Epic, and developing a new campus for its acute-care facility and related services. These investments are providing positive dividends; however, the organization has little room for error in its financial plan.

For the fiscal year ending June 30, 2010, Metro Health's revenues were $286 million. Operating income was $7.3 million (a 3 percent operating margin). However, higher operating income from the hospital was partially offset by investments in Metro Enterprises (the physician group) and a start-up ambulatory surgery center.

Metro Health invests roughly $30,000 per year per physician in the Metro Enterprises physician group. However, losses from these facilities are largely an artifact of an accounting method that does not give medical groups credit for profits from ancillaries. Metro Health leaders believe the employed physician group has been a very positive investment that positions the organization for a future of accountable care.

Metro Health's capital needs over the next five years are significant – $190 million. Additional capital for the Epic system and IT is expected to be $12.7 million. Current plans also call for establishing one additional neighborhood outpatient center per year. The roll-out subsidy for physicians – a combination of subsidies and the costs of starting new practices – is expected to add another $7 million per year. Estimates of capital requirements by year are detailed in Exhibit 2.

Metro Health is actively pursuing opportunities to access additional capital. There is an expectation that some opportunities will come from networking

2 METRO HEALTH CAPITAL NEEDS SUMMARY, 2011 THROUGH 2015 ($MILLIONS)

	Proposed Budget 2011	Proposed Budget 2012	Proposed Budget 2013	Proposed Budget 2014	Proposed Budget 2015	Total
Projected CapX						
Replacement Capital	$5.8	$5.8	$5.8	$5.8	$5.8	**$28.8**
Epic/IT	$2.5	$2.5	$2.5	$2.5	$2.5	**$12.7**
Contingency	$2.0	$2.0	$2.0	$2.0	$2.0	**$10.0**
Total Anticipated Projections	**$10.3**	**$10.3**	**$10.3**	**$10.3**	**$10.3**	**$51.5**
Additional Capital Needs (Estimated Costs)						
Epic Rollout Subsidy						
Metro Active Staff (140 Providers) plus	$1.5	$0.3	$0.3	$0.3	$0.3	**$2.5**
Other Providers	$2.7	$0.5	$0.5	$0.5	$0.5	**$4.5**
Current Neighborhood Outpatient Center Updates	$0.5	$0.2	$0.1	$0.3	$0.1	**$1.3**
Physician Employment (Project based on 2011)	$0.9	$0.9	$0.9	$0.9	$0.9	**$4.7**
New Neighborhood Outpatient Sites (1 per year)		$1.0	$1.0	$1.0	$1.0	**$4.0**
Trauma Advancement (Level 3; 500K Capital)		$0.3	$0.8	$0.3	$0.3	**$1.5**
OR & ER Build Out (6 OR's, Pre & Post OP; 24 ED rooms)			$23.4			**$23.4**
Beds – New Tower[1] (144 patient rooms and interior support space)				$95.5		**$95.5**
Power Plant		$24.0				**$24.0**
Meaningful Use (estimated federal funding for meaningful use)		-$3.3	-$2.4	-$1.6	-$0.9	**-$8.3**
Cardiovascular (Elective Angioplasty)		$10.0				**$10.0**
Days Cash on Hand (40 day increase in addition to operating results)		$6.7	$6.7	$6.7	$6.7	**$26.8**
Total	**$5.7**	**$40.5**	**$31.2**	**$103.8**	**$8.8**	**$190.0**

"Actually, these are our basic needs. The good news is, we have been largely successful with our strategies over the past several years, and this is opening up new opportunities. The bad news is, we've largely used up our ability to finance strategies to take advantage of the new opportunities."

– Michael Faas, CEO

strategies. For example, Pennant's approach to back room services could free up debt capacity through improved operating performance. Other options to be explored involve further affiliation and, as of this date, remain confidential.

CHALLENGES AHEAD

Looking to the future, Metro Health's leaders know they have to make many more changes. These include:

- **Effective population health management.** Metro Health has established a strong platform for population health management; however, more emphasis is needed on prevention. Primary care physicians need to focus more on early diagnosis. In order to free up their time, PCPs need to make better use of mid-levels and nurses.
- **Reducing fragmentation and further aligning incentives.** Metro acknowledges a need to reduce fragmentation among physicians, which will probably require going to a salary model for more of its doctors. They also recognize that as primary care physicians take on a larger role in the management of patients, they should be able to earn as much, or more, than they do under fee-for-service, and the spread between primary care physicians and proceduralists should come down.
- **Involvement in Medicare demonstration projects.** It is recognized that Metro Health should be part of the ACO program under the new health care law. The fact that Metro Health has an advanced EHR at every level makes it possible to participate in this and other new CMS initiatives.
- **Developing physician leadership.** It is recognized that more leadership needs to come from medical specialists. Primary care physicians at Metro Health are struggling financially, and they often lack the time to exert much more leadership than they do today. Metro Health expects to make greater use of primary care and specialist teams to lead the system.
- **Improving access to capital.** Metro has far more opportunities for growth and strategic initiatives than it can finance with its limited capital base. As a small, independent hospital, Metro has relatively limited access to capital. Volumes are high right now, and Metro is doing well financially; however, the system may require additional capital to take full advantage of its opportunities in the emerging environment.

In summary, Metro Health has positioned itself well for moving to new payment environments. Its challenges are to implement well and avoid becoming so capital constrained that it misses key opportunities.

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