Information Technology on the Road to an ACO

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Inspiring medicine. Changing lives.

Disclosure

- Nothing in Today's Presentation Should Be Construed as Advising or Encouraging Any Person to Deal, Refuse to Deal or Threaten to Refuse to Deal with Any Payer, or Otherwise Interfere with Commerce
- Opinions Expressed by Speakers are Their Own
- Advocate Physician Partners is a Partner in CI-Now

Agenda

- Advocate Structure
- New Day and Clinical Integration
- Technology
- ACO Care Management and Data Feedback



Advocate Health Care



- \$4.5 Billion Annual Revenue
- AA Rated
- 12 Acute Care Hospitals
 - 2 Children's Hospitals
 - 5 Level 1 Trauma Centers
 - 4 Major Teaching Hospitals
 - 4 Magnet Designations
- Over 250 Sites of Care
 - Advocate Medical Group
 - Dreyer Medical Clinic
 - Occupational Health
 - Imaging Centers
 - Immediate Care Centers
 - Surgery Centers
 - Home Health / Hospice



Joint Venture: Advocate Physician Partners



Advocate Physician Partners delivers services throughout Chicagoland.

- Physician Membership
 - 1,100 Primary Care Physicians
 - 2,700 Specialist
 Physicians
 - Total Membership
 Includes 900 Advocate Employed Physicians
 - 10 Acute Care Hospitals and 2 Children's Hospitals
- Central Verification Office Certified by NCQA
- 230,000 Capitated Lives/700,000 PPO Lives



Advocate's Physician Platform



Advocate Physician Partners

- Advocate Structure
- New Day and Clinical Integration
- Technology
- ACO Care Management and Data Feedback



Value Based Purchasing Requires Integration

- Bundled Payments
- Payment Denials
- Accountable Care Organizations
- Cost Pressures





BC Acknowledges Difficulty Controlling...

- Utilization of High End Imaging
- Readmissions
- Outpatient Trend
- New Drugs & Technologies
- Ambulatory Sensitive Conditions

... But That APP Is Well Positioned to Do So.



Blue Cross PPO Contract

- Three-Year Deal
- "Attributes" PPO Members to APP Physicians
- Focus on Reducing Trend Relative to Non-APP Providers
 - All Expenses, Including Pharmacy
 - Risk Adjusted
- Regular Incentive Payments



Shared Savings Model



Summary Results of the Physician Group Practice Demonstration Performance Years 1-4*

Physician Group Practice	Percentage of Quality Goals Attained			Goals
	YEAR 1	YEAR 2	YEAR 3	YEAR 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45
Dartmouth-Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34
Forsyth Medical Group, Winston-Salem,NC	100.00	100.00	96.23	96.23
Geisinger Clinic, Danville, PA	72.73	100.00	100.00	100.00
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23

• Because the CMS applied different weights to each quality measure, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

Published in <u>NEJM</u>, 364:198-200, Jan 20, 2011



Summary Results of the Physician Group Practice Demonstration (cont'd)

Physician Group Practice	Shared Savings Payments (\$)				
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	
Billings Clinic, MT	0	0	0	0	
Dartmouth-Hitchcock Clinic, NH	0	6,689,879	3,570,173	328,798	
Everett Clinic, WA	0	129,268	0	0	
Forsyth Medical Group, NC	0	0	0	0	
Geisinger Clinic, PA	0	0	1,950,649	1,788,196	
Marshfield Clinic, WI	4,565,327	5,781,573	13,816,922	16,154,242	
Middlesex Health System, CT	0	0	0	0	
Park Nicollet Clinic, MN	0	0	0	0	
St. John's Clinic, MO	0	0	3,143,044	8,185,757	
University of Michigan Faculty Group Practice, Ann Arbor	2,758,370	1,239,294	2,798,006	5,222,852	

Published in <u>NEJM</u>, 364:198-200, Jan 20, 2011

Attributed Patient Cost Concentration Supports Care Management Model

			Predicted			
	Person	Years	Expenditures			
	Number	Percent	Mean \$	Percent		
Very Low Risk	54,398	30.5%	\$ 784	3%		
Low Risk	78,520	44.1%	\$ 4,054	22%		
Moderate Risk	24,906	14.0%	\$ 11,517	20%		
High Risk	16,056	9.0%	\$ 24,054	27%		
Very High Risk	4,270	2.4%	\$ 91,062	27%		
Total	178,149	100.0%	\$ 7,987	100%		



Challenges for ACOs

- Large Multi-specialty Groups are the Exception
- 9 of 10 Americans Get Their Medical Care in a Solo or Small Practice*
- Infrastructure is Required to Drive Quality Outcomes Demonstrated by Multi-specialty Groups
- Culture is not Created Over Night
- * <u>NEJM</u> 360;7 Feb. 12, 2009

Clinical Integration: Definition

A structured collaboration among APP physicians and Advocate Hospitals on an active and ongoing program designed to improve the quality and efficiency of health care. Joint contracting with fee-for-service managed care organizations is a necessary component of this program in order to accelerate these improvements in health care delivery.



2011 Clinical Integration Program Overview

- Physician Commitment to a Common and Broad Set of Clinical Initiatives
 - 57 Initiatives Broad Area of Focus
 - 146 Individual Performance Measures
 - Primary Care and Specialty
 - 5 Performance Domains
 - Medical and Technological Infrastructure
 - Clinical Outcomes
 - Efficiency
 - Patient Safety
 - Patient Satisfaction





What Clinical Integration Looks Like



Expansion of Program Over Time

CI Program Categories	Reporting YR 2006	Reporting YR 2007	Reporting YR 2008	Reporting YR 2009	Reporting YR 2010	Reporting YR 2011
Med & Tech Infrastructure	5	7	7	8	9	9
Clinical Effectiveness	35	46	63	73	72	90
Efficiency	9	10	11	13	21	30
Patient Safety	2	2	12	10	11	11
Patient Experience	1	3	3	3	3	6
Total Measure Count	52	68	96	107	116	146

Advancing Evidence-Based Medicine and Care

Year	
2004	Physician Reminders for Care
	Chart Based Patient Management
2006	Patient Outreach
2007	Physician Office Staff Training
	Pharmacy Academic Detailing Program
	Generic Voucher Program
2008	Diabetes Collaboratives
	Patient Coaching Program
	Hospitalists
2009	Diabetes Wellness Clinics
	Asthma and HF/CAD Collaboratives Added
2011	Access and COPD Collaboratives Added



Patient Outreach

- Response to Physicians' Concerns About Patient Non-Adherence
 - Encouraging and Educating Patients to Obtain Appropriate Services
 - Enhancing Patient Education
 - Mail
 - Phone
 - Linking/Branding with APP Physicians



Highlights of 2010 Cl Program "Moving the Dial on Quality"

- Generic Prescribing: 6-9% > Local Plans
- LDL Good Control in Patients with Diabetes: 43% > National Rate
- Childhood Immunizations: 55% > National Rate
- Depression Screening: 85% > National Rate
- Diabetic Care: Exceeded National Rate on All 9 Measures
- Asthma Action Plans: 75% > National Rate



US EMR Adoption Model

Stage	Cumulative Capabilities	2009 Final	2010 Final
Stage 7	Complete EMR; CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	0.7%	1.0%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	1.6%	3.2%
Stage 5	Closed loop medication administration	3.8%	4.5%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	7.4%	10.5%
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	50.9%	49.0%
Stage 2	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable	16.9%	14.6%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	7.2%	7.1%
Stage 0	All Three Ancillaries Not Installed	11.5%	10.1%



Computerized Physician Order Entry (CPOE) Adoption and Usage Rates





2011 Value Report



Now Available! The 2011 Value Report

www.advocatehealth.com/app

or call 1-800-3-ADVOCATE (1-800-323-8622)



- Advocate Structure
- New Day and Clinical Integration
- Technology
- ACO Care Management and Data Feedback



Advancing Technologies

Year	
2004	High Speed internet Access in Physician Offices
	Centralized Longitudinal Registries
	Access to hospital, lab and diagnostic test information through a centralized Clinical Data Repository (Care Net and Care Connection)
2005	Electronic Data Interchange (EDI)
2006	Computerized Physician Order Entry (CPOE)
	Electronic Medical Record Roll out in Employed Groups
2007	Electronic Intensive Care Unit (eICU) use
2008	e-Prescribing
2009	Web-based Point of Care Integrated Registries (CIRRIS)
2010	e-Learning Physician Continuing education
	Electronic medical records Roll out in Independent Practices



Clinical Integration Registry and Reporting Information System (CIRRIS)

- Web-Based Commercial Registry
- Integrates All Registries, Pharmacy, Labs, Claims and Performance Reporting
- Integrates Physicians
- Integrated with EMR



CIRRIS Infrastructure Data Inputs





Data Populates Disease & Preventive Care Registries





Progress Report - Examples

Attribute Report -Physician Le	evel by Intelligent Heat	thcare	Printed On: 05/29/2009				
			Advocate Physician Partners				
		-	CIRRIS				
		Attribute Report -Physician Level					
City	c att						
Horowitz, Sto Henderson, Cyr Herron, Burr	oven nthia						
Bone, Rici Saper, Abra Pentozzi, Ro	hand - ihann sbert	Advocat	e Physician Partners (PHO Sample Only)	Printed Cin : 05/01/2009			
Foggs, Mic Hampton, 1 Allen, T	tony	2009 Clinical In	CIRRIS tegratice Progess Report - PHO REPORT				
Stanley, Sreerama, Shar	Ava state	PHO : Good Samaritan	data, anifested Bosovah, Esh. 5885, 5000.				
Eze, En Sethi, R	neka Romi	Clinical Integration Requirements MEDICAL AND TECHNOLOGICAL INFRASTRUCTURE					Printed On : 04/30/2009
Natanawan, Em Dubois, Th	er to ieny	Connectivity Care Connection or CareNet Usage (>= 86%)	- Adv	ocate Physician I	Partners	(Sample Only)	
Byas, R Manaparambil, Sh	tela	Use of Registries CIRRIS Initiative Reporting Compliance (>= 75%)		CIRRIS			
Unitrovic, A	0	CIRRIS Physician/Office Access (>= 65%) Roundtable Information Sessions	Ambrose, Jacqueline 2009 Clinical in Good Samaritan 1st Quarter	data collected through Fel	DIVIDUAL 26th 2009	REPORT	
	420 M	Attendance - CI I -Ovenlaw (>= 75%) Attendance - Two Additional Information Sessions (>= 75%)	Downers Grove Family Practice Clinical Integration Requirements	Family Medicine Denominator	Numerator	Results	Points
Advocate Health Cent	ter Denten Denet	Office Manager Meeting Attendance (>= 50%)	Asthena Caro				0.00.41.0.00
Advocate Health C	Jenter - Beveniy	In Any Medical Specialty (>= 90%)	Asthma Control Assessed (>= 67%)	43	0	0%	0.00 of 1.00
Physician	Spec	In Primary Medical Speciality (>= 86%) CLINICAL EFFECTIVENESS	Asthma Modication Management (>= 80%)	3	0	0%	0.00 of 0.50
Omerovic, Azra	Internal Medic	Smoking Cessation Counseling Inputient (v= 97%)	Appropriate Medication - ACEI or ARBs (>= 53%)	4	0	0%	0.00 of 0.50
Manaparambil Sheela	Internal Medic	Outpatient - Children Pediatric Second Hand Assessment (>= 50%)	Appropriate Medication - Beta Blockers (>= 53%) Childhood immunization	4	0	0%	0.00 of 0.50
Base Dable	here and the sta	Cutpatient - Chatrien Hediatric Second Hand Counseling (>= 75%) Outpatient - Registry Smoking Patiente Counseled (>= 80%)	Childhood Immunization (>= 68%)	4	2	50 %	0.00 of 2.00
byas, Hobs	Friema Mock	Coronary Artery Disease % of Blood Pressure Control < 140/50 mm/Hz (v= 30%)	Depression Screening Depression Screening (>= 65%)	60	0	0%	0.00 of 1.00
Dubole, Thierry	Family Medici	% of Blood Pressure Measurement (>= 50%)	HMO Quality		-		
Natanawan, Emorito	Internal Medic	% of LDLs < 100 mg/dL (>= 56%) % of LDLs > 130 mg/dL or untested (<= 31%)	HMO Guality Study Results (>= 70%)			No Information	0.00 of 0.40
Sethi, Romi	Endocrinology	% of LDLs Performed (>= 81%) Body Mans Index (>= 51%)	APP - Wide Cost Index				
Res Preste		Smoking Cessation Counseling (>= 76%)	APP - Wide Cost Index (<= 1)			1.08	1.32 of 2.00
EZO, EITIOKA	Internal Mock	Use of Anti-Plateist Medication (>= 63%) Diabetes Care	Specialty Care Referral Rate Index (<= 1)			1.24	0.80 of 1.00
Breerama, Shantala	Internal Medic	% Annual Eye Examinations (>= 50%)	Average Length of Stay				
Stanley, Ava	Cardiology	% HbA1c performed (>= \$1%) % HbA1c performed (>= 81%)	Miliman ALOS (Loosely Managed) (<= 3.50) Miliman ALOS (Moderately Managed) (<= 3.10)			2.9	0.33 of 0.33 0.33 of 0.33
10	20072	% HbAto performed < 7 (>= 32%)	Miliman ALOS (Well Managed) (<= 2.40)			2.9	0.00 cf 0.34
Vitribute Report -Physician Le	ovol	% LDL performed (>= 79%)	Generic Medication Usage Generic Revel Lance - Outpatient (no. 70%)	2208	2112		0.70 41 0.70
		% of LDLs < 100 mg/dL (>= 46%)	Pharmaceutical Initiative	3306	2110	04.5	0.70 01 2.20
		Body Mass Index (>= 50%)	Use of Generic Proton Pump Inhibitors (>= 50%)	101	41	41 %	0.33 of 1.00
		Hypertension Control <130/80 mmHg (>= 23%) Hypertension Control <140/80 mmHs (>= 45%)	Hospitalist Affectation Met ALCIP Mod Mod requirement? Yes			Received Attestation Form - Option	2 1.00 of 1.00
		Nephropathy Testing (>= 60%)	Met CareNet/Care Connection requirement? Yes				
		Smoking Cessation Counseling (>= 76%)	ACL Outreach				
		Clinical Internation PHO Processa Report 60000 M	Outpatient Clinical Lab Usage (>= 5) Lise of ACI for OI Registry Patients (>= 1)			118	0.50 of 0.50 0.50 of 0.50
			PATIENT SAFETY			•	2.25 G 0.05
			CPCE CPCE: Total Orders Entered at a Hospital (= Goal Met)			Goal Not Mat	0.00 of 2.00
			Peer Satisfaction Survey Completion - PCPs (>= 80%)			Surveying in Progress	0.00 of 1.00
			BONUS POINTS ACHIEVED				
			Use of Generic Statins (>= 60%)	260	173	67 %	2.00 of 0.00

Advocate Physician Partners

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Physician Resource Use

- Select High-Cost Tests/Procedures with High Variation
 - Compare to External Norms
- Evidence Based
 - Approved by Peers
- On Line Decision Support
 - ERMA System
- Monitor with ERMA, Ingenix and Other Tools
- Multiple Approaches to Reinforce Practice



ERMA (Electronic Referral Management Application)

- Goals of ERMA:
 - Streamline Referral Process
 - Current Evidence for Appropriate Decisions in High Impact Areas
 - Improve Patient/provider Satisfaction
 - In Network Referrals



APP's Clinical Protocols

Diagnostic Tests:

- MRI Brain
- MRI Lumbar Spine
- MRI Cervical Spine
- MRI Knee
- MRI Shoulder
- MRI Breast
- Pet Scan
- Sleep Studies
- Stress Test with Imaging
- Coronary CT Angiography

Other Services:

- Ophthalmology Referral
- Dermatology Referral
- Infertility
- Physical Therapy
- Occupational Therapy
- Podiatry Referral
- Gastric Bypass Consult

Surgeries:

- Cataract Removal
- Bunionectomy
- Knee Arthroscopy
- Gastric Bypass
- Lithotripsy
- Tonsillectomy/Adenoidectomy
- Tympanostomy Tubes
- Capsule Endoscopy

Drugs/Medications:

- Herceptin Infusions
- Avastin Injection/Infusions
- Erbitux Injection/Infusions
- Rituxan Infusions
- Infusable Biologics (Remicade, Orencia) Infusions

Advocate Physician Partners

- Synagis Injections
- Eloxatin Infusions
- Xolair
- Reclast
- Prolia
- Provenge
- Zometa

November, 2010

RMA Electronic Refe	erral Management Application - Windows Internet Explorer provided by Advocate Health Care		5
Edit View Favorites	Tools Help		
💽 👻 👎 https://erma.a	advocatehealth.com/pho/controller?event=main	🔽 🔒 😽 🗙 Live Search	~
🔅 🕂 ERMA Electronic	c Referral Management Application	🏠 🔹 🔝 🕞 🖶 🖬 Page 🔹 🄇	🕻 Tools 🧃
Advocate Physicia	n Partners E.R.M.A.	Home E.R.M.A. Admin Tools My Settings Log	off H
R.M.A. Create New	Referral Request 💞		
Patient Details	Physician Details Referral Details Refer-To Details	Additional Info	
		Rules Built in to	
	In general, most MRI scans of the lumbar spine will not need contrast unless there is previous surgery, suspecte		
	^{II} FOR EVALUATING Lumbar Back pain when ANY ONE of the following:	require ALL or	
	Sub acute or chronic radicular back pain and ALL OF THE FOLLOWING ARE PRESENT:	Somo of	
	Fails to improve after at least 6 to 8 weeks of conservative treatment	Some of	
	Surgical treatment or referral to pain clinic for epidural injections is being considered	Indiantiana ta ha	
	Severe, disabling progressive pain present for at least 2 weeks and unresponsive to any education	indications to be	
	Image: The second se		
	Recent fracture of the lumbar spine requiring invasive treatment (vertebroplasty or surgery)	met	
	Lumbar spine trauma with persistent pain or neurologic abnormality and negative or equivocal lumbar sp	pine xray	
	Previous posterior lumbar spine surgery, to differentiate between scar and bulging disc or disc protrusic FOULOWING ARE PRESENT.	on, and ALL OF THE	
	■ □ Suspected malignancy, as indicated by ANY ONE OF THE FOLLOWING:		
		a patient with localized midline lumbar	
	If GFR is less than 30, intravenous gadolinium contract, could not be administered given higher risk of neph provide BUN/Creatinine results and date of lab docum, tec. referral.	hrogenic systemic fibrosis. MDs must	
	OTHER:		
	□ None of these apply to your patient, indicate your reason for the test below.	Contrast	
	Indications for Test/Service:		
	(required if OTHER checked)	commendations given	
		_	×
	Order Recommended Test: O Order a MRI of the lumbar spine with NO CONTRAST		
	Order Different Test/Service, Specify		
		ing Clints "Sedensial and the referent	
	will be auto-approved. Medical appropriateness for the emergency wi	Ill be retrospectively reviewed.	
CAN			100%
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Electronic Medical Record



- Point of Care Prompts
- Standardized Patient
 Education Materials
- Linked with CIRRIS
- Roll-out to Employed Physician Practices Almost Complete
 - Major Roll-out to Independent
 Practices Began 2010



Customizations to eCW for CI

- Smart Forms
 - Asthma Action Plan
 - Asthma Control Test
 - Smoking Assessment
- Flow Sheets
 - Tracking Wellness Services
 - Tracking Chronic Disease- e.g. Diabetes
- Structured Data Fields in Templates for Quality Measures

. Smart Forms - Patient : (test, M) - ID : (9165)					
Pt. Info Encounter Physical					
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Advoca	Advocate				
	Asthma Action Plan				
Patient Name: M test Date	of Birth: 01/02/1958 MRN:				
Date Control Assessed 📃 🔻	Peak Flow	Age 53 Years			
Control Score	Personal Best 0.0	Height 70 inches			
Test Used ACT 🗢	Predicted	Weight 178 lbs			
		BMI 25.54			
Remember to Get a Flu Shot Every Year! ZONE	CONTROLLER MEDICATIONS These medications reduce airway inflammation USE THESE MEDICATION EVERYDAY	QUICK RELIEVERS These medications open-up airways CARRY YOUR QUICK RELIEF INHALER WITH YOU ALL THE TIME USE ONLY WHEN VEEDED AND BEFORE EXERCISE			
Green Zone - No Coughing, - No Wheezing, - Can do ususal activities Range: 80% to 100% of Personal Best Peak Flow Range 0.0 to 0.0	Medication Dose Frequency Other	Call doctor if using more than 4 times per day Medication Dose Frequency Other			
Yallow Zane - Couphing - Wheezing - Waking at night - Can do some, but not all usual activities - Can do some, but not all usual activities - Can do some, but not all usual activities Peak Flow Range 0.0 to 0.0	Same as Green Zone and add the following Medication Dose Trequency Other	Call doctor if: Peak flow is less than or if you have no relief in symptoms or -Your symptoms worsen after 2 treatments Nedication Dose Trequency Other			
Red Zone - Very short of breath, - Quick relievers not helping, - Can not do usual activities Range: Below 50% of Personal Best Peak Flow Range 0.0 to 0.0	Same as Green Zone and add the following Medication Dose Frequency Other	Call 911 or go to Emergency Department if: - No relief after 2 treatments or symptoms worsen - Make an urgent appointment with your doctor even if symptoms improve Nedication Dose Frequency Other			
Print Preylew Eint Eax Save Close					



- Advocate Structure
- New Day and Clinical Integration
- Technology
- ACO Care Management and Data Feedback



From Clinical Integration to Accountable Care

By Mark C. Shields, Pankaj H. Patel, Martin Manning, and Lee Sacks

A Model For Integrating Independent Physicians Into Accountable Care Organizations

ABSTRACT The Affordable Care Act encourages the formation of accountable care organizations as a new part of Medicare. Pending forthcoming federal regulations, though, it is unclear precisely how these ACOs will be structured. Although large integrated care systems that directly employ physicians may be most likely to evolve into ACOs, few such integrated systems exist in the United States. This paper demonstrates how Advocate Physician Partners in Illinois could serve as a model for a new kind of accountable care organization, by demonstrating how to organize physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results. The partnership has signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield. Other commercial contracts are expected to follow. In a health care system still dominated by small, independent physician practices, this may constitute a more viable way to push the broader health care system toward accountable care.

Mark C. Shidds (mir) Huddubadvocatylealth.com method director of Adeo Physician Partners, in Mi Prospect, Illinois, Parks | H. Patel is method

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meetal of quality improvement and char of the QL and Credentaling Extendition Factoria, in Mil Martin Manning is presiden

Partners in Oak Droak.



The Affordable Care Act of 2010 in-cluded several delivery system re forms intended to address deficien-tion and small-group independent physician practi-and small-group independent physician practiin the way health care is

Editorial

Clinical Integration Provide Quality Improvement: Struc Change

Crossing the Quality Chasm¹ and other reports² have documented the shortcomings of US health care to deliver safe and consistently high-quality care. Furthermore, the continued rise of health care spending above the rate of inflation and the increase in workers' wago highlight the lack of value received for our health care dollars.³

There are a number of proposed policy solutions for the gaps in quality and value in health care, including public reporting, pay for performance, narrowed networks of providers, disease management, and regional networks for health information exchange. However, less attention has been given to the fact that our current organizational structures impede progress on quality and safety. Solo and small group physician practice is dominant (over half the doctors in the United States practice in groups of 3 or fewer physicians) and seem to lag the performance of larger group practices.4 Furthermore, the inability of the current medical staff structure of voluntary hospitals to deliver safe and consistently high-quality care is reflected in the Quality Chasm report and the glacial rate of improvement since the publication of the report.⁵ Insights into these failed structures are offered by

ileges. As associations, they must work within an arcane political structure and follow detailed due process. The cards are heavily stacked in favor of physician autonomy versus their accountability. prysician autonomy versus their accountability... Given what we know of (hospital medical staff organ-izations), however, the nation's energy would be better spent developing innovative models than reha-bilitating a failed one." Morry points out the funda-mental design flaws of the modical staff structure." Berwick's observations on physician commitment continue to be applicable both to outpatient and hos-pital practice: "the challenge of involving physicians is an issue that has arisen repeatedly in health care quality improvement efforts... How shall we involve doctors, who do not seem to see themselves as players in processes, whose financial incentives impede participation in project teams and data collection activi-ties, and who do not strongly believe that their interests are tied to the improv ement of the health care organizations they work in? In fact, barriers to physician involvement may turn out to be the most important single issue impeding the success of qual-ity improvement in medical care." There are numerous reasons for the limitations

real authority is the power to restrict or revoke priv

a number of observers. Baker and Smithson' have of these organizational structures. Solo practition noted that hospital medical staff organizations "are ers and small groups rarely have the capital to

physician alignment e right strategy, the right minit-set

tudy: from skepticism to engagement

etitive physician compensation

RESEARCH

Addition of Generic Medication Vouchers to a Pharmacist Academic Detailing Program: Effects on the Generic Dispensing Ratio in a Physician-Hospital Organization

Vinay Bhargava, PharmD; Mark E. Greg, PharmD; and Mark C. Shields, MD, MBA

ABSTRACT

BACKGROUND: Generic dispensing ratio (GDR) is an important measure of BACASHOUND: Generic uspensing rate (cov) is an important measure of officiency in pharmacy benefit management. A two studies have examined the effects of academic detailing or generic drug samples on GBR. On July 1, 2007, a physician-hospital organization (PHO) with a pay-for-perfor-mance incentive for generic dutization initiate a pilot generic medication voucher program that augmented its existing pharmacist-led academic detailing efforts. No published studies have examined the role of generic edication vouchers in promoting generic drug utilization.

compared with a 6.2 point increase for the control group from 55.9% dur-Ing baseline to 62.1% during the youcher period. The panel data regressio nodel estimated that the medication voucher program was associated with a 1.77-point increase in overall GDR compared with academic detailing alone (P=0.047).

CONCLUSION: Compared with academic detailing alone, a generic medica-tion voucher program providing a 30-day supply of 8 specific medications In addition to academic detailing in PCP groups with low GDR and high escribing volume in an outpatient setting was associated with a small but itstically significant increase in adjusted overall GDR.

taneg Care Pharm. 2010;16(6):xxx-xx syright © 2010, Academy of Managed Care Pharmacy. All rights reserved.

/hat is already known about this subject

ncreasing the generic dispensing ratio (GDR) is associated with reduction in drug costs. For example, Express Scripts, a phar-macy benefits management company, estimated that every 1 perentage point increase in GDR is associated with an approximate 1 percentage point reduction in overall drug expenditures. Scott et al. (2006) found that a generic drug sampling program using automated generic dispensing machines (kiosks) in physi-cian offices was associated with a higher GDR (55.3%) in the first year of the intervention for kiosk users compared with physicians who did not use the kiosks (54.1%), but the 1.2 percentage point difference in GDR was not statistically significant and declined to a 0.8 percentage-point difference in the second year. O'Malley et al. (2006) examined + interventions intended to increase GDR (member mailings, advertising campaigns, free

Proven Methods to Achieve High **Payment for Performance**

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linical performance measures and cost per episode of care are key ingredients of healthcare "value" and are increasingly being viewed as belonging in the public domain. "Pay for pering evacua as seconging in merpuole about a somain. Fury for per-formance (P4P) programs research high performance of clinical processes and "outcome" measures, in particular for those re-lated to chronic disease, patient satisfaction, patient safety, use of information technology, and other measures. At the core of the Advocate Health Partners clinical integration approach are specific prac tice interventions linked with clinical performance targets and supported by an incentive P4P program. Techniques of improvement include the use of registries of patients with specific conditions; clinical protocols; patient outreach with education tools and reminders; office staff training programs physician continuing medical education; ongoing performance feedback; and an incentive program that rewards individual performance as well as collaboration among hospitals, physician hospital organizations, and peers. Key words: Advocate Health Partners; pay for performance; value; disease man-agement; disease registrice; patient outreach; diabetes flowsheet; aufirma action plan

REIMBURSEMENT AND CURRENT MARKET TRENDS

Two market trends will have a significant impact on the future of physician reimbursement. First is the shift from "all pay for volume" to "some pay for performance." This has been largely driven by the Institute of Medicine report Crossing the Quality Chaim, which highlighted sig-nificant and unexplained variation in care and recom-mended higher reward to physicians for better-quality care.1 Second is the demand for transparency of cost and health outcomes data as a means for providers to demon

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strate "value" for health services. This has been largely driven by the unsustainable growth in overall health expen-ditures and the trend for health benefit plans to shift higher costs to patients. Clinical performance measures and cost. which are key ingredients of healthcare value, are increas-ingly being viewed as belonging in the public domain.

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a means for providers to demo "value" for health services

Advocate Physician Partners

Care Management and Data Systems Work Together

- APP Selected Care Management Tool with Data Support for ACO Implementation
- Tool Provides:
 - ActiveAdvice System for Care Management
 - CareEngine for Risk Profile and Gaps in Care
 - Data Analysis and Reporting

Care Management System Linked to Data Sources

- Use Historical Data to Identify Patient and Population Management Priorities
 - Risk Profile of Population
 - Chronic Conditions and Complex Patients
 - Prioritized Gaps in Care
- Use Care Management System to Track Patient Interactions and Handoffs
 - Data Entered by Care Managers Influences
 Risk Profiling and Gaps in Care



Data Warehouse to Monitor Performance

- Key Utilization and Cost Metrics and Trends
- Report Results by Organization, Physician Practice Group and Physician
 - Understand Performance Improvement Opportunities
 - Create Actionable Reports on Physician Performance
- Collect Data from Care Management System to Track Results of Programmatic Initiatives



Questions / Discussion

