Advocate Health Partners Clinical Integration Program

PAY FOR PERFORMANCE: A CATALYZING COMPONENT OF CLINICAL INTEGRATION

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February 7, 2006 **Session: 1.03**

Presentation Overview

- Define Clinical Integration
- Market Place Realities
- Advocate Health Partners (AHP)
- AHP Clinical Integration Program
- Incentive Plan Design
- Results

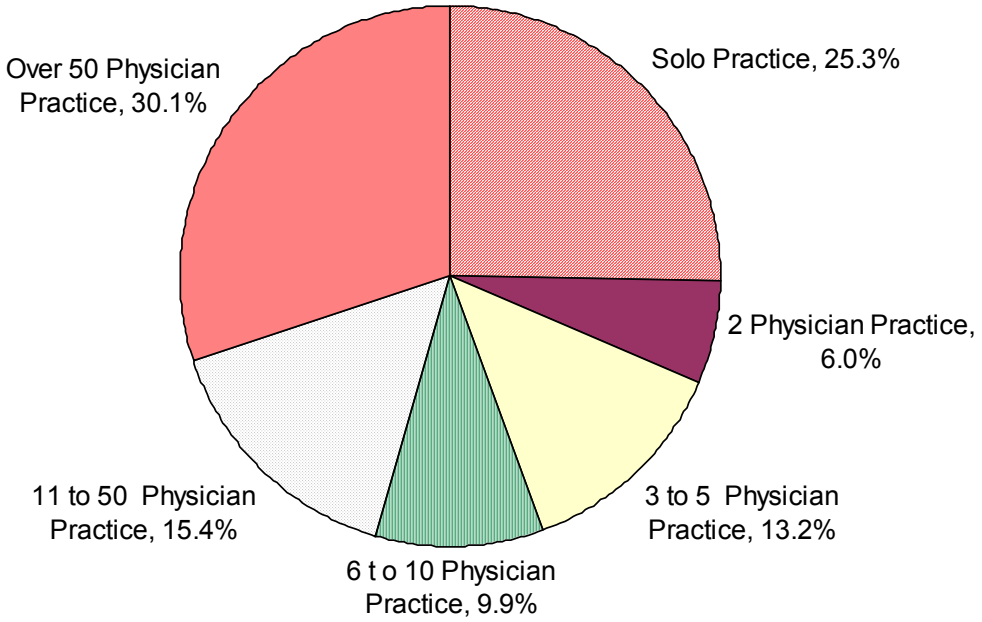
Clinical Integration: Definition

"A set of programs and infrastructure including joint contracting among physicians to improve the care and its efficiency for all the organization's patients and to demonstrate the organization's value to its patients, employers, insurance companies and government regulators."

Market Realities

- Risk contracts disappearing
- Large multi-specialty groups are the exception
- Infrastructure is required to provide the benefits of multi-specialty and single specialty groups

Distribution of Physicians by Size of Practice, 2005*



*Percentages may not sum to 100 because of rounding.
Source: 2001 Patient Care Physician Survey of nonfederal patient care physicians, American Medical Assoc.; Medical Group Management Association, Center for Research, Universe of Group Practice, 2006

Advocate Health Care at a Glance

- Largest faith-based, non-profit provider in Chicagoland
- Intense focus on high quality, efficient health care
- 10 Hospitals/3000 beds
- National Recognition
- 3 Teaching Hospitals

Evolution of Advocate Health Partners

1995

- Founded as a “Super PHO”
- 8 PHO’s – 50/50 Joint Venture
- 90,000 Capitated Lives
- 1 Medical Group

Evolution of Advocate Health Partners

1996	Dreyer Clinic
1998	Advocate Health Centers
1998 – 2000	Medicare Global Capitation
1999 – 2000	Strategic Planning

Evolution of Advocate Health Partners

2000 - Strategic Plan

- PPO Contracts
- Demonstrate Value
- Information Technology

Evolution of Advocate Health Partners

2001 – Changes Driven by Strategic Plan

- Structural Changes
- Centralization/Standardization
- Consolidated Finance Committee
- Utilization Management Committee
- Quality/Credentialing Committee

Advocate Health Partners at a Glance

- Physician Membership
  - 900 Primary Care Physicians
  - 1,800 Specialist Physicians
  - Of these, 600 in 3 multi-specialty medical groups
- 8 Hospitals and 2 Children's Hospitals
- Central verification office certified by NCQA

Advocate Health Partners at a Glance

- 310,000 Capitated Lives
  - Commercial: 280,000
  - Medicare: 30,000
- 700,000 (est.) PPO patients covered

Participating Health Plans

- Risk and fee-for-service contracts
- Base and incentive compensation
- Same measures across all payers
- All major plans in the market except United Health Care
- Common procedures at practice level for all contracted plans

Case Study: Advocate Health Partners (AHP) Clinical Integration Program (CI)

- Large, diverse and consistent network
- Participation by a number of health plans across a large number of patients
- Physician commitment to a common and broad set of clinical initiatives
- Financial and other mechanisms for changing physician performance - Pay-for-Performance

Physician Participation Criteria

2004 - 2005

- Care Net access/office usage
- High speed access required
- EDI submission to AHP
- Participation in risk only or all contracts
- Active participation in AHP Clinical Integration Program

2006

- All of 2004 – 2005 requirements
- ERMA for all risk
- Level 2 eICU®
- Increased minimum panel size for all PCPs in risk programs

AHP Infrastructure Support for CI

- Medical Directors
  - Each of 8 PHOs
  - QI Committee Chair
  - Senior Medical Director
- CI Director – 1 FTE
- Analyst – 1 FTE
- Quality staff - 6 FTE
- Pharmacist - 1 FTE

AHP Infrastructure Support for CI

- Provider relations staff - 13 FTE
- Data support staff - 3.5 FTE
- Also contracting, finance and administrative support
- For CI only
  - $1.65 M/year in salaries and benefits
  - 18.5 FTE's

IT Infrastructure Available for CI

- CareNet/Care Connection - Patient information via the internet
- eICU - Remote monitoring of ICU patients
- MIDAS (medical information data access system) - inpatient care
- Ingenix - Risk adjusted comparisons of MDs
- TSI - Detailed ordering of inpatient and outpatient services by doctors
- Lawson system - Supply utilization monitoring
- AHP Quality Improvement Database – Web-enabled physician interface

Guidance in Selection

- IOM, Priority Areas
- The Leapfrog Group
- Healthy People 2010, U.S., HHS
- HEDIS of NCQA
- Quality Improvement Organizations of CMS, 2002
- ORYX of JCAHO
- Advocate efficiency and cost information

Clinical Integration Program Overview

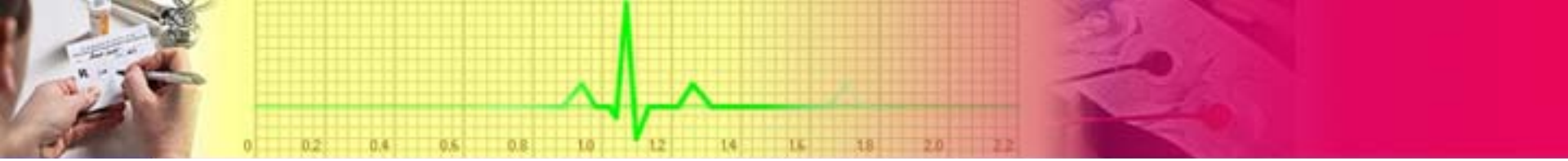
PCP	SCP	Clinical Integration Program	Outcome Criteria
X	X	**eICU participation**	Physician agreement at Level 3 or greater. 80% of patients managed by eICU level 3 or 4 (PHO)
X	X	**CareConnection including High Speed Access & CPOE**	CareConnection access IP and OP and CPOE for Inpatients
X	X	**Generic usage (outpatient)**	Generic utilization by ordering physician, 48% top tier, 43-47% mid tier, 38%-42% low tier
X	X	**CAD Ambulatory Outcomes for patients after AMI, PTCA, CABG**	78% LDL performed as indicated on flow sheet cardiac and level of control thresholds

Clinical Integration Program Overview

PCP	SCP	Clinical Integration Program	Outcome Criteria
X	X	**Diabetic Care Outcomes**	75% HgbA1c, 73% LDLs and 43% eye exams performed as indicated on diabetic flow sheet and level of control thresholds
X	X	**Asthma Outcomes**	85% completion of asthma action plans. < 6% readmission rate, < 2% ED revisit rate (PHO)
X	X	**Effective Use of Resources**	Ingenix efficiency ratio between 0.8 and 1.2 (measures I/P and O/P utilization)
X	X	**QI Activity**	98% participation in AHP QI activities and 100% passage of MR audits, 95% for PHO

Clinical Integration Program Overview

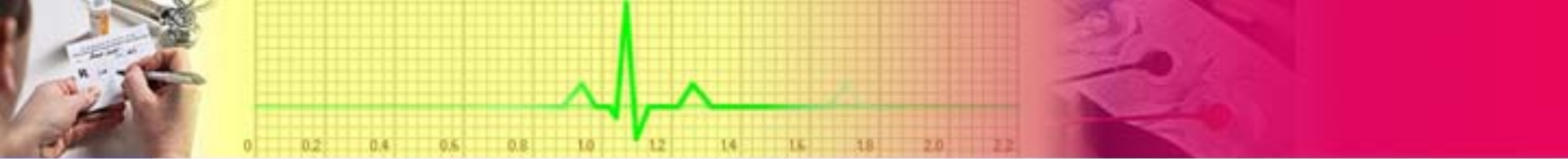
PCP	SCP	Clinical Integration Program	Outcome Criteria
X	X	**Physician Roundtables**	75% attendance at AHP/PHO educational meetings
X		**Hospitalist Utilization**	Physicians use a Hospitalist or agree to perform at that level
X	X	**Depression Screening for Cardiovascular patients**	30% of patients have depression screening completed
	X	**OB Risk Initiative**	80% of medical record elements in place Completion of Advocate CME on fetal monitoring



Clinical Integration Program Overview

Hospital Measures

Clinical Integration Program	Outcome Criteria
Smoking Cessation Counseling	Assessment and counseling documentation
Asthma Outcomes	Patient education and improve outcomes. Provision of action plans to patient who receives emergency room inpatient services
Clinical Excellence Initiatives **CHF (Congestive Heart Failure** **DVT (Deep Vein Thrombosis)** **AMI (Acute Myocardial Infarction Inpatient)** **CAP (Community Acquired Pneumonia)**	Compare AHP provider performance to that of all AHHC providers



Clinical Integration Program Overview

Hospital Measures

Clinical Integration Program	Outcome Criteria
Hospital Quality Indicator	Clinical effectiveness Hospital Ratio. (Risk adjusted mortality and complications)
Effective Use of Resources	Resource utilization including length of stay compared to M&R

Clinical Integration Program Overview

PHO Measures

(Includes below and all individual physician measures)

Clinical Integration Programs	**Outcome Criteria**
Formulary usage (inpatient)	Maintain baseline compliance rate to Advocate Hospitals Inpatient Formulary
Smoking cessation counseling	67% documented assessment and counseling of smoking cessation in office record, 61% hospital record
Hospital QI projects Congestive Heart Failure Deep Vein Thrombosis Acute Myocardial Infarction Community Acquired Pneumonia	Use of Advocate Hospital clinical practice guidelines for patients with CHF, MI, Pneumonia, DVT when clinically appropriate
Supply Chain Initiative	100% use of Advocate's preferred orthopedic primary implants

Clinical Integration Changes for 2006

Additional Initiatives

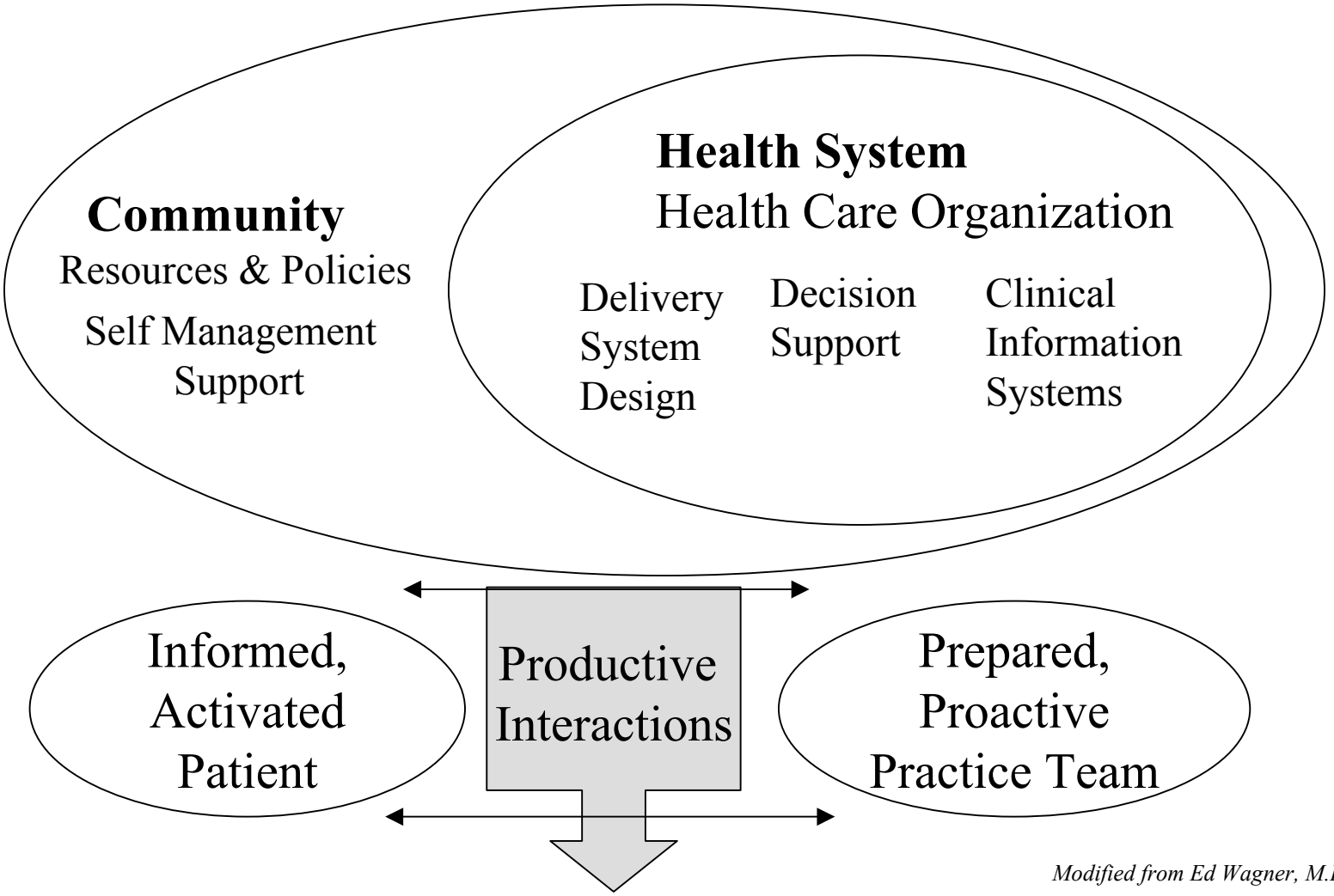
- Patient Satisfaction – Inpatient data on physician performance from the hospital survey
- Childhood Immunization – Include all HMO and add PPO patients when available
- ACL Outreach Clinical Lab Usage
- Patient Safety CME
- EDI usage for all payers

Clinical Integration Changes for 2006

Expanded Clinical Criteria

- Raised the bar on virtually all initiatives
- Generic Usage – Specialty specific tiers
- Coronary Artery Disease – Use of anti-platelets
- Diabetic Care – Added Nephropathy measure

Chronic Care Model



Modified from Ed Wagner, M.D. et al

IMPROVED OUTCOMES

Techniques of Improvement

- Patient registries
- Clinical protocols
- Patient education tools
- Patient reminders
- Mandatory provider education/CME

Techniques of Improvement

- Office staff training
- Credentialing
- Report cards tied to incentive payments
- Peer pressure and medical director counseling
- Penalties and/or sanctions

Incentive Fund Plan Design Principles

- Build on experience since 2002 for incentive
- Create efficiencies, lower cost, increase quality
- Meet objectives of regulators, purchasers, and patients
- Motivate physicians through rewards for professional productivity and quality
- Assist physicians to maintain competitive compensation

Size of Incentives: 2005

- Clinical Integration incentive: over $13 Million
- Additional PCP incentive (subset of CI goals): $4 Million
- Compared to $50 Million for Integrated HealthCare Association program for entire State of California

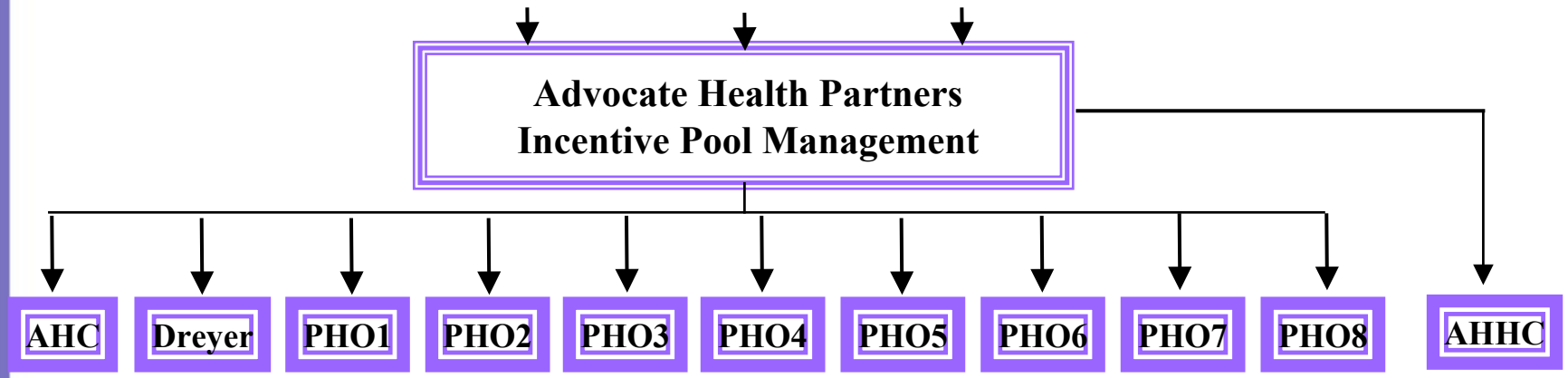
Incentive Design

Incentive Pools – There are separate incentive funds for the medical groups, PHOs, and hospitals.

Incentive Pool Management – AHP is managing all pools but not be involved in claims processing for PPO contracts.

Incentive Pool Methodology – Clinical criteria applies to all patients covered under AHP contracts. The same approach to incentive pools and clinical integration criteria will apply to all payers.

Proposed Funds Flow and Incentives



Basic Plan Elements

- ✓ 70% Distribution based upon Individual Clinical Criteria Achievement Scores ($ based upon individual w/h generated that year)
- ✓ 30% Distribution based upon Group Clinical Criteria Achievement Scores ($ split into 3 tiers: 50% Tier1; 33% Tier2; 17% Tier3)

Incentive Fund Design

Source of Funds:
Future Rate Increases
Cost Savings
Capitation

AHP Functions:
Accounting
Performance Measurement
Incentive Fund Distributions

PHO1

Dreyer Clinic Incentive Pool

AHC Incentive Pool

Hospitals Incentive Pool

Group / PHO Incentives (30%)

Group Distribution

Tier 1 (50%)

Tier 2 (33%)

Tier 3 (17%)

****Residual Funds***

Group / PHO Criteria

Individual Tiering Based On Physician's Individual Score

Individual Incentives (70%)

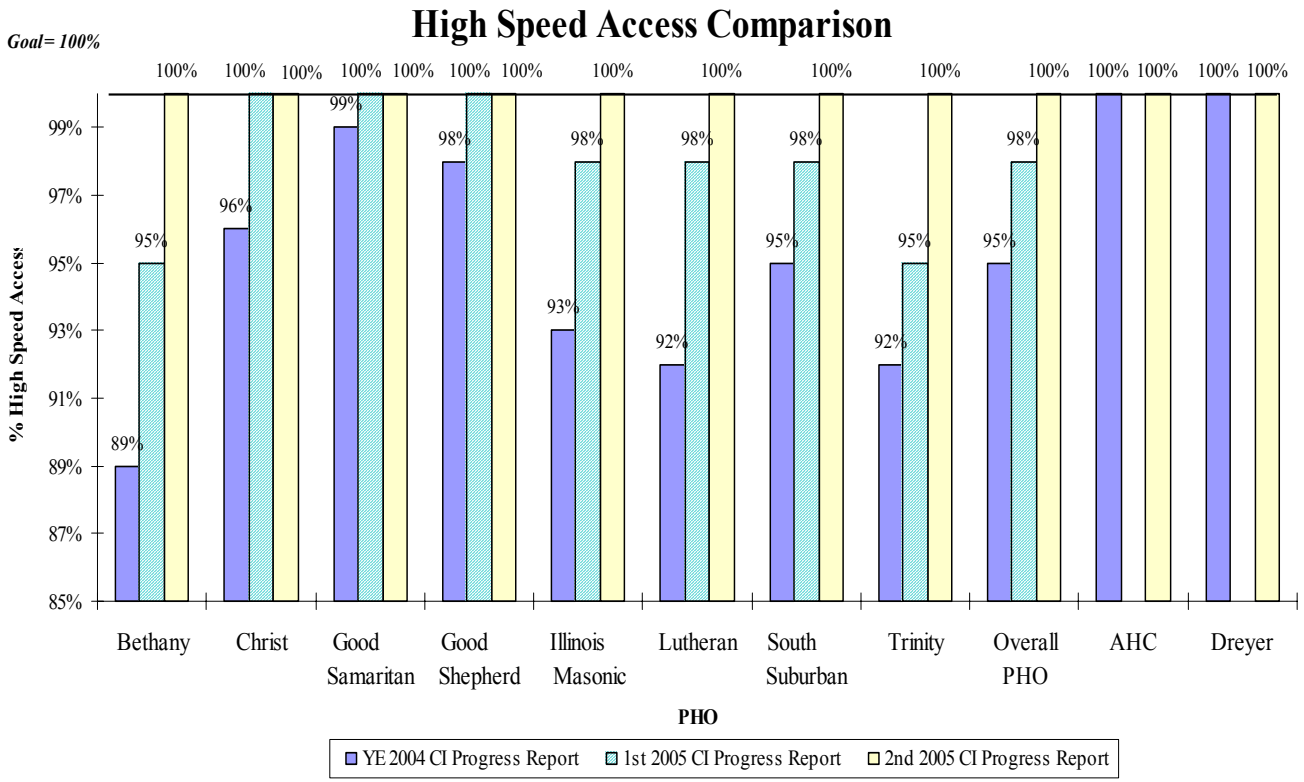
Individual Criteria

Individual Distribution

****Residual Funds***

** Residual Funds are rolled over to the following year CI fund*

High Speed Internet



100% with high speed internet connection

High Speed Internet Implications

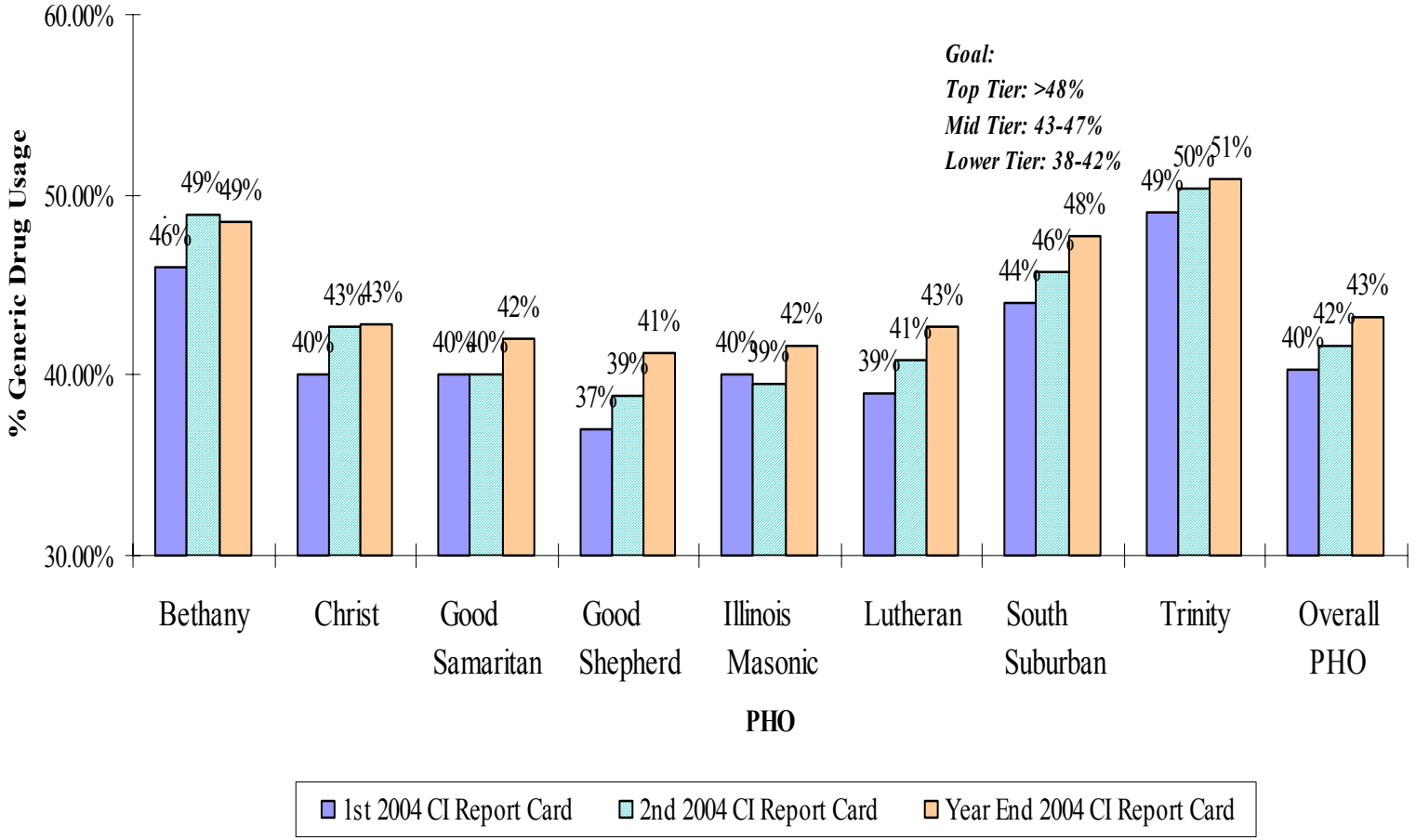
- Over 2,700 physicians access
  - Electronic Referral Module
  - AHP Website
  - Carrier connections
  - Clinical protocols and patient education material available on-line
  - Clinical Reference Tools
  - QI Database
  - CareNet/CareConnection

Generic Prescribing

Industry Facts

- National spending for prescription drugs was $179.2 billion in 2003 and has been the fastest growing segment of health care costs over the last five years.
- Substituting a generic drug for a branded drug results, on average, in a savings of $44.23 or 67 percent.

Generic Drug Usage Comparison



Generic Prescribing

AHP 2004 Outcome

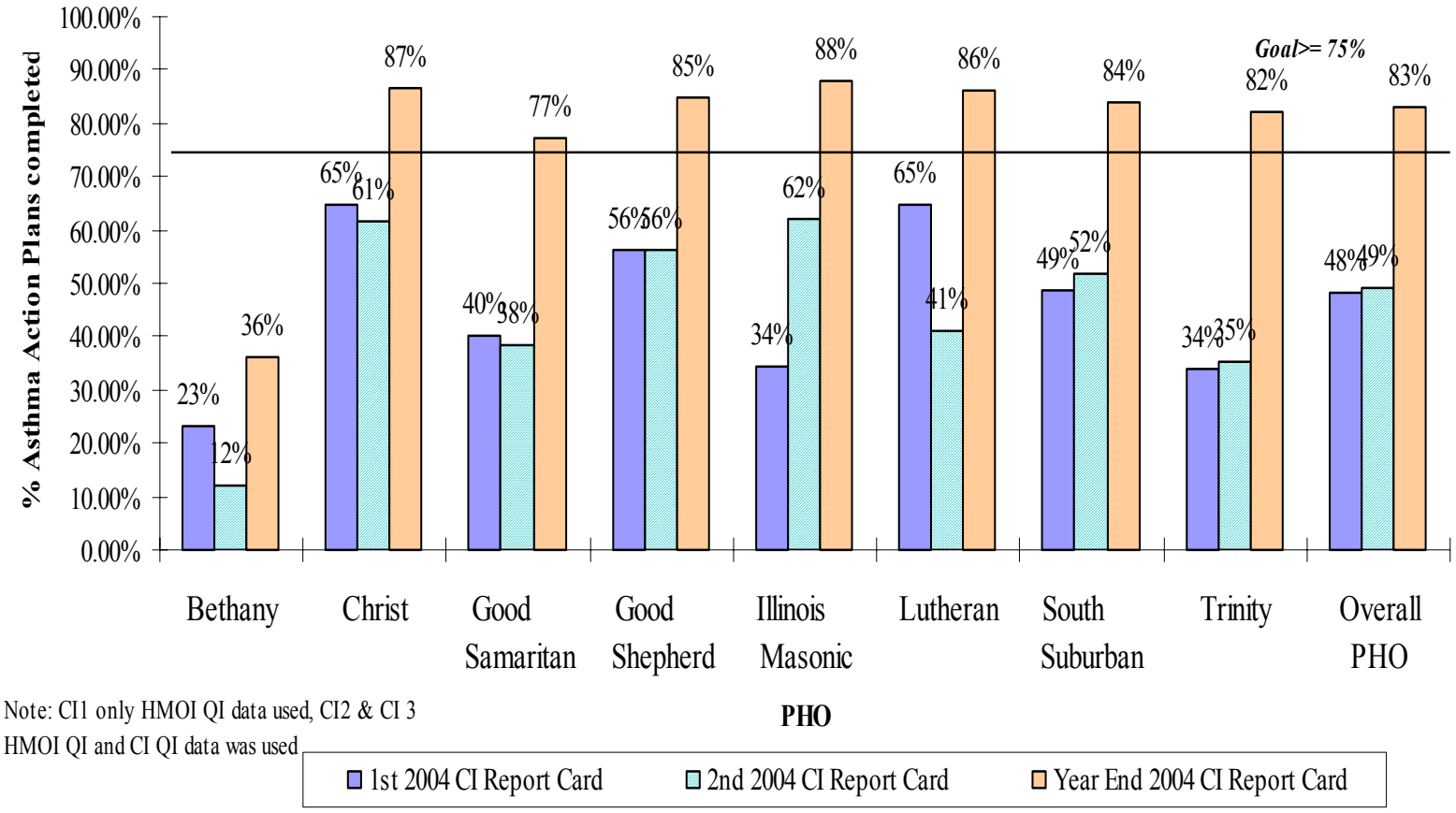
The increase in Generic Prescribing by AHP physicians in 2004 resulted in additional savings of at least $8.3 million to health plans, employers and patients.

Asthma Outcomes

Industry Facts

- In 2000, the direct cost of asthma in the United States was $9.4 billion and the indirect cost was $4.5 billion, related to 14.5 million missed workdays and 14 million missed school days.
- Several studies have shown that disease management programs for asthma can reduce hospitalizations and the cost of care.

Asthma Action Plan Comparison



Note: CI1 only HMOI QI data used, CI2 & CI 3 HMOI QI and CI QI data was used

Asthma Outcomes

AHP 2004 Outcome

Advocate Health Partners Asthma Outcomes initiative resulted in an incremental medical cost savings of $759,920 and indirect savings of $357,162, compared to national averages.

Pitfalls for Clinical Integration

- Lack of commitment
  - From doctors
  - From governance
- Inability to show sustained improvement
- Inability to contract with adequate number of payers
- Regulatory hurdles
- Community and employer recognition

Antitrust Allegations

- 2003
  - United Healthcare agreement with Advocate Health Care and Advocate Health Partners ends December 31, 2003
    - United requests double-digit decrease to 2003 hospital and medical groups rates
    - United refuses to contract with AHP independent physicians for the clinical quality program - Clinical Integration

United Seeks Remedy via Arbitration

- United Healthcare Demands
  - Payment of approximately $250,000,000 in monetary damages
  - A non-negotiated, five-year contract upon Advocate Hospitals at rates determined by United
  - Submission of Advocate and AHP's current and future contracting to an ongoing "compliance panel"

Defending Clinical Integration

- 2 years
- $5 million to outside counsel
- Immeasurable hours of management and staff time
- 120+ boxes and 42 CD's of data – locate, copy and review for appropriate disclosure

American Arbitration Association (AAA) Ruling

"On Friday, November 18, 2005, all parties received a ruling from the AAA arbitrators stating that United lost on all counts and Advocate and Advocate Health Partners had been cleared of all allegations."

Taken from Advocate Health Care Press Release
November 22, 2005

Critical Success Factors

- Clinician driven
- Evidence based criteria
- Minimize additional administrative costs
- Same metrics across all payers
- Focus on improvement

Critical Success Factors

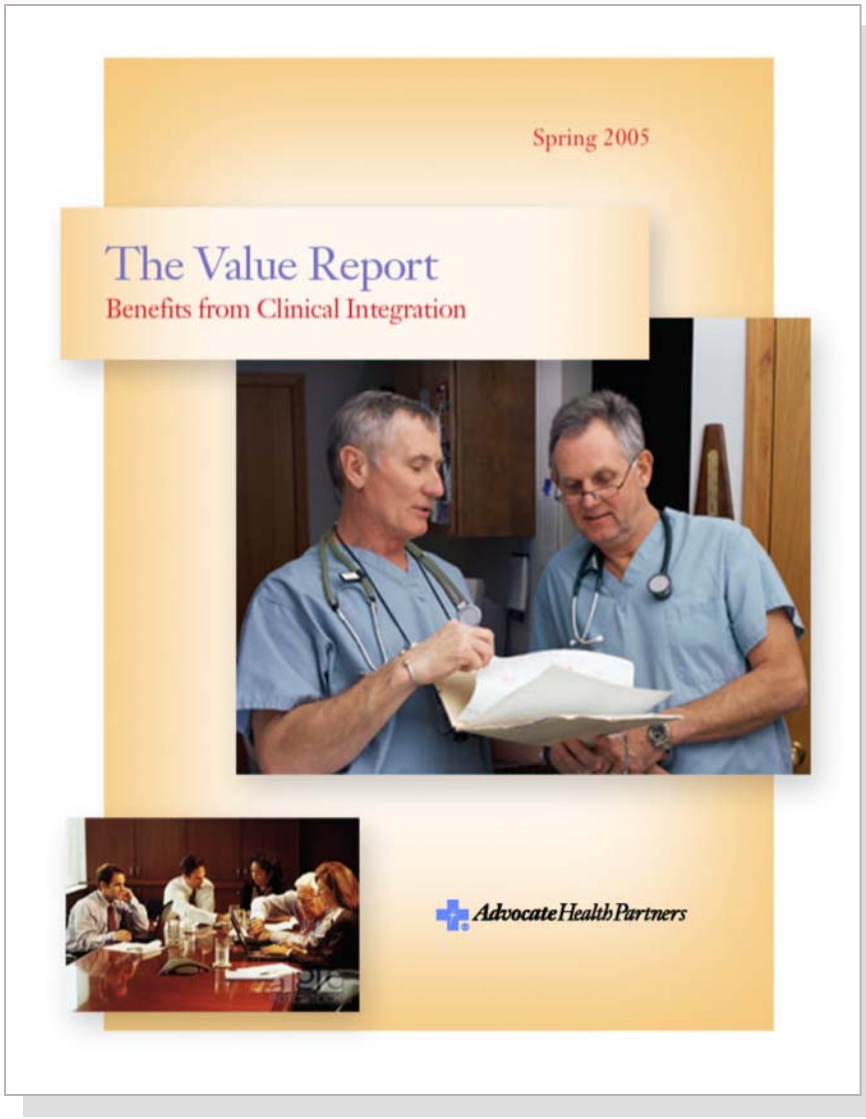
- Additional funds recognize extra work by physicians and staff
- Infrastructure necessary to support improvement
- Both individual practice and group PHO incentives
- Collaboration – Physician/Hospital alignment

Going Forward

- Regulators need to clarify and acknowledge role of clinical integration
- Governmental payers need to participate
- Payers need to cooperate
  - provide data, stop competing efforts
- Allow for marketplace “experiments”
- Enhance program annually

Going Forward

- More group incentives
- Reward improvement as well as reaching threshold
- Collaborate with employers, consultants, payers on program design and benefits
- Develop infrastructure to assist physicians with non-compliant patients
- Public reporting of results through the Web



www.advocatehealth.com

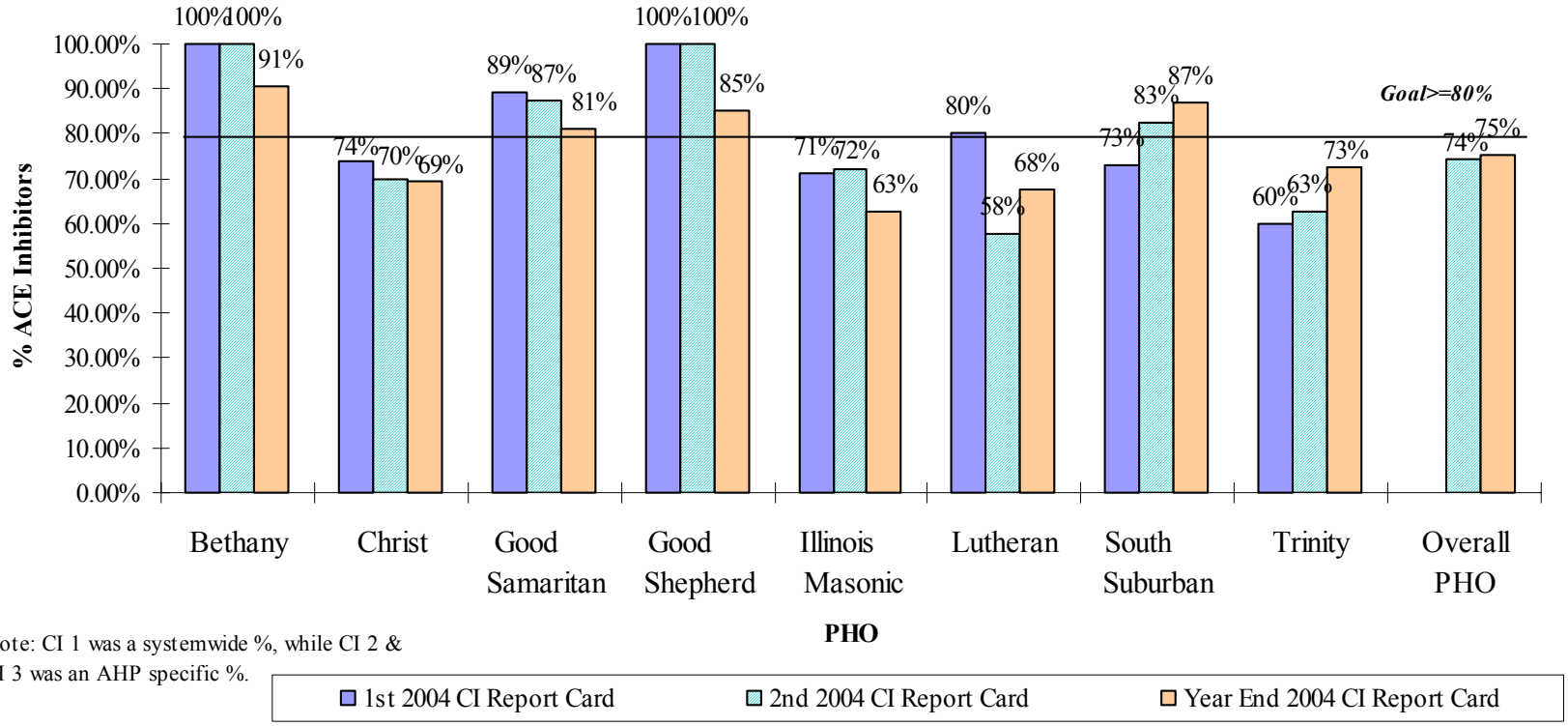
Search for: 2004 Value Report

Coronary Artery Disease (CAD) and Congestive Heart Failure (HF)

Industry Facts

- The direct health cost impact of CAD and HF is estimated to be $51.1 billion and $22.1 billion, respectively, almost 5 percent of the nation's total health care expenditures.
- HF - ACE inhibitor medication can reduce hospitalization by 30 percent, an estimated economic savings of $3,198 per patient.
- CAD - beta-blocker medication decreases mortality by 22 percent and repeat heart attacks by 27 percent.

CHF ACE Inhibitors Comparison



Note: CI 1 was a systemwide %, while CI 2 & CI 3 was an AHP specific %.

Coronary Artery Disease (CAD) and Congestive Heart Failure (HF)

AHP 2004 Outcome

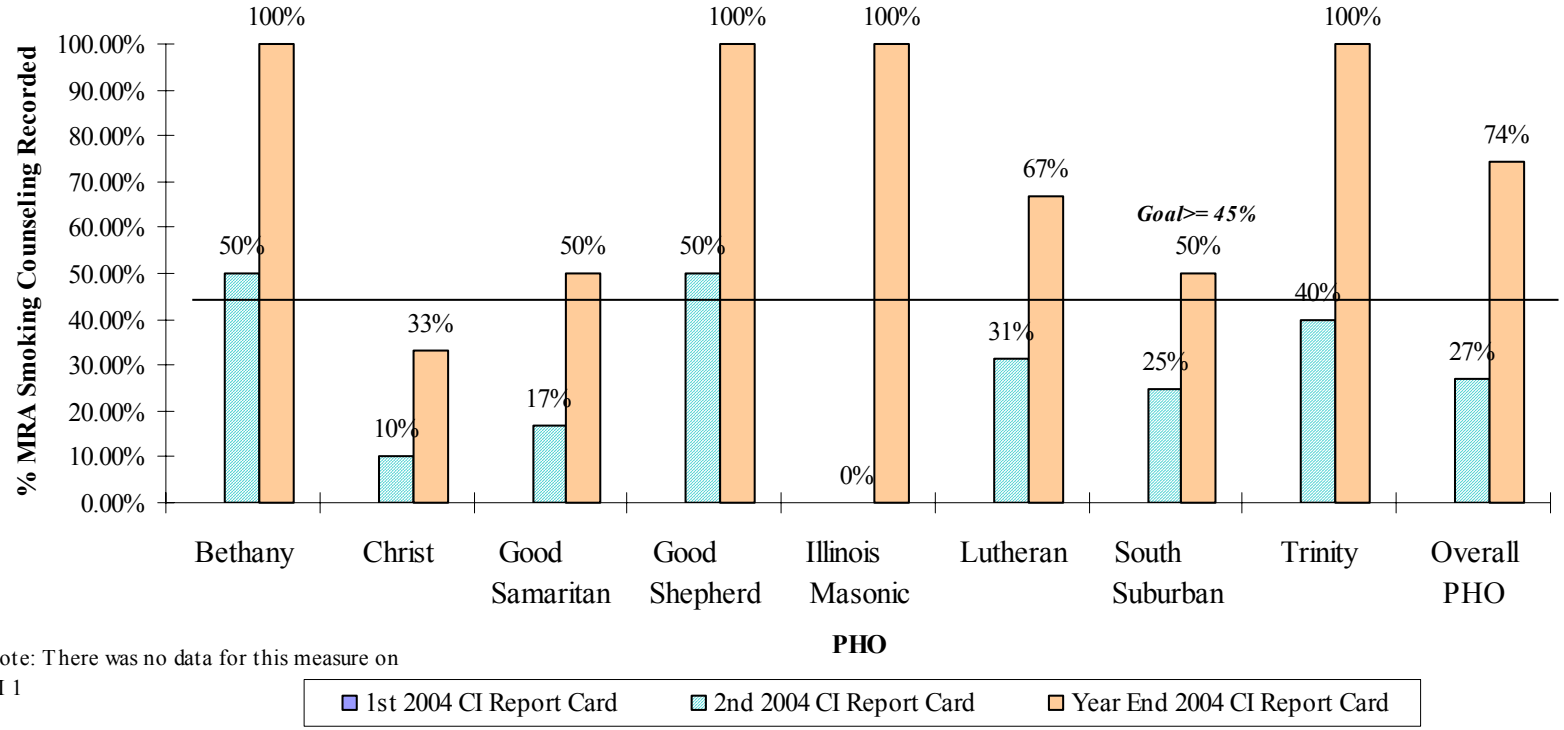
Advocate Health Partners' combined initiatives for CAD and HF resulted in an estimated additional 46.1 lives saved, 30 hospitalizations avoided and 173.3 fewer days of work lost, compared to national averages.

Smoking Cessation

Industry Facts

- In 1999, the average cost of lost productivity per smoker was $1,760 per year and the average cost of excess medical expense per smoker was $1,623 per year.
- 33 percent of medical records evidence no documentation of smoking status and only between 21 and 44 percent of smokers recall being advised by their physician to quit smoking.

Medical Record Audit Smoking Cessation Counseling Comparison



Note: There was no data for this measure on CI 1

Smoking Cessation

AHP 2004 Outcome

Advocate Health Partners' efforts resulted in an estimated additional 1,125 patients quitting smoking, resulting in incremental direct medical cost savings of $1.8 million and indirect savings of $1.9 million due to increased productivity, compared to national averages.

Orthopedic Implant Initiative

Industry Fact

Supply costs represent the second largest category of health care expenditures after labor.

AHP 2004 Outcome

In 2004, Advocate's annual savings for orthopedic devices was $2.5 million.