Clinical Integration as an Effective Physician Alignment Strategy

First Illinois Chapter HFMA Fall Summit 2013

Presented by:

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Outline for Discussion

• **Overview & Evolution of NorthShore Physician Associates**
  – How we got to where we are today

• **What is Clinical Integration?**
  – As noun (FTC definition, requirements, test), and verb (bringing together clinicians to improve care)
  – The Value Proposition for Stakeholders
  – CI as an Offensive or Defensive Strategy

• **How to build a CIN:**
  – Physician engagement & hospital commitment
  – Selection of vendor partners
  – Network contracting
  – Payor engagement
  – Selection of CI Initiatives
  – Meeting with the FTC

• **Evaluation and Evolution of a CIN:**
  – First Generation Challenges & Successes
  – Positioning for “Accountable Care”
  – Where we go from here

• **Open Discussion/Q&A**
Outline for Discussion: Learning Objectives

1. Defining “Clinical Integration”
2. Detailing the process to build a Clinically Integrated Network (CIN)
3. Articulating the value proposition of CI for physicians, patients, payors and hospitals
4. Understanding how to work with hospital leadership and leadership of your employed physician group to create an inclusive approach with independent medical staff physicians
5. Selecting data management partners for your CIN
6. Illustrating how to find physician leadership to select CI initiatives and drive a physician-led CIN
7. Evaluating performance in a CIN
NPA History & Evolution

• Rush North Shore Practice Organization- RNSPO (1993-2009); a PHO

• North Suburban Associated Physicians- NSAP (2009-2011); an IPA

• Became NorthShore Physicians Associates- NPA January 1, 2012 via acquisition by NorthShore University HealthSystem; an HO
Successful PHO managing 10,000 capitated HMO lives and a portfolio of PPO contracts
• Created Clinical Integration Program in 2004
• Differentiated “value proposition” to independent physicians in the community (CI, BA, UHC, “the little guy”)
• Pursued direct to consumer engagement/advertising

At height of success when we were informed the hospital was being sold to another health system that didn’t want us, and we had six months to get out of the building
• Converted to an IPA 1/1/09 and hired Valence Health to manage HMO and CI programs
• The health system that didn’t want us couldn’t be nicer to us
• Health reform came in 2009 and we both needed an “alignment strategy”
• After careful consideration and a visit with the FTC, NSAP was acquired by NorthShore and became NorthShore Physician Associates as of 1/1/12
Globally: How doctors and hospitals work together to improve the process of care, outcomes of care, and patient satisfaction via EBM (central to CMS’ VBP initiative, CMS Core Measures, PQRI, BCBS, UHC “scores”, other outcomes measures).

For managed care contracting: How competing businesses (physicians) can jointly contract legally (central to the future value proposition of organized physician networks; IPAs/PHOs), and in turn, market themselves to consumers as an integrated health system.

FTC/DOJ: Clinical integration can be evidenced by a network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

Defining “Clinical Integration”: Noun, Verb and FTC
Clinical Integration can be achieved via:

1. The use of common information and technology to ensure exchange of all relevant patient data
2. The development and adoption of clinical protocols
3. Care review based on the implementation of protocols
4. Mechanisms to ensure adherence to protocols

*(DOJ Statements of Anti-Trust in Healthcare, 1996)*

Also, attorneys will tell you that you need to demonstrate “ancillarity” to contracting.
How A Typical CI Program Works

- CIN receives data from practices and other providers
- Data is aggregated in the CIN Data Warehouse
- Compliance with Evidence-Based Medicine (EBM) pathways and other metrics measured across all physicians/specialties
- CIN provides affiliated practices with tools via website/secure portal (profiler, registry)
- CIN reports patient-centric and population-based measures, physician performance linked to incentive funds/reimbursement
- Physicians incentivized to (a) use tools to proactively manage patient visits, (b) identify/treat gaps in care, and (c) update database via patient registry tools
Defining “Clinical Integration”: Typical CI Program

1. Use of Health IT:
   - Utilization of e-tools/EDI
   - EMR plan
   - E-prescribing

2. Compliance with EBM Care Protocols:
   - IP Core Measures
   - OP Protocols
   - Outside data sources to obtain: Hospital, Lab, Pharmacy, external providers

3. Administrative Quality:
   - Patient Safety Course
   - Physician Education programs
   - Compliance with Re-Appointment Standards
   - Generic RX prescribing
Building a Clinically Integrated Network

- Physician engagement and leadership
- Hospital commitment
- Seek excellence in vendor partners
- Network contracting
- Payor engagement
- Selection of CI Initiatives
- Meeting with the FTC
- Take the time to educate physicians and office staff on using CI/ACO tools, or they won’t
# Physician Alignment Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Selective Membership</th>
<th>Care Standards</th>
<th>Coordination Infrastructure</th>
<th>Performance Management</th>
<th>Meaningful Incentives</th>
<th>Joint Contracting¹</th>
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<tr>
<td>Extensive Employment</td>
<td><img src="image" alt="Circle" /></td>
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<tr>
<td>Bundled Payment</td>
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<td><img src="image" alt="Segment" /></td>
<td><img src="image" alt="Circle" /></td>
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<tr>
<td>Joint Venture</td>
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<td><img src="image" alt="Circle" /></td>
</tr>
</tbody>
</table>

Legend:
- ![No Ability](image)
- ![Minimal Ability](image)
- ![Moderate Ability](image)
- ![Significant Ability](image)
- ![Complete Ability](image)
CI, Physician Alignment Support Pillars of Tomorrow’s World

- **Value-Based Purchasing**: All payors are moving toward reimbursing providers based on their performance, not based on negotiating leverage or brand name. (FKA: P4P)
- **Evidence-Based Medicine (EBM)**: Medicine has been an art, not a science. Clinicians are increasingly migrating to clinical pathways and guidelines to deliver care, and payors are measuring care outcomes based on the use of “best practices” supported by EBM.
- **Integration**: Starting with “100,000 Lives” report, the evidence clearly points to fragmentation of care/unaligned incentives as the biggest problem in health care delivery in the U.S. Central to all reform concepts is integration of care, and the processes, people, workflows, and technologies that provide it, including funding and reimbursement.
- **Technology**: The technology revolution will touch all transactions and workflows (clinical, administrative, business) within the operating platform of the U.S. healthcare system (inter-organizationally, business-to-business, provider-to-patient). It is expensive and time consuming.
- **Patient/Consumerism** Someone else has always paid for our healthcare (Medicare, employer-sponsored coverage), so we’ve never had to shop for healthcare. With increased cost shift to consumers, and mandated individual insurance purchasing, we can anticipate “retail” shopping behaviors and tools to support it. Expanded coverage means more patients, enrolled in a variety of plan options. Increased focus on “wellness” and “patient engagement” models.
Why NPA and CI? Positioning for transformation

Transition and Transformation

- Physician Hospital Silos
  - Physician Hospital Integration
- Employer Based or Gov’t Sponsored Healthcare Coverage
  - Individual Plan Selection
- Provider Centric Healthcare System
  - Patient Centric Healthcare System
Why NPA and CI? Transition to VBP

Supporting Better Performance
Pay for Reporting
- RHQDA/PU
- PQRI
- Stage 1 Meaningful Use

Payment for Coordination
- Medical Home
- Patient-Centered Medical Homes (PPACA Section 3502)

Paying for Better Performance
Pay for Performance
- Future Stages of Meaningful Use
- Never Events
- Hospital-Acquired Conditions (Section 3008)

Episode-Based Payments
- Bundled Payments (PPACA Section 3025)
- Readmissions Reduction Program (PPACA Section 3025)

Paying for Higher Value
Shared Savings with Quality Improvement
- One- or Two-Sided ACO Risk Model
- Accountable Care Organizations (PPACA Section 3022)

Partial or Full Capitation with Quality Improvement
- ACO with partial capitation
- Global payment

Payment Reforms Progressively Move Away from FFS & Support Sustainable Health Care Reform
Progressively Requires Greater Risk Management, Data, Analytics
NorthShore Physician Associates (NPA)

QUALITY LEADERSHIP COMMITTEE
1. Develop integrated quality platforms
2. Manage integrated quality data
3. Evaluate patient outcomes
4. Determine physician participation criteria

PHYSICIAN CONTRACTING LEADERSHIP COMMITTEE
1. Determine allocation and distribution of incentives
2. Review and approve all contract terms

NORTHSHORE MEDICAL GROUP PHYSICIAN POD

NORTHSHORE AFFILIATE PHYSICIAN POD

NORTHSHORE PHYSICIAN CONTRACTING TEAM
Our goal is to become the physician preferred clinically integrated IPA in the region

2012:

- Transition and Expansion
- Cultural Integration
- Deployment of new CI platform and Quality Agenda
- Engage Payors in our mutual mission

2013 and ongoing:

- Provide solution to practices for health benefits
- Assessing NPA physician participation in CI Program to “Tier 1” status for NorthShore employee benefit plan
- Position for Shared Savings and other “accountable care” contracts
- Assessing EMR initiatives for Independent Physicians
- Begin patient engagement and external marketing initiatives
NPA Mission, Vision & Strategy

To drive the highest level of value for the members of our community through clinically integrated care

• Improve health outcomes and quality of care
• Increase efficiency and drive cost reduction
• Facilitate collaboration among physicians
• Strengthen engagement between NorthShore and its physician partners
• Position NorthShore and our Physician partners to participate in evolving reimbursement mechanisms
CI Program Components for all participating physicians:

I. Readiness for Health Information Technology/HIT (5 measures)

II. Administrative Quality Measures (4 measures)

III. Efficiency Measures (7 measures)

IV. Inpatient & Ambulatory Clinical Measures (33 measures)

A robust CI program with over 60 quality measures, representing 12-30 measures per specialty, crossing the full continuum of care
• **2013 Quality Measures**
  - **Readiness for HIT**
    • High Speed internet use, EDI Claims Submission, Email communication with IPA, ePrescribing, EMR Use or Plan for Use
  - **Administrative Measures**
    • Risk Management/Patient Safety Course Completion, CI Education Completion, Physician Reappointment Standards Met, Medication Reconciliation
  - **Efficiency Measures**
    • Generic Rx Prescribing, LOS Variances, Readmissions Rates
  - **Inpatient and Ambulatory Clinical Measures**
    • Ex: Acute Pharyngitis. Antibiotics Discontinued Within 48 hrs of Surgery, Critical Lab Test turnaround, Beta Blockers for AMI, Prenatal Care, Osteoporosis Screening for High Risk Patients, etc
Clinical Integration Data Flow

Physician Offices
- Ambulatory data from Practice Management systems using vMine

Hospital Data
- Lab Data (Quest, LabCorp, Other)

Payer/PBM Data

Electronic Health Records

Electronic Encounter Data

Data Warehouse

vC
- vCore

vN
- Vision

Reports and Support Tools
Our Clinical Integration Solution

Our Philosophy:

• Patient-centric approach

• Provide an opportunity for all specialties to participate, > 90 protocols

• An option where clinical data is collected, and physicians DON’T do more administrative work or have EMR to participate
### Data & Reports

<table>
<thead>
<tr>
<th>What is available:</th>
<th>What is not available:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reports showing compliance with Guidelines and Quality Measures</td>
<td>• We do not collect/obtain financial information</td>
</tr>
<tr>
<td>• Comprehensive view of care delivery across the continuum including Inpatient, ED, and Labs</td>
<td>• Lack of “Outside Provider” Data sometimes can skew scores low</td>
</tr>
<tr>
<td>• Patient profiles to support practices in coordinating care:</td>
<td>• Patient level information can only be seen by a physician who has treated the patient</td>
</tr>
<tr>
<td>– Action Lists with identified gaps in care and prospective care needs</td>
<td>– Treating physician status is validated by the encounter information collected by Valence</td>
</tr>
<tr>
<td>– Identification of conditions</td>
<td>– More stringent criteria can be applied for sensitive info</td>
</tr>
<tr>
<td>• Registry reports and patient outreach capability to support population management</td>
<td>• e.g., Behavioral Health treatment, Genetic testing, HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>– Web portal password is physician specific</td>
</tr>
</tbody>
</table>
Note to self: Look at this link at least twice this year to meet the Annual Incentive requirements!
The Patient Profiler: Outreach, Filling Gaps in Care

Note to staff: Please send a visit to reminder to all patients who are missing an office visit!

Dates in yellow are compliant.

Non-compliance can be due to:
1) Date outside of compliance window
2) Does not meet frequency threshold
Note to nurse: During interview with patient, please check the patient profiler and identify any missing services that need to be addressed during today’s office visit!
A View of Network Level Reporting

### Guideline Compliance Report Card

**vMine Measurement Period: April 1, 2009 - March 31, 2010**

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Current Compliance %</th>
<th>Compliance Indicator</th>
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</thead>
<tbody>
<tr>
<td>Acute Pharyngitis-Pediatrics</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Adolescent Well Care Visits</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Barretts Esophagus</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Cataracts - Pre-op</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Ages 21-30</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Ages 31-64</td>
<td>44%</td>
<td></td>
</tr>
</tbody>
</table>

### Manual Measurement Period: January 2010 - March 2010

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Current Compliance %</th>
<th>Compliance Indicator</th>
</tr>
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<tbody>
<tr>
<td>Cataracts</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Diabetic Foot Care</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Well Child</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

**Compliance % =

# Compliant
# Eligible**
## Patient Claims Detail

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Procedure Code</th>
<th>Procedure Description</th>
<th>Provider Name</th>
<th>Provider Specialty</th>
<th>Diagnosis</th>
<th>Diagnosis Description</th>
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<tbody>
<tr>
<td>2009-11-19</td>
<td>J2785</td>
<td>Regadenoson injection</td>
<td></td>
<td>Cardiology</td>
<td>414.00</td>
<td>Coronary atherosclerosis of unspecified type 0</td>
</tr>
<tr>
<td>2009-11-19</td>
<td>A9505</td>
<td>TL201 thallium</td>
<td></td>
<td>Cardiology</td>
<td>414.00</td>
<td>Coronary atherosclerosis of unspecified type 0</td>
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<td>2009-11-19</td>
<td>A9500</td>
<td>Tc99m sestamibi</td>
<td></td>
<td>Cardiology</td>
<td>414.00</td>
<td>Coronary atherosclerosis of unspecified type 0</td>
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<tr>
<td>2009-11-19</td>
<td>93015</td>
<td>Cardiovascular stress test</td>
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<td>2009-11-19</td>
<td>78480</td>
<td>Heart function add-on</td>
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<td>78478</td>
<td>Heart wall motion add-on</td>
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<td>Cardiology</td>
<td>414.00</td>
<td>Coronary atherosclerosis of unspecified type 0</td>
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<tr>
<td>2009-11-19</td>
<td>78455</td>
<td>Heart image (3d), multiple</td>
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<td>Cardiology</td>
<td>414.00</td>
<td>Coronary atherosclerosis of unspecified type 0</td>
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<tr>
<td>2009-11-12</td>
<td>G6448</td>
<td>Pt vis doc w/non-CCHT EHR</td>
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<td>Some prescrip print or call</td>
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<tr>
<td>2009-11-12</td>
<td>99213</td>
<td>Office/outpatient visit, etc</td>
<td></td>
<td>Internal Medicine</td>
<td>496</td>
<td>Chronic airway obstruction, not elsewhere clas</td>
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</tbody>
</table>

Showing 1 to 10 of 131 entries
Summary & Conclusion

• CI and Physician Alignment is a journey not a destination
• An integrated system must be able to manage financial integration and risk models, as well as clinical integration and attribution models
• CI and next generation Accountable Care models provide significant value proposition to patients, payors, physicians and hospitals
• In an era of rapid physician employment, CI may be a transitional strategy
• Be it risk or attribution, physician alignment and integrated models of care need to be patient centric, not just physician centric, to have sustainability
• The transition from Volume to Value encompasses many aspects of healthcare delivery and financing, but it begins with Physician Alignment and Clinical Integration
Questions & Open Discussion

Thank you for attending!

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