Clinical Integration Talking Points

Recommended Responses to Physician Questions and Concerns
Introduction

As new accountable payment models place pressure on hospitals to engage physicians more closely in care delivery redesign, a number of institutions are looking to Clinical Integration (CI) as an alignment strategy. While physicians have much to gain from CI participation, many may be wary of making the requisite investment in performance improvement or of collaborating so closely with a hospital partner. Based on conversations with successful CI programs and legal experts, the Health Care Advisory Board has compiled a set of talking points designed to help organizations overcome this challenge and engage physicians in CI. This brief provides physician-friendly responses to frequently asked questions and common concerns held by physicians around CI participation requirements, physician oversight of program strategy, and potential membership benefits.

Contents

Questions and Answers Applicable to All Physician
I. General Background on Clinical Integration ........................................ 4
II. Clinical Integration and Accountable Care/Health Care Reform ........ 8
III. Participation Requirements for Physicians ..................................... 10

Specialty-Specific Questions and Answers
I. Primary Care Physicians ............................................................ 14
II. Community-Based Medical Specialists ...................................... 18
III. Proceduralists ........................................................................... 20
IV. Hospital-Based Non-Admitting Specialists .................................. 23

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A Note to Program Sponsors

The following talking points are designed to help organizations engage physicians in Clinical Integration (CI), providing responses to frequently asked questions and common concerns held by potential program participants.

A few notes about this document: First, while answers to many basic questions about CI are pertinent for all physicians, other responses will vary depending on a physician’s specialty. For example, primary care physicians (PCPs) will likely derive different participation benefits than specialists. As a result, this document is structured to first answer questions applicable to all physicians, such as an explanation of the legal environment around CI and an overview of participation requirements for program participants. These general responses are then followed by sections customized for different physician types to describe participation benefits and potential performance initiatives.

Second, for some questions, the response provided describes a process or decision—such as the choice that physicians need not use an ambulatory electronic health record to participate—that is typical for most CI programs, but may not be pertinent for every institution. Please customize these talking points based on your individual organization’s plans as appropriate. We have provided additional notes on customization throughout this document in italic text.

Finally, these talking points are intended for use as part of a larger effort to engage physicians in CI. In addition to clear messaging, conversations with successful CI programs and legal experts offer the following suggestions for communicating with physicians around CI:

- Message delivery exclusively by physician leaders, not hospital administrators, to avoid any perception that CI represents a takeover of independent medical practice by the hospital
- Repeated communication around CI across multiple forums, including newsletters or mailings, one-on-one meetings with physicians, general medical staff gatherings, online communications, etc.
- Patience and persistence, with an appreciation that growth in the CI program’s physician ranks will likely be slow but steady

For more lessons on launching a CI program—including guidance on engaging and organizing physicians—please see the Health Care Advisory Board publication entitled Building the Performance-Focused Physician Enterprise: Road Map for Assessing and Implementing a Clinical Integration Strategy, available for download at www.advisory.com/hcab/publications.
CI is a strategy in which physicians make a significant, collective commitment to performance improvement, supported by jointly negotiated payer contracts.

A legally viable CI program—one that is able to contract jointly on physicians’ behalf—must meet a three-part antitrust standard.

Questions and Answers Applicable to All Physicians

I. General Background on Clinical Integration

Q. What is Clinical Integration?

A. At a high level, Clinical Integration (CI) is a strategy in which physicians—often in partnership with a hospital or health system—make a significant, collective commitment to performance improvement and an investment in infrastructure to facilitate these quality and efficiency gains. To support these efforts, independent physicians participating in a CI network may negotiate jointly for commercial payer contracts under a “safe harbor” from antitrust law, often receiving favorable reimbursement or performance-based bonuses as a result.

Q. What are the hallmarks of a legally viable Clinical Integration program?

A. The term “clinical integration” is sometimes used loosely in reference to informal efforts by hospitals and physicians to collaborate on quality or share data across sites. But a legally viable CI program—one that passes antitrust muster and is able to contract jointly on physicians’ behalf—must meet a three-part legal standard outlined by the Federal Trade Commission (FTC) and Department of Justice (DOJ):

1. Participants in the CI network must demonstrate a significant commitment to cost control and quality improvement with realistic expectations of achieving their stated goals.

2. Joint contracting with commercial payers is permissible only to the extent that it is “ancillary” or subordinate to other activities—in other words, “reasonably necessary” to support the program’s investment in performance infrastructure and ensure participating physicians can easily collaborate.

3. The collaboration will not give participating providers too much market power. Generally, market share above 35 to 40 percent of physicians in any specialty can raise market power concerns, although substantially higher market share may be tolerated if the collaboration is non-exclusive (meaning physicians are free to contract with payers individually if the network cannot reach a joint contract). In a legally acceptable CI program, payers sign joint contracts with the network because they see value in performance activities, not because of the network can command market power.
Eight program components are vital to achieving quality and efficiency improvement and passing antitrust scrutiny

I. General Background on Clinical Integration (Continued)

Q. These legal descriptions are a little vague. In practice, what components does a CI program need to include?

A. The FTC and DOJ have been reluctant to define requirements for CI programs too specifically, fearful of limiting providers’ flexibility to respond to specific market characteristics and needs. But a review of their published guidance and conversations with existing CI programs highlight the following eight program components as vital to achieving quality and efficiency improvement and passing antitrust scrutiny:

1. **Selective Physician Partners**: Inclusion of only those clinicians who are willing and able to advance program’s performance improvement goals
2. **Physician Oversight**: Broad engagement of participating physicians in leadership and governance roles
3. **Meaningful Performance Metrics**: Selection of initiatives and goals that will generate real quality and efficiency improvements without overwhelming network capabilities
4. **Optimized IT Infrastructure**: Platforms to facilitate data exchange between practices and care sites
5. **Support for Clinical Redesign**: Technology tools and staffing to aid physicians in effective care management and coordination
6. **Performance Monitoring**: Systems to monitor network performance against goals and remedy any identified shortfalls
7. **Payer Engagement**: Joint contracts that support CI program investment and facilitate care coordination between physicians
8. **Performance-Based Incentive Pool**: Bonus structure that rewards physicians both individually and collectively for meeting program goals
I. General Background on Clinical Integration (Continued)

Q. Why is the hospital/health system interested in CI?

A. Many hospitals and health systems are now partnering with physicians to create CI networks. Several key reasons underlie this growing interest in CI:

• Preparing for performance-based pay and accountable care: Across the next few years, payers (led by Medicare) will shift toward new reimbursement models that put physicians and hospitals at more risk for cost and quality outcomes. These new payment structures include increased use of pay-for-performance bonuses; “bundles” that combine hospital and physician payment for an inpatient stay or episode of care; and shared-savings contracts that pay provider groups a portion of any cost savings achieved. CI provides a framework for physicians and hospitals to work together on improving efficiency, coordination, and consistency of care for success under these new payment models.

• Stabilizing private-practice economics: Many independent physicians—including both primary care physicians and specialists—are feeling a sense of financial instability, thanks to volume declines, reductions in professional fees and ancillary reimbursements, and rising practice costs. Combined with uncertainty around the impact of health care reform, these changes are leading some physicians to seek shelter in hospital employment. Yet many physicians still prefer to remain in private practice. By offering access to favorable contracts, performance-based bonuses, strong referral networks, and care management resources, CI helps independent physicians gain financial stability and remain in private practice if they desire.

• Partnering with physicians to improve hospital quality: Through CI, hospitals can work closely with physicians to reach longstanding goals for hospital performance, such as reducing hospital-acquired infections, improving core measures compliance, or avoiding unnecessary readmissions. CI provides physicians with an opportunity to take a leadership role in these efforts while strengthening the relationship between the hospital and its medical staff. In addition, by bringing together different specialties under common incentive and governance structures, CI creates—and rewards—collaboration between groups of physicians who may not work together today.

• Attracting payer and employer interest: Performance gains achieved by the CI program are ultimately intended to generate value—better quality at lower cost—for consumers. As such, many payers and employers are attracted by the ability to contract with the CI program as a market leader on quality and efficiency. These contracts may bring new patients to the hospital and physicians and are often structured to provide favorable reimbursement or bonuses to further support the CI program’s quality improvement efforts.
I. General Background on Clinical Integration (Continued)

Q. What is the hospital’s or health system’s role in developing and supporting the CI program?

A. At its root, CI is about physician performance improvement—an investment by physicians in quality and efficiency that provides an antitrust safe harbor for physician joint contracting. Most CI networks contract jointly with payers only for physician reimbursement; hospital payments are not included in those contracts.

As a result, the hospital’s primary role when it comes to CI is to facilitate this physician-led effort and to streamline any barriers on the inpatient side that might prevent the CI network from reaching its goals. The hospital will fulfill this role by providing funding to support program operations and representatives to sit on the program’s board and operating committees. But the hospital will not maintain a controlling stake in any aspect of governance or management. Rather, physicians will play an active role in setting strategic direction for the program and retain oversight of selecting performance initiatives and care standards for their respective clinical areas.

Q. How will the CI organization be different from the physician-hospital organizations (PHOs) that many hospitals and physicians established during the 1990s?

A. In the 1990s, most organizations developed PHOs to manage capitation contracts or other arrangements that put physicians at full shared financial risk for the care furnished to patients. PHOs were—and indeed still are—permitted to jointly negotiate these risk contracts with payers under a second safe harbor from antitrust regulations, known as “financial integration,” under the argument that the potential for financial loss provides an incentive for physicians to work together on producing care efficiencies for consumers. As capitation and other forms of full-risk contracting fell out of favor, however, PHOs established during the 1990s struggled to remain relevant, with many remaining in business only as “messengers” for ferrying contracts between payers and physicians or repositories for limited practice management services.

CI has provided an opportunity for PHOs to undergo a quality-focused renaissance. Interestingly, the infrastructure and processes needed to succeed under both capitation and CI are essentially the same—commitment to performance improvement, data monitoring capabilities, care management and coordination resources, etc. The primary difference is that financial integration relies on external funding mechanisms to give physicians a vested interest in quality and efficiency, while CI creates internal mechanisms to do the same. As a result, many CI programs today have grown out of PHOs and other organizations originally established in the 1990s.
Clinical Integration Talking Points

II. Clinical Integration and Accountable Care/Health Care Reform

Q. I’ve been hearing a lot about accountable care organizations (ACOs). What is the relationship between a Clinical Integration network and an ACO?

Note: The following is a basic description of the relationship between CI programs and ACOs. Program sponsors may wish to customize this description based on their own plans to develop or partner in an ACO.

A. An accountable care organization (ACO) is a group of providers who come together to manage the cost, quality, and utilization of services for a given population of patients. Starting in 2012, Medicare will launch a program to pay these ACOs through a new Shared-Savings Program that provides an incentive to manage down the cost of care for a population of Medicare beneficiaries. Voluntary at first, this new payment model is intended eventually to expand across the entire Medicare population. As with other trends in Medicare reimbursement, many commercial payers are expected to follow suit and also begin transitioning toward accountable payment across the next few years; some markets are already seeing interest from their commercial payers.

In order to successfully manage accountable payment models, ACOs will need to take several steps: tightening integration between physicians and hospitals; ramping up use of clinical IT; enhancing primary care; managing chronic disease; avoiding unnecessary inpatient utilization; and strengthening coordination with post-acute providers. Many of these changes are facilitated by CI, with its focus on quality and efficiency improvement through evidence-based care standards, care coordination, and data exchange. As a result, CI can be a building block toward accountable care, bringing physicians together in a performance-focused network to form the foundation of an ACO.

That said, a CI program can pass antitrust scrutiny without taking on the full spectrum of functions needed to succeed as an ACO.

That said, CI and ACO are not wholly interchangeable concepts. A CI program can deliver adequate consumer efficiencies to pass antitrust scrutiny without taking on the full spectrum of care coordination and population health management functions needed to succeed as an ACO. The table on the next page highlights some key differences between the imperatives faced by a CI program operating in a traditional fee-for-service environment and one operating in an accountable care environment. Many CI programs begin toward the left side of this table and migrate toward the right as physicians grow more comfortable working together on performance improvement.
Q. Why should I participate in CI or any other preparations to become an ACO when the health care reform law might be revised or repealed?

A. Despite legal challenges and a new Republican majority in the House of Representatives, it is unlikely that changes to Medicare reimbursement contained in the Patient Protection and Affordable Care Act (PPACA, the federal health care reform law) will be overturned. The most contentious portions of PPACA concern insurance coverage expansion; by contrast, delivery system reform—catalyzed by new payment methodologies such as the Shared-Savings Program or bundled payments—enjoys considerably more bipartisan support. As the population ages, the federal government is facing punishing financial obligations, and few lawmakers see virtue in Medicare’s current fee-for-service incentive scheme. As a result, the shift toward increased provider accountability in payment is likely to continue, regardless of what happens to the insurance coverage provisions in PPACA.

Furthermore, participation in CI can provide physicians with many benefits outside an accountable care environment. Many commercial payers are also beginning to demand greater reliability and quality from providers, and CI provides physicians with the opportunity to access contracts that reward them for that commitment. Indeed, one of CI’s primary advantages is its ability to reward physicians today—in a continued fee-for-service environment—for the commitment to performance improvement, while also preparing them to navigate the still-uncertain path toward greater accountability.
III. Participation Requirements for Physicians

Q. What will participation in the CI program require of physicians?

Although the CI program is still under development, physicians who participate in CI are typically asked to commit to the following:

• **Performance improvement initiatives:** Performance improvement initiatives describe the quality, efficiency, and administrative goals the CI program will pursue to deliver value—for example, improving diabetes management or increasing generic drug utilization. Each participating physician will be expected to follow all performance measures that are relevant to his or her specialty. *(For more on performance initiatives, please see the section on specialty-specific questions and answers.)*

• **Performance monitoring processes:** Performance measurement allows the CI program to track individual and group progress against network goals. Through monitoring, the program can identify physicians who may need assistance or support, determine how goals should be revised year over year, and prove program value to payers, employers, and patients. For physicians, the commitment to performance monitoring generally entails the following:
  o Report practice-level outcomes data to the CI program, usually by extracting from practice management systems or electronic health records if available
  o Review personal and group performance data to identify areas for improvement
  o Participate in remediation or disciplinary action plans should physician fall short of program benchmarks

• **Use of information technology (IT) systems:** CI programs rely on a web of clinical and administrative IT systems to collect and exchange data. These systems—which may include disease registries, Internet-based “portals” into a data warehouse, and physician “report cards”—support physicians’ ability to manage and improve patient outcomes, and the network’s ability to monitor and improve performance overall. Physicians will be expected to utilize these IT platforms actively as a condition of participation. *(Some networks also choose to mandate that physicians use an electronic health record (EHR) as a condition of participation, but most CI programs operate successfully without an EHR. See page 12 for more on EHR requirements.)*

• **Attendance at educational, governance, or other program-sponsored meetings:** These sessions are designed to aid physicians in achieving quality goals or setting program strategy. Time spent attending such meetings is also a form of “sweat equity” investment in the CI program—a key indication from an antitrust perspective that physicians are legitimately integrated and may pursue joint contracting.
Joint contracting is vital to ensure that patients can remain within the performance-focused CI network and to support program investments.

III. Participation Requirements for Physicians (Continued)

Q. What will participation in the CI program require of physicians? (continued)

- **Participation in all jointly negotiated payer contracts**: The CI program will be “non-exclusive,” meaning that if the network cannot reach a joint agreement with a payer, physicians will be free to contract individually with that payer outside the network. However, joint contracting is vital to ensure that patients can remain within the performance-focused CI network—enhancing care coordination and increasing data available for performance monitoring—and to support program investments in other ways. As a result, if a joint agreement is reached with a payer, CI physicians will be expected to participate in that contract.

- **Payment of organizational dues (optional, depending on how the CI program is structured)**: As the CI program is incorporated under an organization that is jointly owned by physicians and the hospital, physicians will be expected to contribute financially to its operations on an annual basis. This investment on physicians’ part is, again, a clear demonstration of commitment to program success, helping to prove—along with the “human capital” investments of time spent on program operations and performance initiatives—that physicians are legitimately integrated and legally capable of joint contracting.

Finally, CI programs place a heavy premium on physician involvement in governance and management. Although physicians will not be required to take a leadership role in the CI program, many may ultimately choose to do so, for example, by serving on committees to select performance metrics or oversee bonus distribution. Physician oversight of the CI program ensures that performance expectations are physician-friendly, enhances collaboration between providers, and again demonstrates physicians’ investment in program success.
Most existing CI programs operate successfully without requiring ambulatory EHR use as a condition of participation.

### III. Participation Requirements for Physicians (Continued)

**Q. Will physician practices be required to use an electronic health record (EHR) to participate in CI?**

*Note: The following answer represents the decision made on EHR use by most CI programs. Please customize as needed to describe your own institution’s planned strategy for collecting and sharing data.*

A. No. While a common EHR can facilitate clinical integration—for example, by making it easier to share data between sites or embed clinical decision support tools at the point of care—most existing CI programs operate successfully without requiring ambulatory EHR use as a condition of participation. Like those networks, our program will instead rely on other means to collect and share data between participating providers, such as an Internet-based “portal” that will allow physicians to view information pulled from practice management systems, inpatient EHRs, disease registries, and other systems.

For physicians who are interested in adopting an ambulatory EHR, the CI program will offer assistance, such as subsidies for purchasing a common record system and implementation support. The program also will support physicians who already maintain an EHR to best leverage the system for quality improvement and data sharing. Through this assistance, the CI program will gradually support a long-term goal of expanding EHR use among participating physicians.

**Q. Will physicians be required to refer patients only to providers affiliated with the CI program?**

A. No. The CI program will not require in-network referrals. However, as the program works to enhance communication and build collaboration between its members, participating physicians may increasingly choose to refer patients to other clinicians and facilities within the network, in order to ensure that patients receive coordinated, high-quality, cost-effective care across the continuum. Indeed, antitrust authorities have acknowledged that one rationale for permitting joint contracting in a CI setting is to protect physician-driven in-network referrals by guaranteeing that all physicians participate in the same health plans.

The CI program will not require in-network referrals, though better communication may lead to referral shifts.
Physician oversight is a hallmark of an effective CI program—vital to ensure the selection of initiatives and infrastructure most likely to achieve realistic and meaningful gains.

Hospital-employed physicians will be integral to the CI program’s success.

### III. Participation Requirements for Physicians (Continued)

**Q. How will physicians be involved in the development and leadership of the CI program?**

A. Physician oversight is a hallmark of an effective CI program—vital to ensure the selection of initiatives and infrastructure most likely to achieve realistic and meaningful quality and efficiency gains. Physicians will make up 50 percent (or more if applicable) of the network’s board of directors and have similar representation on all program operating committees, which cover areas such as performance monitoring, payer contracting, and performance bonus distribution. In addition, physicians will be responsible for selecting clinical performance initiatives, care standards, and guidelines for their respective specialties. The CI program will also employ a chief medical officer (or other administrative physician leadership—please customize based on your program’s staffing structure).

**Q. I’ve heard that membership in the CI program will be “selective.” What does that mean?**

A. The CI program’s aim is to be as inclusive as possible. That said, participation in the network’s activities and contracts will be limited only to those physicians who are willing and able to help the program achieve its objectives for performance improvement. This “network selectivity” has been cited by federal antitrust agencies as a key component in ensuring that CI programs can legitimately achieve quality and efficiency aims. In practice, network selectivity means that physicians will be expected to commit to quality and efficiency improvement initiatives, share performance data, and meet other participation standards outlined above. The CI network will monitor physician performance to ensure all network members meet these standards and will provide resources and support to assist physicians in addressing any identified areas of underperformance.

**Q. Will physicians who are employed by the hospital also be able to participate in the CI program?**

A. Yes. Hospital-employed physicians will be integral to the CI program’s success. The employment contract alone is not sufficient to support physicians in quality and efficiency improvement; like their private-practice peers, employed physicians too need resources to aid performance efforts, particularly as the reimbursement environment tips toward accountable payment models. The participation of employed physicians also benefits the CI program as a whole by expanding the quality-focused referral network, increasing the amount of data available for outcomes monitoring, and providing an opportunity for different physician groups to collaborate on initiatives that strengthen patient care across the medical staff.
Specialty Specific Questions and Answers

The sections below provide greater detail about participation benefits and performance initiatives for physicians divided into the following four groups:

Key Physician Groupings for CI

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<th>Representative Specialties</th>
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Joint contracts are often particularly meaningful for PCPs, given their lower base reimbursement relative to specialist peers

I. Primary Care Physicians (PCPs)

Q. Primary care physicians will be making a significant commitment to the CI program. What benefits will they realize in return?

A. Primary care physicians (PCPs) have much to gain from participation in a CI program. Expected benefits of membership include the following:

* **Increased reimbursement:** CI contracts typically provide favorable reimbursement rates compared to those attained by independent physicians negotiating individually, and/or performance-based bonuses to reward physicians financially for their investment in performance infrastructure and improvements. These rewards are often particularly meaningful for PCPs, given their lower base reimbursement relative to specialist peers. While specific contract terms vary between payers and markets, many CI program report that joint contracts and performance-based bonuses have provided a large enough revenue boost to stabilize faltering primary care economics and keep PCPs in private practice.
I. Primary Care Physicians (Continued)

Q. Primary care physicians will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

• Assistance with care management or IT support: The CI program will provide access to several tools designed to help provide better care, such as the following:
  - Disease registry
  - Care management staff (e.g., disease management, discharge planning, patient activation, health coaches)
  - Care guidelines
  - Referral tracking
  - Decision support tools
  - Patient portal

These tools are intended to aid in managing chronic disease, coordinating referrals, and reducing unnecessary utilization of high-cost care—key goals for the PCP. While these resources will be used by all CI-participating physicians, they will be particularly useful to PCP participants.

• Transition to new primary care models: Many CI programs provide services to assist PCPs in implementing new, more effective models of primary care. For example, programs frequently offer consulting and other resources to practices interested in becoming a certified patient-centered medical home (PCMH). Joining the CI network also will provide PCPs with access to payer contracts that financially support these efforts to redesign and strengthen the primary care enterprise.

• Opportunity to collaborate with peers: The CI program will bring together physicians from multiple practices to coordinate on patient care improvement. While this collective effort is valuable for all physicians, it may be particularly so for PCPs, whose opportunities to interact with peers outside the practice have become more limited as they spend less time in hospital settings. Primary care committees offer PCPs a chance to play an active and collaborative role in selecting high-value clinical initiatives, suggesting key resources for care management, setting care standards, and steering CI program direction.

• Strengthened referral communication: The CI program will not require that PCPs refer only to other providers within the CI network. However, the program will strive to build bridges between participating PCPs and specialists in order to improve communication around patient handoffs, ensure care quality/efficiency, and maximize the amount of patient data available to the program for performance improvement analysis. These efforts will improve PCPs’ ability to track care received by patients in specialty, acute, and post-acute settings and to follow-up or coordinate services as needed.
Joining a CI network today allows PCPs to ensure access to high-quality partners and other assistance as reimbursement models begin to shift.

I. Primary Care Physicians (Continued)

Q. Primary care physicians will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

• Preparation for new reimbursement models: As new accountable payment structures place more risk for patient outcomes on providers, physicians will need to work together and with hospitals to improve coordination and prevent unnecessary utilization. PCPs will be at the heart of that enterprise, in a position of both more power and more responsibility. Joining a CI network today allows PCPs to begin this process—to ensure they have access to high-quality partners and performance improvement assistance as reimbursement models begin to shift.

• Opportunity to improve care quality and costs: At the end of the day, PCPs want what is best for their patients. CI programs have a proven track record of improving quality outcomes and slowing the rate of health care cost growth—with many of the most visible and highly touted improvements coming in primary care-focused areas such as diabetes, heart failure or asthma management. Participation in the CI program will allow PCPs in our market to effect similar changes for their own patients.

Q. What types of performance initiatives will PCPs pursue?

A. The CI program will target a mix of clinical and administrative performance initiatives and goals. Administrative initiatives generally apply to all participating physicians and will be selected by a physician-led committee for use across the program. Clinical initiatives are often specialty-specific in application and chosen by physicians working in the relevant specialty area. Primary care initiatives will be chosen by physician subcommittees with expertise in specific disciplines such as family practice, hospitalist medicine, or pediatrics.

Metric selection will be based on potential for care improvement, patient needs, physician capabilities, and availability of data to monitor performance against goals. Initiatives will also evolve over time as physicians become more adept at collaborative performance monitoring and improvement. For example, many CI programs begin by working against familiar Physician Quality Reporting Initiative (PQRI) metrics, then evolve toward a more complex performance agenda as network capabilities grow.

Initiatives and goals thus vary between CI programs based on network composition and capabilities. However, to provide a sense of what sort of primary care metrics physicians in our program might develop, the list below includes examples used by other CI programs.

Primary care initiatives will be chosen by subcommittees with expertise in disciplines such as family practice or hospitalist medicine.
Select CI Program Initiatives for Primary Care Physicians

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<thead>
<tr>
<th>Initiative Type</th>
<th>Possible Initiatives</th>
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| Administrative          | • Utilization of clinical technology (e.g., disease registry)  
                          • Participation in CI program operations (e.g., committee service)  
                          • Reporting of practice data for performance monitoring  
                          • Patient or peer satisfaction  
                          • Use of standardized referral communication  
                          • Board certification  
                          • Continuing medical education attendance |
| Clinical Quality and Efficiency | • Prevention and management of chronic disease (e.g., diabetes patients with hemoglobin A1c in good control, patients with asthma action plans)  
                          • 30-day readmission rate for congestive heart failure (CHF)  
                          • Childhood immunization  
                          • Depression screening in chronic disease patients  
                          • Generic drug utilization  
                          • Smoking cessation education |

Q. How does the CI program relate to other efforts to transform primary care, especially the creation of patient-centered medical homes?

A. CI and the patient-centered medical home (PCMH) are by no means mutually exclusive. Many of the initiatives pursued by the CI program are consistent with PCMH goals, such as use of disease registries or other efforts to better manage chronic illness. CI programs often include PCP practices that have transitioned or are transitioning to PCMH status, and frequently offer consulting or other resources to support practices in making this shift. As noted above, payer contracts negotiated by the CI program also can financially support PCPs in meeting PCMH goals—for example, by increasing PCP reimbursement enough to fund a health coach or other support personnel.

Many of the initiatives pursued by the CI program are consistent with patient-centered medical home goals.
II. Community-Based Medical Specialists

Q. Community-based medical specialists will be making a significant commitment to the CI program. What benefits will they realize in return?

A. Community-based medical specialists have much to gain from participation in a CI program. Expected benefits of membership include the following:

- **Increased reimbursement**: CI contracts typically provide favorable reimbursement rates and/or performance-based bonuses to reward physicians financially for their investment in performance infrastructure and improvements. These rewards may be particularly meaningful in specialty areas, such as cardiology, that have been hard hit recently by cuts in professional fees or in-office ancillary reimbursement.

- **Assistance with care management or IT support**: The CI program will provide access to tools such as disease registries, care coordination staff, clinical decision support systems, and other resources that help physicians provide better care but may be too difficult for individual providers to acquire and manage on their own. Most of these tools are intended to aid in managing chronic disease, coordinating referrals, and reducing unnecessary utilization of high-cost acute care—key goals for cardiologists, oncologists, and other community-based specialists. While these resources will be used by all physicians in the CI network, therefore, they will be particularly useful to participants in these specialty areas.

- **Robust referral stream**: The CI program will not require that physicians keep referrals within the CI network. However, CI programs do strive to build bridges between participating primary care physicians (PCPs) and specialists in order to improve communication around patient handoffs, ensure care quality/efficiency, and maximize the amount of patient data available to the program for performance improvement analysis. For community-based medical specialists, this effort to strengthen collaboration across the continuum can have a meaningful impact in ensuring referral availability from PCPs (particularly important as new accountable payment models put pressure on specialty care utilization).

- **Improved care coordination**: Just as PCPs may be more likely to refer patients to in-network specialists known for their quality and accessibility, specialists stand to gain when patients referred from in-network PCPs are appropriately managed and when communication around those hand-offs is strong. The CI program will also provide care managers and other resources to strengthen the specialist’s ability to track care received by patients referred down the continuum to proceduralists and acute care settings.
Many improvements achieved by CI programs occur in areas meaningful to community-based medical specialists, such as diabetes or congestive heart failure.

II. Community-Based Medical Specialists (Continued)

Q. Community-based medical specialists will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

- Preparation for new reimbursement models: As new accountable payment structures place more risk for patient outcomes on providers, physicians will need to work together and with hospitals to improve coordination and prevent unnecessary utilization. Along with PCPs, medical specialists will be at the heart of that enterprise. Joining a CI network today allows physicians to begin this process—to ensure they have access to high-quality partners and performance improvement assistance as reimbursement models begin to shift.

- Opportunity to improve care quality and costs: At the end of the day, all physicians want what is best for their patients. CI programs have a proven track record of improving quality outcomes and slowing the rate of health care cost growth—with many of the most visible and highly touted improvements coming in areas meaningful to community-based medical specialists, such as diabetes or congestive heart failure. Participation in the CI program will allow physicians in our market to effect similar changes for their own patients.

Q. What types of performance initiatives will community-based medical specialists pursue?

A. The CI program will target a mix of clinical and administrative performance initiatives and goals. Administrative initiatives generally apply to all participating physicians and will be selected by a physician-led committee for use across the program. Clinical initiatives are often specialty-specific in application and chosen by physicians working in the relevant specialty area, such as cardiology or endocrinology.

Metric selection will be based on potential for care improvement, patient needs, physician capabilities, and availability of data to monitor performance against goals. Initiatives will also evolve over time as physicians become more adept at collaborative performance monitoring and improvement. For example, many CI programs begin by working against familiar Physician Quality Reporting Initiative (PQRI) metrics, then evolve toward a more complex performance agenda as network capabilities grow.

Initiatives and goals thus vary between CI programs based on network composition and capabilities. However, to provide a sense of what sort of metrics community-based medical specialists in our program might develop, the list below includes examples used by other CI programs.
### Select CI Program Initiatives for Community-Based Medical Specialists

<table>
<thead>
<tr>
<th>Initiative Type</th>
<th>Possible Initiatives</th>
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</thead>
<tbody>
<tr>
<td><strong>Administrative</strong></td>
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<td></td>
<td>- Continuing medical education attendance</td>
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<tr>
<td><strong>Specialty-Specific Examples</strong></td>
<td>- Hemoglobin A1c in good control (endocrinology)</td>
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<td></td>
<td>- 30-day readmission rate for congestive heart failure (cardiology)</td>
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<td>- Timely post-partum follow up (OB/GYN)</td>
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<td></td>
<td>- Participation in the ASCO Quality Oncology Practice Initiative (medical oncology)</td>
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<tr>
<td><strong>Other Clinical and Efficiency Metrics</strong></td>
<td>- Depression screening in chronic disease patients</td>
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<td>- Generic drug utilization</td>
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<td>- Smoking cessation education</td>
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<td>- Timeliness and accuracy of inpatient documentation</td>
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### III. Proceduralists

**Q.** Proceduralists will be making a significant commitment to the CI program. What benefits will they realize in return?

**A.** Proceduralists have much to gain from participation in a CI program. Expected benefits of membership include the following:

- **Robust referral stream:** The CI program will not require that physicians keep referrals within the CI network. However, the program will strive to build bridges between participating PCPs and specialists in order to improve communication around patient handoffs, ensure care quality/efficiency, and maximize the amount of patient data available to the program for performance improvement analysis. As a result of these improvements, PCPs and community-based medical specialists may increasingly choose to refer patients to in-network providers. Participation in the CI program will help proceduralists retain and strengthen those referral relationships—connections that will likely become even more important as new accountable payment models put pressure on specialty care utilization.
The CI program will work to strengthen links between inpatient and office-based IT platforms, helping proceduralists better track their patients across care settings.

Though the accountable care discussion often focuses on PCPs, proceduralists will play an important role in strengthening inpatient quality and efficiency.

III. Proceduralists (Continued)

Q. Proceduralists will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

• **Improved care coordination:** Just as PCPs may be more likely to refer patients to in-network specialists known for their quality and accessibility, proceduralists stand to gain when patients referred from in-network PCPs are appropriately managed and when communication around those hand-offs is strong. The CI program will also provide care managers and other resources to strengthen post-acute follow-up and patient engagement, helping proceduralists perform better on initiatives targeting readmissions, complications, infections, and other such measures.

• **Increased reimbursement:** CI contracts typically provide favorable reimbursement rates and/or performance-based bonuses to reward physicians financially for their investment in performance infrastructure and improvements. While these rewards are admittedly less meaningful (as a percent of income) for highly paid specialists than for PCPs, the potential gains can still have an impact, especially for specialties facing stagnant professional fees, recession-related volume declines, or cuts to ancillary reimbursement.

• **Assistance with IT support:** The CI program will provide access to tools such as clinical decision support systems and ambulatory electronic health records (EHRs)—resources that help physicians provide better care but may be too difficult for individual providers to acquire and manage on their own. Physicians will not be required to use an ambulatory EHR as a condition of CI participation, but will have access to subsidies and implementation support through the program should they choose to implement one. The CI program will also work to strengthen links between inpatient and office-based IT platforms, helping proceduralists better track their patients across care settings.

• **Preparation for new reimbursement models:** As new accountable payment structures place more risk for patient outcomes on providers, physicians will need to work together and with hospitals to improve coordination and prevent unnecessary utilization. Although much of the discussion around accountable care focuses on PCPs and others responsible for care management, proceduralists have an important role to play too in strengthening the reliability, quality, and efficiency of inpatient and procedural services. Joining a CI network today allows specialists to ensure they have access to partners and performance improvement assistance as reimbursement models begin to shift.
III. Proceduralists (Continued)

Q. Proceduralists will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

• **Opportunity to improve care quality and costs**: At the end of the day, physicians want what is best for their patients. CI programs have a proven track record of improving quality outcomes and slowing the rate of health care cost growth—including in areas that are relevant to proceduralists, such as surgical antibiotic administration or inpatient length of stay. Participation in the CI program will allow specialists in our market to effect similar changes.

Q. What types of performance initiatives will proceduralists pursue?

A. The CI program will target a mix of clinical and administrative performance initiatives and goals. Administrative initiatives generally apply to all participating physicians and will be selected by a physician-led committee for use across the program. Clinical initiatives are often specialty-specific in application and chosen by physicians working in the relevant specialty area, such as general surgery or orthopedics.

Metric selection will be based on potential for care improvement, patient needs, physician capabilities, and availability of data to monitor performance against goals. Initiatives will also evolve over time as physicians become more adept at collaborative performance monitoring and improvement. For example, many CI programs begin by working against familiar surgical care core measures, then evolve toward a more complex performance agenda as network capabilities grow.

Initiatives and goals thus vary between CI programs based on network composition and capabilities. However, to provide a sense of what sort of metrics proceduralists in our program might develop, the list below includes examples used by other CI programs.
For hospital-based physicians, strong referral relationships will become even more important as new accountable payment models put pressure on acute care utilization.

### Select CI Program Initiatives for Proceduralists

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<td>- Continuing medical education attendance</td>
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<tr>
<td>Clinical Quality and Efficiency</td>
<td>- Administration and discontinuation of prophylactic antibiotics for surgical patients (and other surgical core measures)</td>
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<td></td>
<td>- Surgical on-time starts</td>
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<td></td>
<td>- Timely foley catheter removal (to reduce infection rates)</td>
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<td></td>
<td>- Blood usage and post-operative complications in CABG</td>
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<td></td>
<td>- Reduction in ventilator-associated pneumonia</td>
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<td>- Generic drug utilization</td>
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<td>- Use of consultants</td>
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### IV. Hospital-Based Non-Admitting Specialists

Q. Hospital-based physicians (e.g., emergency medicine, radiology, anesthesiology, pathology) will be making a significant commitment to the CI program. What benefits will they realize in return?

A. Hospital-based physicians have much to gain from participation in a CI program. Expected benefits of membership include the following:

- **Robust referral stream**: The CI program will not require that physicians keep referrals within the CI network. However, the program will strive to build bridges between participating PCPs and specialists in order to improve communication around patient handoffs, ensure care quality/efficiency, and maximize the amount of patient data available to the program for performance improvement analysis. As a result of these improvements, PCPs and others may increasingly choose to refer patients to in-network physicians and hospitals. Participation in the CI program will help hospital-based physicians ensure facility quality and strengthen referral relationships—connections that will likely become even more important as new accountable payment models put pressure on acute care utilization.
A data warehouse may help emergency medicine physicians quickly access key information about patients and provide radiologists a more complete view of the patient when interpreting exams.

CI committees offer hospital-based specialists a chance to play an active role in selecting clinical initiatives or setting care standards.

IV. Hospital-Based Non-Admitting Specialists (Continued)

Q. Hospital-based physicians (e.g., emergency medicine, radiology, anesthesiology, pathology) will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

- **Improved care coordination:** Just as PCPs may be more likely to refer patients to in-network physicians and facilities known for their quality and accessibility, specialists stand to gain when patients referred from in-network physicians are appropriately managed and when communication around those hand-offs is strong. For example, a data warehouse provided by the CI program may help emergency medicine physicians quickly access key information about patients and provide radiologists a more complete view of the patient when interpreting exams.

- **Increased reimbursement:** CI contracts typically provide favorable reimbursement rates and/or performance-based bonuses to reward physicians financially for their investment in performance infrastructure and improvements. While these rewards are admittedly less meaningful (as a percent of income) for highly paid specialists than for PCPs, the potential gains can still have an impact, especially for specialties facing stagnant professional fees, recession-related volume declines, or cuts to ancillary reimbursement.

- **Opportunity to collaborate with peers:** The CI program will bring together physicians from multiple disciplines to coordinate on patient care improvement. While this collective effort is valuable for all physicians, it may be particularly so for hospital-based specialists, whose opportunities to contribute to development of referral protocols or other discussions around cross-continuum care are often limited. CI committees offer hospital-based specialists a chance to play an active and collaborative role in selecting high-value clinical initiatives, setting care standards, and steering CI program direction.

- **Preparation for new reimbursement models:** As new accountable payment structures place more risk for patient outcomes on providers, physicians will need to work together and with hospitals to improve coordination and prevent unnecessary utilization. Although much of the discussion around accountable care focuses on PCPs and others responsible for care management, hospital-based specialists have an important role to play too in strengthening the reliability, quality, and efficiency of inpatient services. Joining a CI network today allows specialists to ensure they have access to partners and performance improvement assistance as reimbursement models begin to shift.
Introduction of Clinical Integration Talking Points

Q. Hospital-based physicians (e.g., emergency medicine, radiology, anesthesiology, pathology) will be making a significant commitment to the CI program. What benefits will they realize in return? (Continued)

• Opportunity to improve care quality and costs: At the end of the day, physicians want what is best for their patients. CI programs have a proven track record of improving quality outcomes and slowing the rate of health care cost growth—including in areas that are relevant to hospital-based physicians, such as inpatient length of stay, accuracy of test results, or reduction of hospital readmissions. Participation in the CI program will allow specialists in our market to effect similar changes for their own patients.

Q. What types of performance initiatives will hospital-based specialists pursue?

A. The CI program will target a mix of clinical and administrative performance initiatives and goals. Administrative initiatives generally apply to all participating physicians and will be selected by a physician-led committee for use across the program. Clinical initiatives are often specialty-specific in application and chosen by physicians working in the relevant specialty area, such as radiology or emergency medicine.

Metric selection will be based on potential for care improvement, patient needs, physician capabilities, and availability of data to monitor performance against goals. Initiatives will also evolve over time as physicians become more adept at collaborative performance monitoring and improvement. For example, many CI programs begin by working against familiar Core Measures, then evolve toward a more complex performance agenda as network capabilities grow.

Initiatives and goals thus vary between CI programs based on network composition and capabilities. However, to provide a sense of what sort of metrics hospital-based physicians in our program might develop, the list below includes examples used by other CI programs.

Improvement areas that are relevant to hospital-based physicians include inpatient length of stay, accuracy of test results, or reduction of hospital readmissions.

IV. Hospital-Based Non-Admitting Specialists (Continued)
## Select CI Program Initiatives for Hospital-Based Specialists

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<td></td>
<td>● Continuing medical education attendance</td>
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<tr>
<td>Specialty-Specific</td>
<td>● Acute myocardial infarction—aspirin on arrival (emergency medicine)</td>
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<td>● Appropriate utilization of CT scans in the emergency department</td>
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<td>● Timely completion of surgical pathology reports (pathology)</td>
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<td></td>
<td>● Timing of CT/MRI/ultrasound/etc. reports—transcribed to verified (radiology)</td>
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<td></td>
<td>● Immediate post-operative normothermia—colorectal surgery (anesthesiology)</td>
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<tr>
<td></td>
<td>● Surgical on-time starts (anesthesiology)</td>
</tr>
<tr>
<td>Other Clinical Quality and Efficiency</td>
<td>● Length of stay</td>
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<td>● Generic drug utilization</td>
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