SURVIVAL OF COMMUNITY MISSION: THE NEED FOR NEW INFORMATION AND PARTNERSHIPS IN THE ERA OF MANAGED CARE

Hospital Trustees of New York State

The Challenge of Governance

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I. Introduction

The introduction of managed care and the deregulation of health care in New York State has fundamentally and permanently changed the way health care services are delivered. These changes present to providers both opportunities and increased risks. Hospitals who identify and quickly respond to these new realities will thrive, those hospitals that do not respond will find their community mission threatened, and may not, and probably should not, survive.

Managed care is rapidly changing the relationship between providers. Most importantly, managed care has diminished the importance of hospitals and the acute-care patient in health care delivery and financing system. Hospitals are still an essential, albeit equal participant in the healthcare delivery system, and are increasingly treated as just another cost center along the continuum of care. Managed care has also raised the prominence of physicians by using physicians, in many cases, to control access to the entire health care delivery network.

Boards of Trustees and hospitals have responded to the changing health care environment through mergers, affiliations, consolidations, and layoffs. However, to insure long-term success and the survival of their community mission, hospitals must partner with physicians and use this partnership to develop a new set of information which will help the partners increase efficiencies by redesigning the way care is delivered. Hospitals and physicians must work together to ensure care is delivered at the right time, in the right setting, for the right price. Health care delivery systems need to create information which identifies the costs of providing care as a patient moves through the delivery network.

Yesterday

Regulated

Data

Requirements

Today

Patient Care

Information

Requirements

New integrated delivery networks are developing which consist of not only of hospitals, but also of home health care, ambulatory surgery, long-term care, hospice, rehabilitation, and physicians. The effectiveness of these healthcare delivery networks will depend upon whether system components can work together to create efficiencies, and ultimately, lower health care costs.
Success will come from aligning financial incentives among network components, especially hospitals and physicians, and providing these components with the information necessary to manage risk, improve quality, align incentives and increase value. Creating provider partnerships, aligning financial incentives between partners, and providing the system with timely administrative, financial, and clinical information will be the “glue” that binds these systems together and determines their ultimate competitive success.
II. Managed Care and Information

Managed care is changing the way health care is delivered and the information required to deliver care. Health care is an information business, and those who manage and control information will have a distinct advantage in the race to control the delivery of health care services. Hospitals need to use information to effectively negotiate rates and fees in a deregulated environment. These same information resources can be used to create the infrastructure essential to manage care in the most efficient and effective manner.

What is meant by managed care? Currently, most managed care efforts are focused on managing costs, not care, and are being performed by managed care organizations, not hospitals or physicians. Managed care organizations are attempting to manage care over the telephone, by restricting access to the emergency room and by managing inpatient utilization, focusing almost exclusively on lowering costs.

True managed care however, consists of providing the right care, in the right setting, at the right time, for the right price. True managed care focuses on both the cost and quality of care. True managed care requires the management of care consistent with the concurrent improvement of quality and reduction of costs in providing that care.

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<th>True Managed Care</th>
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<td>QUALITY</td>
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Efficiently managing care requires information that is drawn from multiple sites and providers, and is coordinated across the network to insure optimal efficiency. Information will serve as the basis for reshaping and managing how care is delivered.

In this new information environment, providers are being placed at risk, through capitation or other financial mechanisms, for the utilization and costs of a defined population. Unfortunately, most hospitals do not have the information available to make utilization and cost estimates for a given population, because most hospital information systems were designed to function under the old, regulated environment. These information systems cannot define the costs of providing services or the population-based utilization of these services and do little to assist in defining and defending the quality of service provided. Uncertainty results, as the risks of capitated
contracting cannot be estimated, or managed, due to lack of information, and the hospital is left negotiating in a vacuum.

Information is therefore needed on cost and utilization measures in response to the changing payment structures of managed care. Information that describes all elements of patient care as a patient moves through the system is needed in order to effectively manage care. Coordinated, reliable and accurate financial, administrative, and clinical data must be made readily available to support clinical decision making, create accountability and to create a patient-centered, information environment.
III. Changing Information Needs

Health care is changing, with the transition away from fee-for-service payment systems to a prepaid approach, which creates a need to manage and redesign the way health care services are provided, and places greater emphasis on defining and defending health care service value. These changes identify the scope of a hospital’s information needs. Historical information systems structured to support regulated inpatient care are rapidly becoming obsolete and need to be replaced with systems that focus on the patient, the provider, the diagnosis, and encounters across the continuum of care.

The new information requirements for both hospitals and physicians will involve the integration of financial and clinical information across the delivery network. Financial data will be used to determine both direct and indirect costs of various procedures, in addition to creating population-based utilization profiles. Clinical and demographic information will be integrated with financial encounter and procedure information to create an accurate picture of both the costs and the process of providing care throughout the delivery network. These new information needs include:

- **A Single Patient Identification Number** - The patient record must become computerized for consistent access across the continuum of care, with a common patient number accessible for all providers;

- **Encounter Data** - Information on population-based utilization patterns, including community utilization patterns which measure use rates for all local healthcare facilities, outliers, and referrals;

- **Clinical Data** - Information on demographics, treatments, choices, protocols, practice variation, outcomes, test results, and pharmacy claims;

- **Process Data** - Information on patient satisfaction, resource consumption, and identification of efficient providers;

- **Financial Data** - Information on direct and indirect cost per procedure, population utilization, severity adjusted productivity.
Competition for the health care dollar will be based increasingly on the concept of value, a relative measure of the quality and cost of health care services. Hospitals will increasingly have to define and defend their concept of value to payers, including Medicare and Medicaid programs which are rapidly moving to managed care, employers, managed care organizations, physicians and other potential network partners, and most importantly, patients. The definition of value will depend on information, for without information, quality and cost cannot be measured or modified.
IV. Information and Quality Improvement

The key to restructuring health care delivery and increasing efficiency is the creation of information-based quality measures, which, when used properly, will help hospitals and physicians evaluate and improve the value of the health care services they provide.

Quality improvement initiatives build upon the underlying goals of health care delivery and attempt to measure the extent to which these goals are achieved. The quality improvement process also identifies delivery system problems and tracks information-based solutions. Information on quality can also be used to administer system-wide patient care. Information is needed which tracks patients as they move through the health care delivery system, to assure referrals to appropriate sources for care, to receive follow-up care, and to receive, and take, prescribed medications. Successful and unsuccessful procedures also need to be tracked, as it is difficult to identify repetitive, duplicative, or unnecessary tests or procedures without information.

Quality indicators for which information is needed include:

- Risk-Adjusted Mortality Rates
- Malpractice Claims
- Immunization Rates
- Readmission Rates
- Post-Treatment Quality of Life

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<th>Common Quality Improvement Goals</th>
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<td>Trustees should work with hospital administration to develop information which measures achievement of the following quality improvement goals:</td>
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<tr>
<td>- Reduce Inappropriate Admissions</td>
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<td>- Measure Effects of Preventative Practices</td>
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<td>- Lower Cesarean Section Rates</td>
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<td>- Reduce Inappropriate or Excessive Ancillary Procedures</td>
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<td>- Reduce Variation in Procedural Outcomes</td>
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<td>- Improve Communication with Patients</td>
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<td>- Improve Immunization Rates</td>
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<td>- Identify and Address Outliers</td>
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<tr>
<td>- Lower Readmission Rates</td>
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<td>- Lower Emergency Room Utilization</td>
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<tr>
<td>- Eliminate Excessive Pharmaceutical Use</td>
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<tr>
<td>- Improve Overall Patient Satisfaction Levels</td>
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<td>- Lower Length of Stay</td>
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Patients ultimately decide the quality of treatment they receive, and often focus on the patient-physician relationship. However, by tracking the following events, hospitals can begin to build the clinical databases necessary to assess community needs, manage care, improve value, redesign the delivery of care, achieve identified quality goals, and partner with physicians and other providers:

- **Access to Care** - Creating information to ensure access is adequate, appropriate, and timely;

- **Preventative Care** - Focus on diagnosis, immunizations, and screening tests;

- **Appropriate Diagnosis and Treatment** - Clinical guidelines, follow-up, patient tracking;

- **Management of Chronic Care** - Monitoring of continuity of care and identification of any breakdowns;

- **Preventable Adverse Outcomes** - Clinical review, readmissions, deficiencies, and preventative hospitalizations.

Several of these measures require clinical input from physicians. Information thus becomes the tool by which clinicians and system administrators coordinate and redesign the delivery of health care. Working with physicians to create clinical integration is therefore an initial first step in the quality improvement process.
V. Working With Physicians

Managed care is changing the way hospitals receive patients. Historically, hospitals received patients through their relationships with physicians, or through patient preference. To a large extent, physicians controlled hospital utilization. In areas of high managed care penetration, managed care has successfully taken control of referral patterns and made hospitals compete for referrals on the basis of price. Physicians, however, still have control over length of stay, clinical quality, and overall hospital costs. Hospitals, if they are to increase value, must develop physician-driven partnership programs to redesign health care and reduce the costs of providing care.

Cooperation between physicians and hospitals is a prerequisite to the successful redesign of care. Physicians are care-givers and the primary source of patient contact, even under managed care. Historically, hospitals and physicians have had arms-length relationships and have found themselves adversaries due to conflicting incentives created by the fee-for-service system of the past. Managed care has forced hospitals to recognize the necessity for clinical integration by aligning financial incentives between the physician and the hospital. Closely aligned hospitals and physicians can, working together, create a health care delivery system which is more customer friendly, more cost effective, and more attractive to managed care providers and other payers.

The days of hospital dominance are rapidly dwindling, as hospitals are treated more and more like cost centers along a continuum of care and not as the primary focal point of health care delivery. Managed care has also elevated the prominence of the physician to the point where, in many managed care models, the physician controls access to the entire health care delivery system. Hospitals who have recognized these trends have created balanced delivery networks and formed equal partnerships with physicians to manage the delivery of care and ensure care is delivered at the right time, in the right setting, for the right price.

Creating partnerships and alliances, and working together with physicians is the most appropriate way for hospitals to meet their community mission. Creating integrated delivery networks is not an ends in preparing for managed care, but is only a means to creating the infrastructure necessary to effectively manage care. Successfully redesigning and managing care, and increasing efficiencies, is the larger purpose and the reason for hospital and physician integration.

Physician and hospital integration efforts need to be patient focused. Integration efforts should not be designed around the needs of the organization, but rather around the needs of the patient, who, even in a managed care environment, is the ultimate customer. Patient satisfaction will continue to be an important measure of quality of care, and hospital and physician integration
efforts should focus on increasing patient satisfaction, while controlling the costs of health care delivery and creating a common culture where hospitals and physicians are treated fairly and equitably.
VI. Physician Integration Strategies

Managed care is bringing hospitals and physicians closer together by creating incentives which reward each provider economically for improving the efficiency of health care. By working together, hospitals and physicians have a greater chance of mutual success in the increasingly competitive health care marketplace. Hospitals and physicians can identify and achieve common goals by working together.

Integration between physicians and hospitals can be accomplished using a variety of models. There is no right or wrong way to integrate; the appropriate integration model depends upon the individual and mutual goals and objectives of physicians and hospitals, and the specifics of the local market. Additionally, integration strategies need to evolve as physicians and hospitals work together in joint contracting efforts and as they build the trust, confidence, and informational infrastructure necessary as opportunities for larger and more risky joint ventures grow.

Today, managed care provides mutual interests for physicians and hospitals in partnership and integration initiatives. One of the goals of hospital and physician integration should be to control, to the extent possible, the local health care delivery market to better meet the changing needs of the local community. Managed care organizations, in many areas, are setting the terms for local healthcare delivery. By partnering, physicians and hospitals, the patient care providers, can together create an efficient delivery system designed to improve value and preserve the local community mission.

Second, physicians and hospitals, working together, can obtain a larger portion of the managed care dollar than either one could individually. By partnering, hospitals and physicians can increase their leverage over managed care entities by jointly providing health care services required by consumers.

Third, physicians and hospitals have many joint interests in a managed care environment, including the improvement of patient care, fulfillment of the community mission, maintaining autonomy, preserving local control, and the mutual need of hospitals for physicians, and physicians for hospitals.
Forms of Integration

Integration strategies can take several forms. Strategies such as Physician Hospital Organizations (PHO) are strictly joint contracting vehicles, where the individual hospital and physician partners remain separate entities and join together only for managed care contracting opportunities. A Management Services Organization (MSO), also provides a joint contracting vehicle for both hospitals and physicians, but also incorporates the information infrastructure necessary to manage care. A third integration option for hospitals is physician practice acquisition, where the hospital actually purchases and manages physician practices. A brief description of these integration structures follows:

• **Physician Hospital Organization (PHO)**- A PHO is an organization which contracts with managed care entities to provide both hospital and physician services. A PHO has the ability to commit both hospitals and physicians to provide services at a set, negotiated price. Under the PHO structure, physicians retain control and ownership of their practices. Established PHOs often provide administrative support to physician groups for managed care contracting and can provide risk management services. An Open PHO is open to all hospital medical staff members, while a Closed PHO offers membership only to physicians who meet predetermined cost and quality benchmarks. Most PHOs receive start up capitalization from their hospital partners.

• **Management Services Organization (MSO)**- A comprehensive MSO manages the practice for the physician, provides risk management services, provides the infrastructure necessary to manage care and negotiates managed care contracts on behalf of the hospital and the physicians. Most MSOs provide utilization review and quality assurance services, and many also provide physician recruitment services.

• **Physician Practice Acquisition**- A hospital or health system purchases both the tangible and intangible assets of a physician group practice. The hospital controls all the revenues of the physicians, not just the managed care revenues, and provides administration, risk management, clinical, and contracting services. In states such as New York, which have strong prohibitions against the corporate practice of medicine, hospitals create a non-profit subsidiary, called a Foundation, which owns physician practice assets.

Hospitals can also work with physicians outside of formal affiliation structures through the use of global service contracts. In a global service contract, hospitals join with certain specialists to negotiate fixed-price managed care contracts for individual services, such as cardiology, oncology, or obstetrics. These joint contracts between hospitals and physicians can be created.
as an initial step in the integration process, with the goal of early successes leading to more comprehensive integration structures.

The success of hospital and physician integration efforts depends upon the identification of physician leaders, the commitment of both hospitals and physicians, the development of a mutual trust and understanding, the creation of a partnership culture, and the creation of several small, early joint successes.

KEYS TO INTEGRATION SUCCESS

Whether they are accomplished through acquisition or joint contracting, successful hospital and physician integration efforts have the following common characteristics:

**Physician Leadership** - All successful integration efforts have physician leaders in positions of prominence.

**Physician and Hospital Trust and Commitment** - Trust and commitment between physicians and their hospital partner is required for successful integration.

**Covered Lives** - Many integration efforts are created as a single signature response to managed care and are only successful to the extent they manage covered lives. Securing, expanding, and retaining covered lives is a key component to success.

**Adequate Staff** - The integration activity needs adequate staff to manage the day to day operations.

**Adequate Capital** - Adequate capitalization is required to meet staffing, equipment, services, and cash flow needs.

**Balance of the Network** - An essential component of integration success is balancing the needs of primary care physicians and specialists, hospitals, and providers along the continuum of care.

**Market Responsive** - The integration activity must be responsive to the needs of payers, whether they are insurers, self-insured employers, or managed care companies.

**Advanced Information Systems** - In the future, healthcare providers will compete in terms of both price and quality. Management information systems will help to define, defend, manage,
and report on cost and quality, and provide an integrated information link across the continuum of care.
VII. Integrating Physicians and Information

Using information to redesign health care and using information to integrate and partner with physicians are essential components of any hospital’s survival strategy in today’s changing health care delivery environment. Successful delivery systems will develop access to information needed to redesign and manage care and will also have the information needed to align financial incentives properly between physicians and hospitals.

Physicians, to a large extent, still control hospital utilization, costs, and quality, because they still control the admission of patients and the hospital resources that patients use. Although managed care is changing these historical patterns, the efficiency of health care delivery will still be determined by the physician, with the support and encouragement of the hospital. Physicians respond to valid empirical data. Inefficient practice patterns must be identified, and the information should be used to align financial and operational incentives between physicians and hospitals. Without appropriate information, however, it is difficult to change what you can’t measure. Currently, physicians and hospitals have little information to assist in the identification of clinical treatments that work. Instead there is little standardization and a system in which costs and treatments vary widely. When hospitals work with physicians to redesign the delivery of health care, information can be used to standardize practice patterns, focus on identifying best practices and profile provider performance and outcomes.

Hospitals can work with physicians to develop and implement provider performance profiles. Provider profiling involves developing resource and utilization statistics for individual physicians, identifying practice patterns, and benchmarking these statistics against norms to determine outlier and efficient providers. Working together, hospitals and physicians can identify problem areas, and, if financial incentives are properly aligned, develop responses that will benefit both the physician and the hospital. Individual practice pattern profiles may include:

- Risk-Adjusted Hospital Inpatient Admission Rates;
- Average Length of Stay;
- Specialty Referrals;
- Laboratory Tests; and
- Outpatient Visit Rates.

Hospitals can enhance value, and increase health care delivery efficiencies by aligning incentives between hospitals and physicians. This alignment requires the same types of information used to evaluate performance. Physicians and hospitals must have incentives to keep patients out of the hospital, while assuring appropriate, necessary, and cost effective care.
The fee-for-service environment encouraged the unlimited use of physician and hospital services. In a prepaid services environment, hospitals and physicians benefit when appropriate health care services are employed to maintain the health of a population. Financial incentives must be aligned between physicians and hospitals to ensure both groups are rewarded for efficient use of services. Since physicians still control hospital utilization, if physicians are reimbursed on a fee-for-service basis, and hospitals are receiving prepayment, incentives are not aligned, and hospitals are assuming all the risk for behaviors a hospital does not control. When physicians and hospital incentives are aligned to treat patients in the lowest cost environment, both parties benefit from the efficient delivery of care, and the system becomes more attractive to payers.

Information must be available which allows hospitals and physicians to identify the cost and utilization risks associated with providing care for patient populations. The risks and rewards of caring for these patient populations should be shared between both hospitals and physicians and can be accomplished only through a mechanism which is data-driven and ties risk-adjusted performance to economic rewards. Incentives must be based on the components of performance under the direct control of either the hospital or the physician. The financial incentives need to be easily understood by both parties and the parties need to be educated about the risks and rewards of the financial arrangements through the use of cost, utilization, and practice pattern information.
VIII. Conclusions

The health care industry is changing very rapidly in New York State. A fundamental shift in who determines community health care needs is currently taking place among health care payers, managed care organizations, and the providers of health care services, i.e., hospitals and physicians. The ability of local health care providers, in concert with patients, to determine their own community health care needs will depend largely on the development and effective use of information needed to restructure and manage health care.

Health care is an information business, and information is at the core of the changes that are now occurring. Information and data initiatives should play a major role in the current strategic initiatives of every hospital and health care system. Restructuring health care delivery requires current, complete information in an easily understandable form, for use by hospital trustees, administrators, physicians, the payer community, including employers, Medicare, and Medicaid, and the ultimate consumer, the patient.

Partnering with physicians also requires information. Physicians and hospitals, working together, with financial incentives aligned, can form alliances to manage the task of restructuring health care delivery, with the goal of increasing the value of community services. Information needed to redesign health care delivery is not currently available, although increasing efficiencies will be contingent on creating information to manage the redesign process.

Local, regional, and multi-state consolidation is occurring in the health care delivery system. Most of these consolidations do not address the need for redesigning and managing care. Increasing the efficiency of care is a local effort, requiring local information and the commitment of both hospitals and physicians. Efficiencies will not be created by managing care over the telephone, but will only be created by a patient-centered information system used to facilitate the reengineering of care.

Hospitals need to anticipate the changes occurring in the health care marketplace, the increasing focus on efficiency and value, and partner with physicians to address the changing requirements of the health care community. Those hospitals that develop the information necessary to increase value, manage risk and align incentives with their physician partners, will have a greater chance of success in the new health care environment.
IX. Glossary

**Benchmarking** - A process which identifies best practices and performance standards, to create normative or comparative standards (benchmark) as a measurement tool. By comparing an organization against a national or regional benchmark, providers are able to establish measurable goals as part of the strategic planning and Total Quality Management (TQM) process.

**Best Practices** - Those practices which have demonstrated superior performance in both their operational and clinical processes. Best practices are identified as such because of their highly successful clinical performance, and the resulting favorable outcomes of the procedures.

**Capitation (CAP)** - A risk sharing reimbursement methodology based on a preset per member, monthly payment to providers for covered services. Capitation rates are set by contract between a managed care organization and a provider, who agrees to provide services to HMO members regardless of how frequently members use the services. Usually expressed in units of per member per month (PMPM), capitation rates may vary by factors such as age and sex of the enrollee.

**Case Management** - Also known as large case management, catastrophic case management, or medical case management; case management refers to a method of coordinating treatment for specific diagnoses which are considered to be high cost medical conditions. The goal is to coordinate patient care to lower costs settings, improve continuity, and the resulting quality of care.

**Closed Panel** - A managed care plan that contracts with or employs physicians on an exclusive basis for services and does not allow those physicians to see patients of other managed care organizations.

**Continuum of Care** - The key characteristic of an integrated delivery system, the continuum of care is the entire range of healthcare services required for a defined population. This full range of services can include preventive care, physician care (primary or specialty), home health, ambulatory surgery, acute/tertiary care, sub-acute, rehabilitation and long term care.

**Cost** - The direct and indirect (overhead) amount of money necessary to perform a medical procedure or provide the necessary medical services for a patient over time.

**Credentialing** - The process of reviewing and verifying documentation regarding a providers clinical expertise, skills and training.
**Data Retrieval** - The process of gathering patient care data from medical records. This data is commonly used to improve quality of care and review utilization.

**Disease State Management** - An approach to controlling chronic conditions that require continuous care, by integrating all components of healthcare in order to achieve the most desirable outcomes. The goal is to prolong healthiness, expedite recovery and improve quality of life. Disease state management is accomplished through the use of tools such as case management, practice guidelines and patient education.

**Electronic Data Interchange (EDI)** - Computer networks that transmit healthcare data between participating organizations. With EDI, providers can receive immediate eligibility verification and authorization from a patient’s health plan.

**Enrollment** - Refers to (1) the process used by a health plan to sign up new members. (2) The total number of covered lives associated with a health plan.

**Health Plan Employer Data and Information Set (HEDIS)** - The Health Plan Employer Data and Information Set, developed by the National Committee on Quality Assurance, is a set standard for measurement and evaluation of HMO and physician performance.

**Independent Practice Association (IPA)** - In New York State, an IPA is a physicians group formed with the sole purpose of holding managed care contracts, contracts which transfer some or all of the risks associated with patient care to the IPA.

**Integration** - Refers to the process by which physicians and hospitals partner to jointly execute direct employer or managed care contracts, and share the risks inherent in such contracts.

**Integrated Delivery System (IDS)** - A local or regional healthcare network that provides a full range of services (i.e. continuum of care) for a defined population. These services may include, but are not limited to, preventive care programs, ancillary services, acute care, long term care, hospice, and home health. By offering a full range of alternatives, an IDS is able to provide care for the patient in the most appropriate setting. Usually, an IDS will form contractual relationships with other providers for services they do not provide directly.

**Management Information System (MIS)** - The common term for integrated computer hardware and software systems used by healthcare organizations to store, process, analyze and retrieve data. Managed care has greatly increased the need for advanced MIS, and applications include: claims processing, utilization review, clinical outcomes tracking, and resource utilization.

**Management Service Organization (MSO)** - An MSO is a type of integrated healthcare organization that emphasizes the efficient management of medical care. A distinct advantage for physicians joining or establishing an MSO is that they can continue to own and operate all
clinical aspects of their practices, while reducing overhead through economies of scale and efficient utilization of healthcare resources. The three main types of MSOs are: Service Bureaus, Management Only and Asset Acquiring MSOs.

**National Committee for Quality Assurance (NCQA)** - A non-profit accrediting body created by the Group Health Association of America, Inc. Composed of independent healthcare quality experts, employers, union representatives and consumers, NCQA’s accreditation program focuses on quality improvement, utilization review, credentialing, members rights, preventive health and medical records.

**Open Panel** - A managed care plan that contracts with physicians who see patients in their own offices. An IPA would be an example of an open panel.

**Outcomes** - The final results of medical treatment, indicated by level of recovery, disability, mortality, morbidity or patient satisfaction.

**Outcomes Measurement** - The process of tracking and measuring the effectiveness and quality of medical care. By quantifying the outcome of treatment, it is possible to perform a cost-benefit analysis of medical care.

**Physician Hospital Organization (PHO)** - A type of integrated delivery system that links hospitals and a group of physicians for the purpose of contracting directly with employers and managed care organizations. A PHO is a legal entity which allows physicians to continue to own their own practices, and see patients under the terms of a professional services agreement. This type of arrangement offers the opportunity to better market the services of both physicians and hospitals, as a unified response to managed care.

**Physician Organization (PO)** - Formed as a single signature response to managed care contracting and risk management, this is a general term used to define many newly formed types of organizations such as Integrated Group Practices, and Specialty Networks.

**Point of Service Plan (POS)** - A type of managed care plan that allows patients to use “out of network providers” for an additional fee.

**Practice Guidelines** - Formal procedures and techniques for the treatment of specific medical conditions that assist physicians in achieving optimal results.

**Practice Pattern** - The way in which an individual provider uses medical resources to treat patients. Increasingly, managed care organizations and hospitals are monitoring physician practice patterns in an attempt to lower utilization of medical services.

**Preferred Provider Organization (PPO)** - A plan that contracts with independent providers at a discount for services. Generally the PPOs network of providers is limited in size. Patients
usually have freedom of choice to choose any provider, but are given strong financial incentives to select one of the designated preferred providers.

**Provider Profiling** - The process of measuring individual provider practice patterns, and comparing the results to some normative standards, to identifying exceptional patterns. Statistics on practice patterns may include hospital admission rates, average length of stay, referral rates, and utilization of ancillary services.

**Quality** - The success and effectiveness of a medical procedure or process.

**Quality Assurance (QA)** - A process that measures the level of patient medical care being provided by physicians, hospitals or other healthcare organizations to ensure that patients are receiving the best and most appropriate care possible. The level of care is measured against pre-established standards, some of which are mandated by state and federal laws.

**Reinsurance** - A type of insurance purchased by providers and health plans to protect themselves from extraordinary losses. Types of reinsurance coverage include: individual stop loss, aggregate stop loss, out-of-area protection and insolvency protection.

**Risk** - The possibility of unexpected financial liability associated with the medical care of a person or a defined population.

**Risk Sharing** - Shared financial responsibility associated with the medical care of a defined population. In a capitated environment both providers and managed care plans share the risk of medical treatment. Providers are at risk if the cost of medical care exceeds the capitated payments. Likewise, managed care organizations are at risk when the capitated payments are in excess of the cost of medical care.

**Severity Adjusted Clinical Outcome** - A measure of healthcare quality that considers the severity of a patient’s illness in the analysis of the end results of care. By adjusting for severity, it is possible to compare cases an equal terms.

**Utilization Review (UR)** - A tool used commonly by managed care plans to assess the appropriateness of the resources consumed in treating a patient. This process also serves as way of determining what portion of the risk sharing pool an individual provider will receive.

**Value** - The quality of health care received for a dollar of health care cost. Also defined as quality divided by cost. Managed care organizations and purchasers of healthcare are looking for organizations who provide value. To increase value, providers must either increase quality or lower cost.