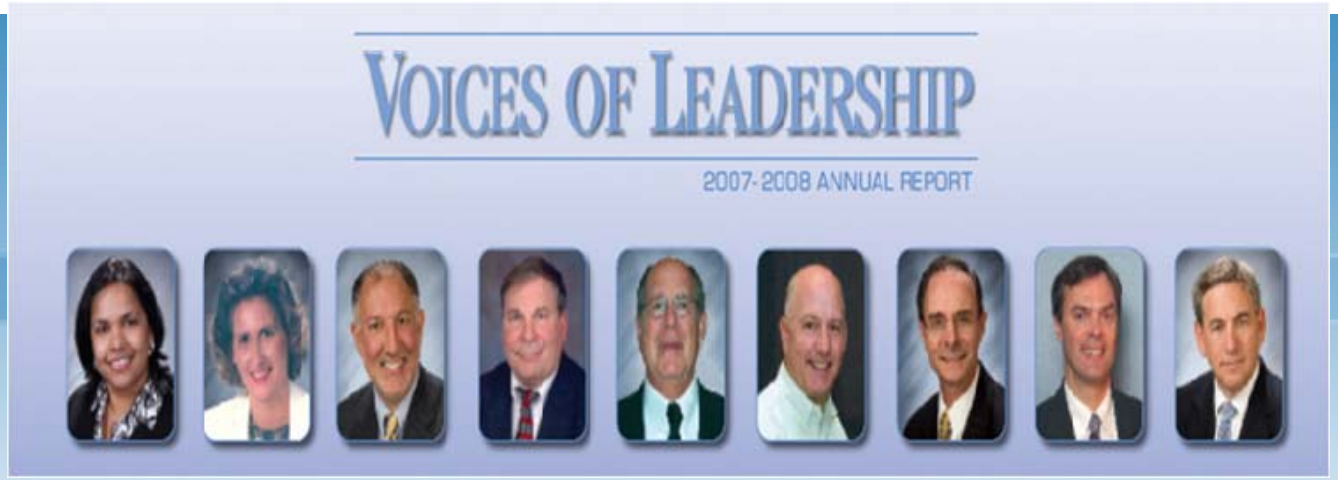

Clinical Integration and P4P: Using Pay for Performance to Build Clinical Integration within a Physician-Hospital IPA

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CIPA WNY IPA, Inc.

A Partnership for Medical Excellence

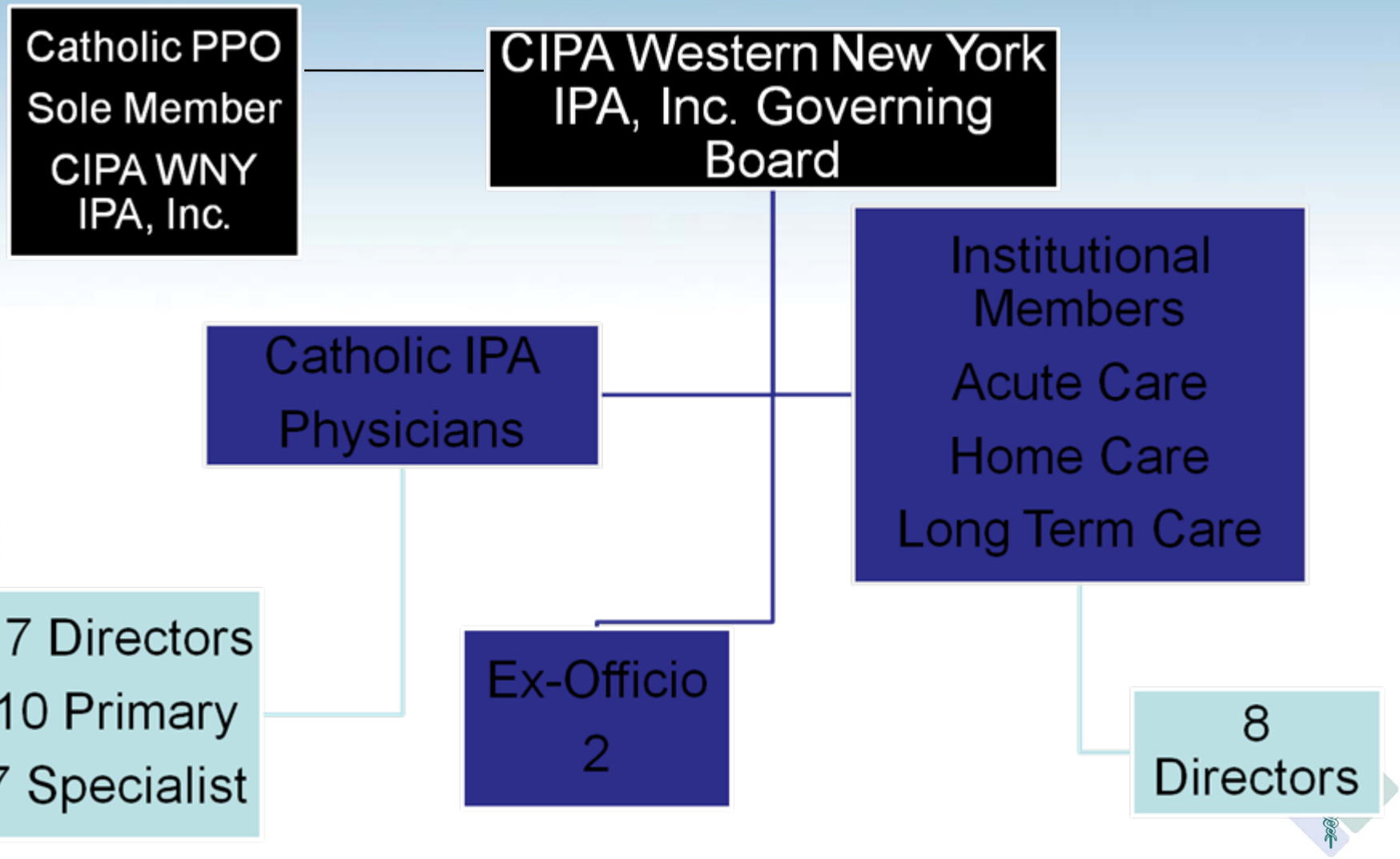
Objectives for Today

- What is CIPA and the Catholic Health System of Buffalo
- Review Role of Physicians and Hospitals in Health Care Transformation.
- Discuss how Clinical Integration can promote the PCMH and Disease Management.
- Understand how CI and P4P allows an organization to transition to an Accountable Care Organization (ACO)

Organizational Overview

- Not-for-profit membership organization founded in 1997
- >840 physicians, < than 30% of market
- Physician Participating Agreement is non-exclusive
- Four acute care hospitals - Erie/Niagara counties
- Six health plan contracts including: Commercial, Medicare and Medicaid
- 140,000 members

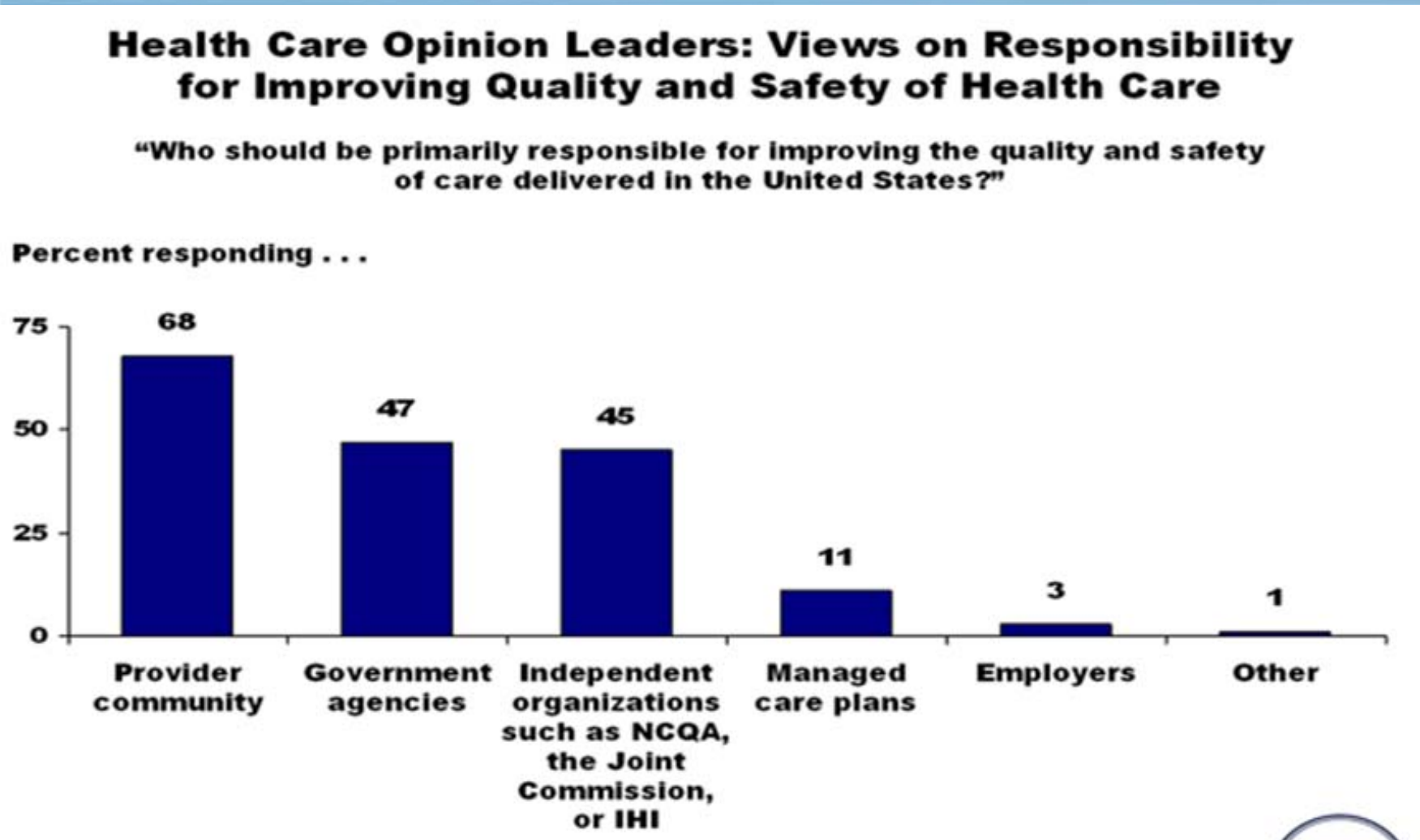
CIPA Western New York IPA, Inc. Organizational Graph



Who Will Bring Value?

- Health Plans
- Disease Management Companies
- Physicians and Hospitals

Who are the Leaders?



Case for Clinical Integration

- Costs are high
- Quality is overall mediocre
- **Significant Variation**
- Fragmented Uncoordinated Systems
- Overworked Physicians
- Decreased Physician Involvement with Hospitals
- Need for further Investment in HIT

Criteria for Clinical Integration

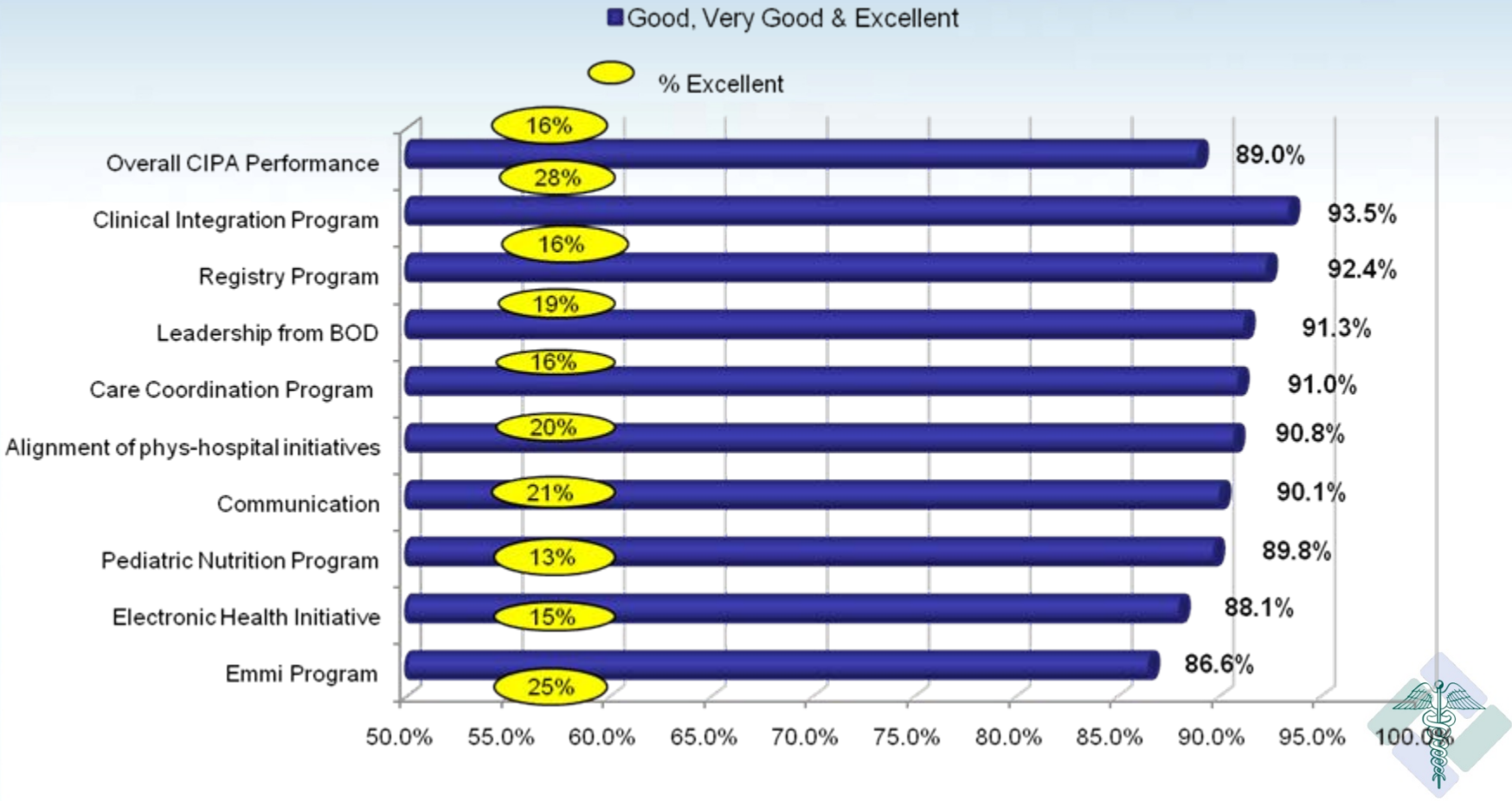
- Clinical integration is the development of organized processes to improve clinical care
- Clinical integration programs engages physicians in initiatives that address gaps in quality of care
- Clinical integration programs are likely to result in improvement
- Clinical integration programs would not be possible without joint contracting

Physician Leadership

- Key to Success
- Need to direct Input and Feedback
- Need to provide effective communication and education as it relates to evolving economic model
- Need to be realistic in expectations
- Need to Listen

CIPA Performance Attributes

CIPA physicians evaluated CIPA on service attributes perceived most relevant to its physician panel: communication, advocacy with the health plans, quality initiatives and the electronic health record initiative. All service attribute ratings remained at about 90% overall positive ratings.



Tactics To Meet Goals of CI

- Invest in human resources and infrastructure to improve care
- Develop organized processes
- Measure results
- Provide interventions
- Take corrective actions

Specific Gaps to be Addressed:

- Technology
- Clinical Office Design
- Utilization Management
- Patient Centric Continuum of Care

Closing Quality Gaps: Technology

Eliminate paper medical records by 2012

- Electronic Health Record Initiative

  36 months of financial support for physicians who adopt (CCHIT) certified EHR vendor (started September 2006)

- Beginning to Sunset Program

  Will end December 31, 2012

CIPA's EHR Health Record Adoption

Closing Quality Gaps: Technology

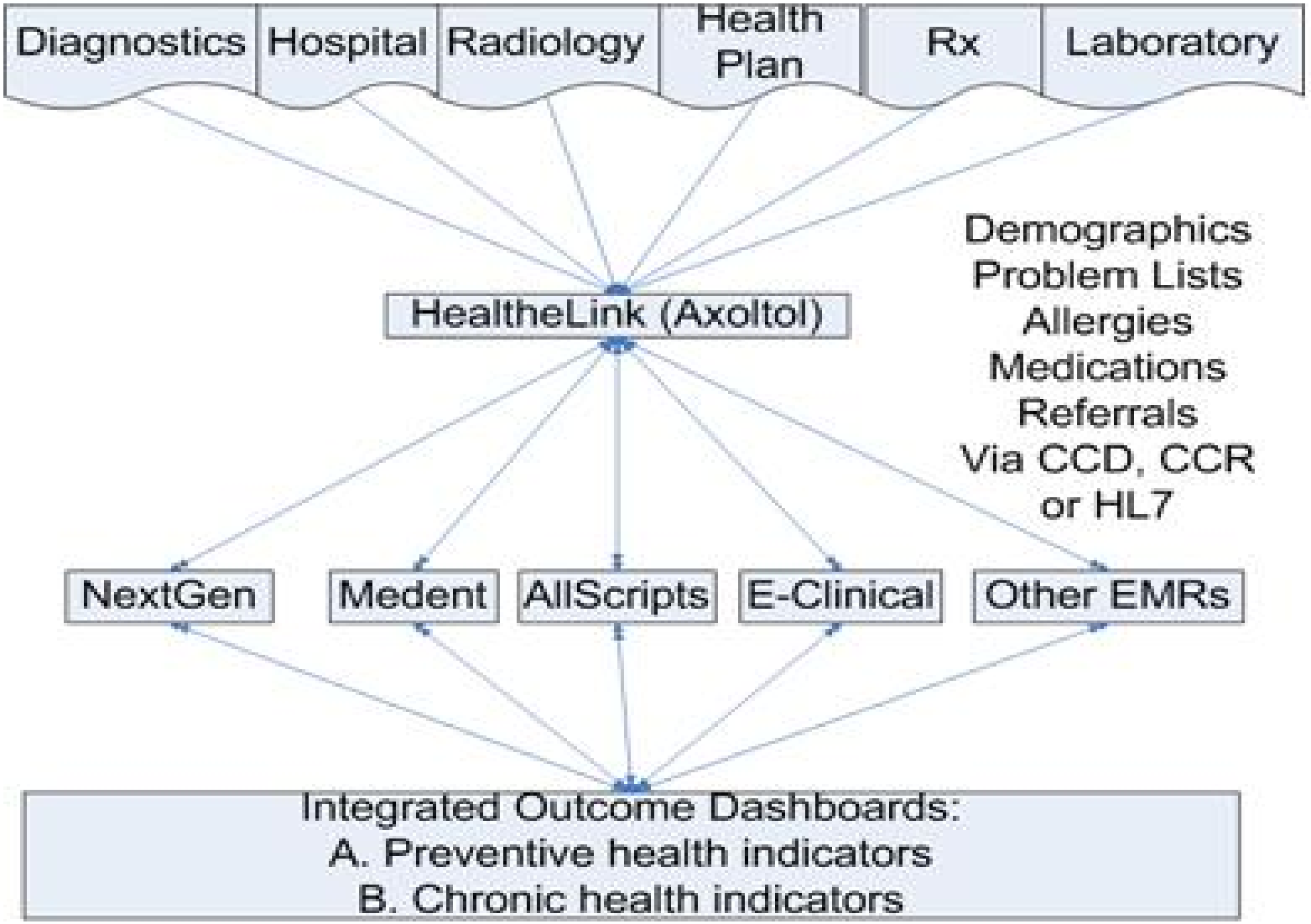
- Financial support for connectivity

  -Connecting to hospital, labs, imaging
- Hospital Investing EHR
- Working with local RHIO (HealtheLink):

  -Interface between multiple systems

  -Interoperability (MSSNY)

Interoperability Model



Closing Quality Gaps: Clinical Office Design

To meet increasing demand for quality and value medical care needs to be provided by knowledgeable and efficient teams of health care professionals

- Provide Clinical/Technical support to clinical offices

  -Meaningful Use (E-prescribing, Registries, Patient Reminders)

  -How to change office flow/data entry

  -How to generate reports

Closing Quality Gaps: Clinical Office Re-Design

Provide Office Based Disease Management (Program initiated 2008)

- Trained RNs, LPNs in principles of disease management, EBM, coaching and coordination of care
- Enhance or replace health plan disease management programs
- Bring added resources to patients and families
- Systematic monitoring of patient care using registries and data warehouse

Closing Quality Gaps: Clinical Office Re-Design

- Pharmacy Support

  -Utilizing Pharmacist in conjunction with care coordination and care transition

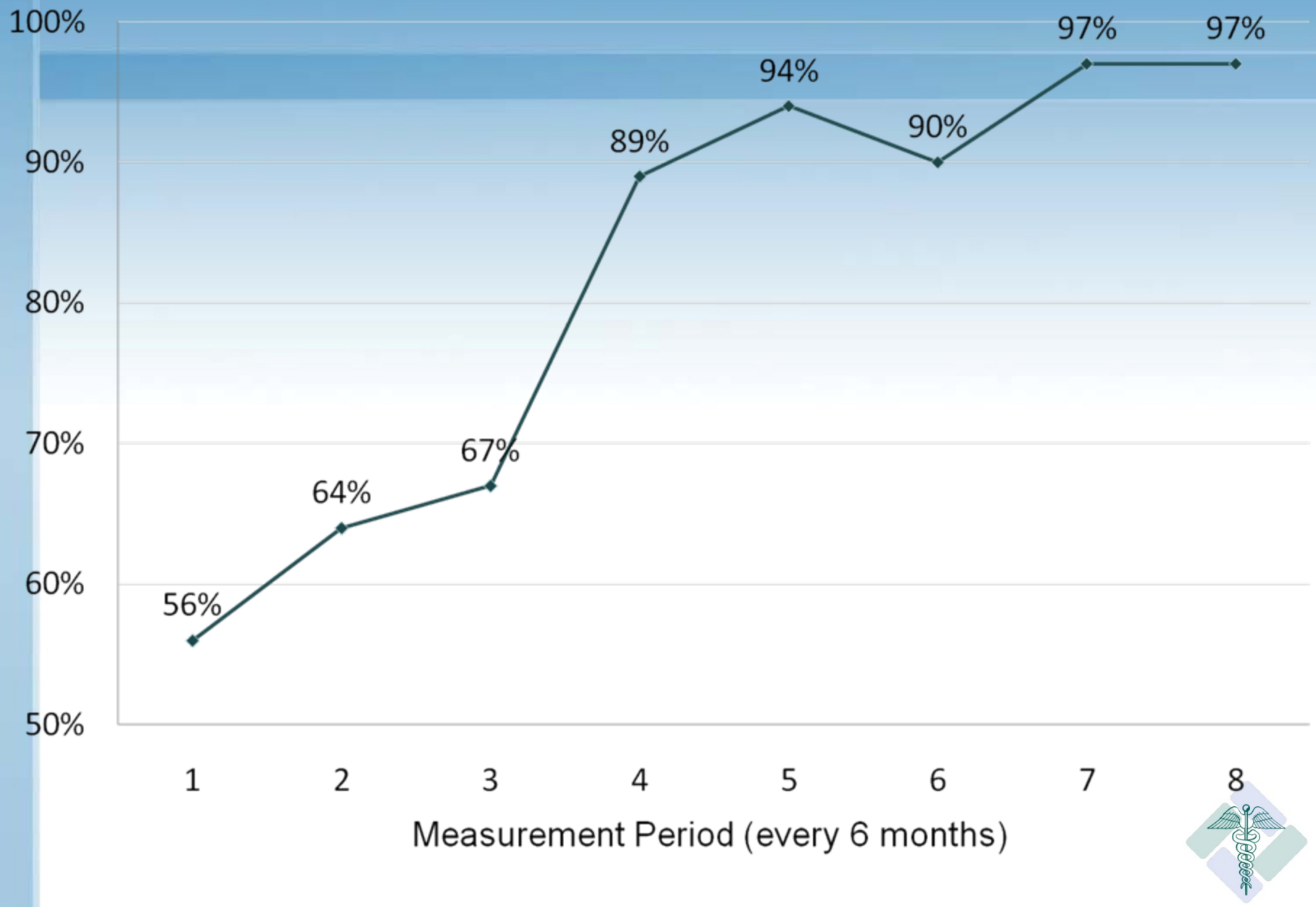
  -In office and virtual

- Nutrition Support

  -Utilizing Nutritionist to train staff

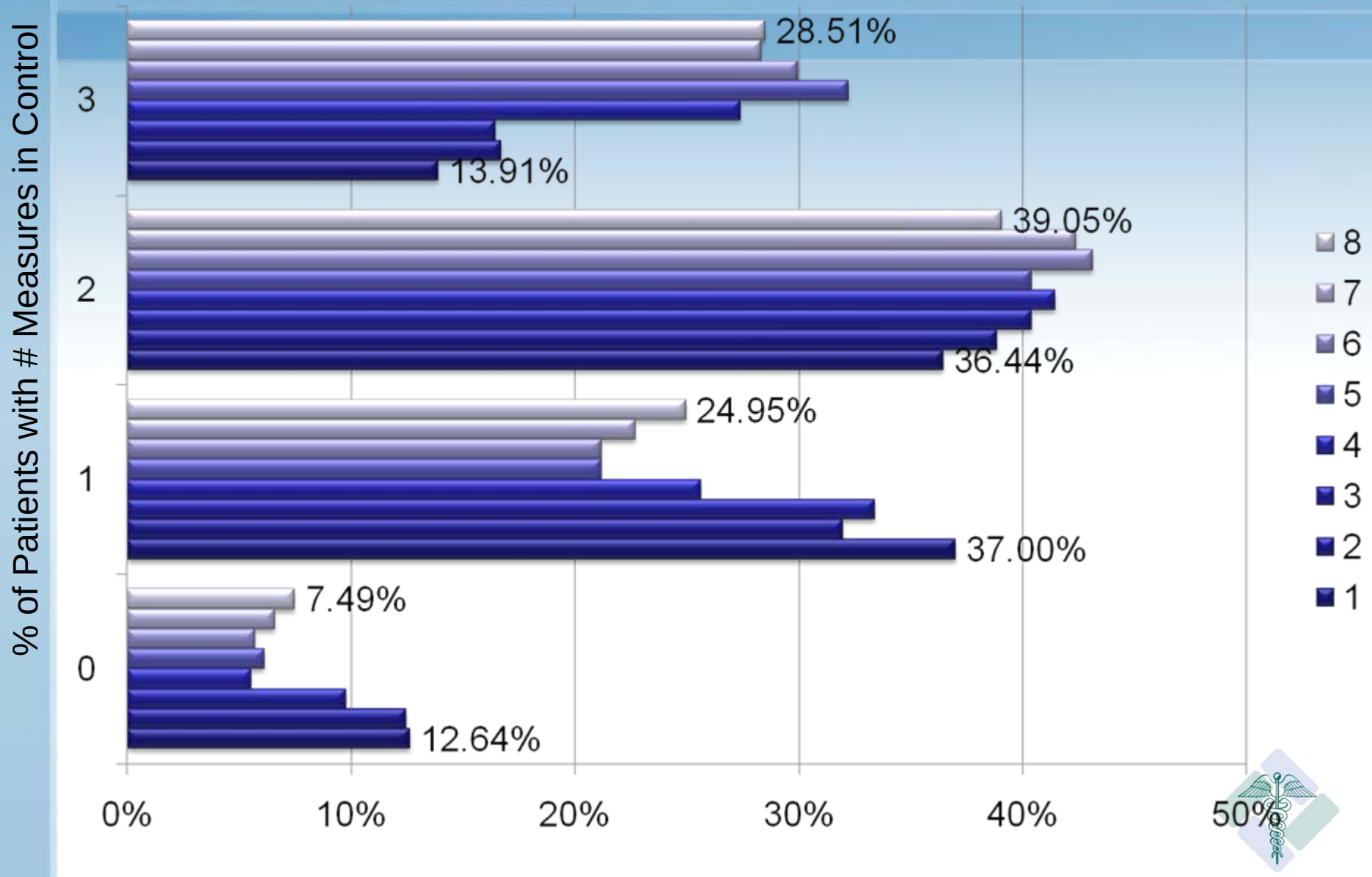
  -Provide group programs

Percentage of CIPA Doctors Reviewing Charts



Diabetes Measures of Perfect Care by Cycle (6 Months)

3 Measures: HbA1c <7 LDL <100 BP <=130/80



Closing Quality of Gaps: Utilization Management

- Need Reliable Data Warehouse

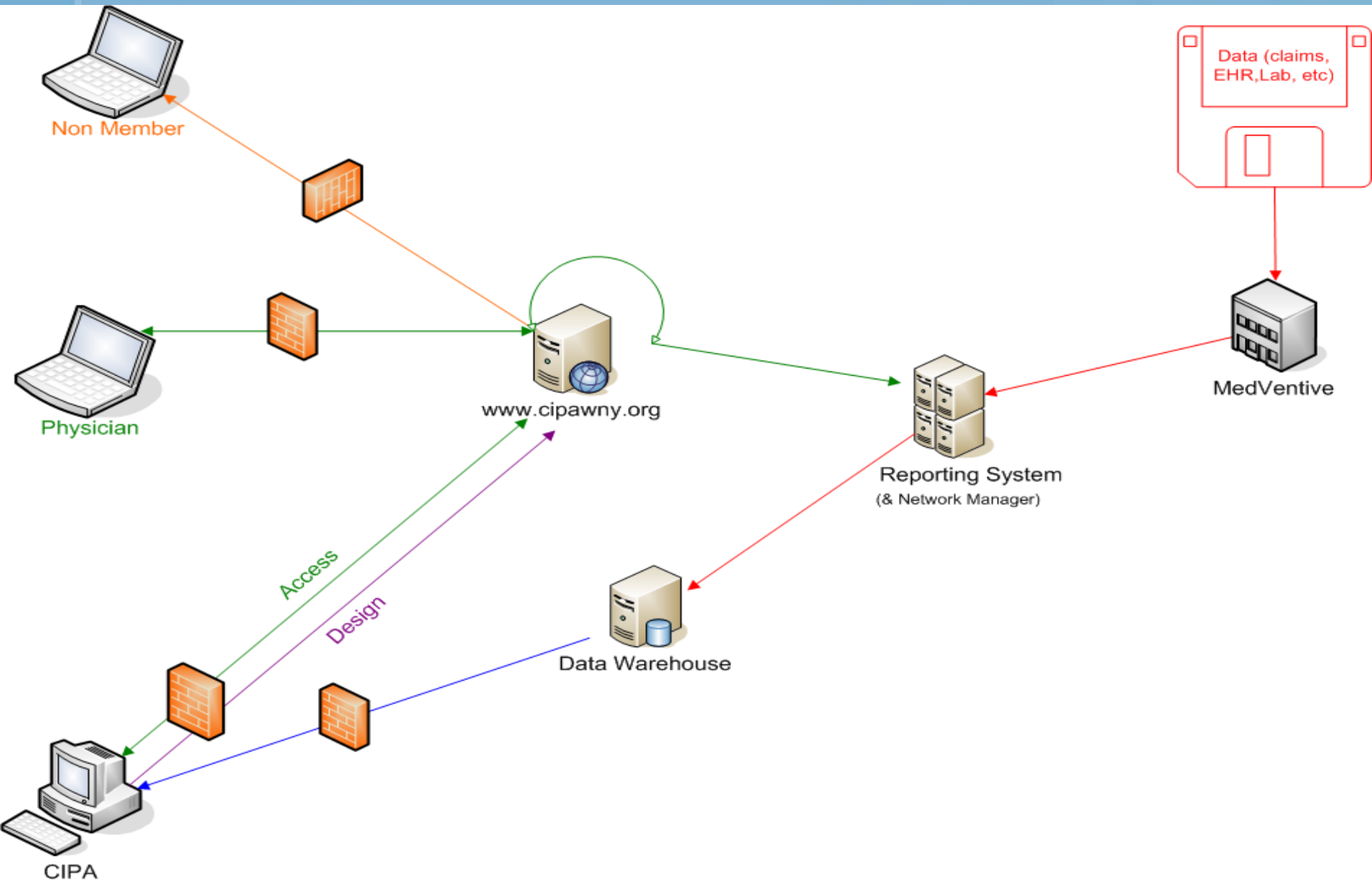
  -Claims and Clinical data

- Generate Meaningful Reports

- Electronic Health Record Report

  -Extract Transfer and Load to DM System

CIPA Data Warehouse



Closing Quality of Gaps: Utilization Management

- Develop Programs to Act on Reports - Reduce Waste

  -Physician focused (Rx and imaging)
- Spans the Delivery System
  - Need consistency between outpatient and inpatient
- Need to look at Overall Impact
  - Example formulary impact

Closing Quality Gaps: Patient Centric

Patients who are informed about their health care needs and are involved in their care have greater probability of meeting desired treatment objective.

- Patient Education

  -Multi-media, supported by physician but performed by team

- Patient Coaching

  -Key component of office based DM

- Patient Activation (PAM)

  -Consistently engage the patient

Closing Quality Gaps: Patient Centric

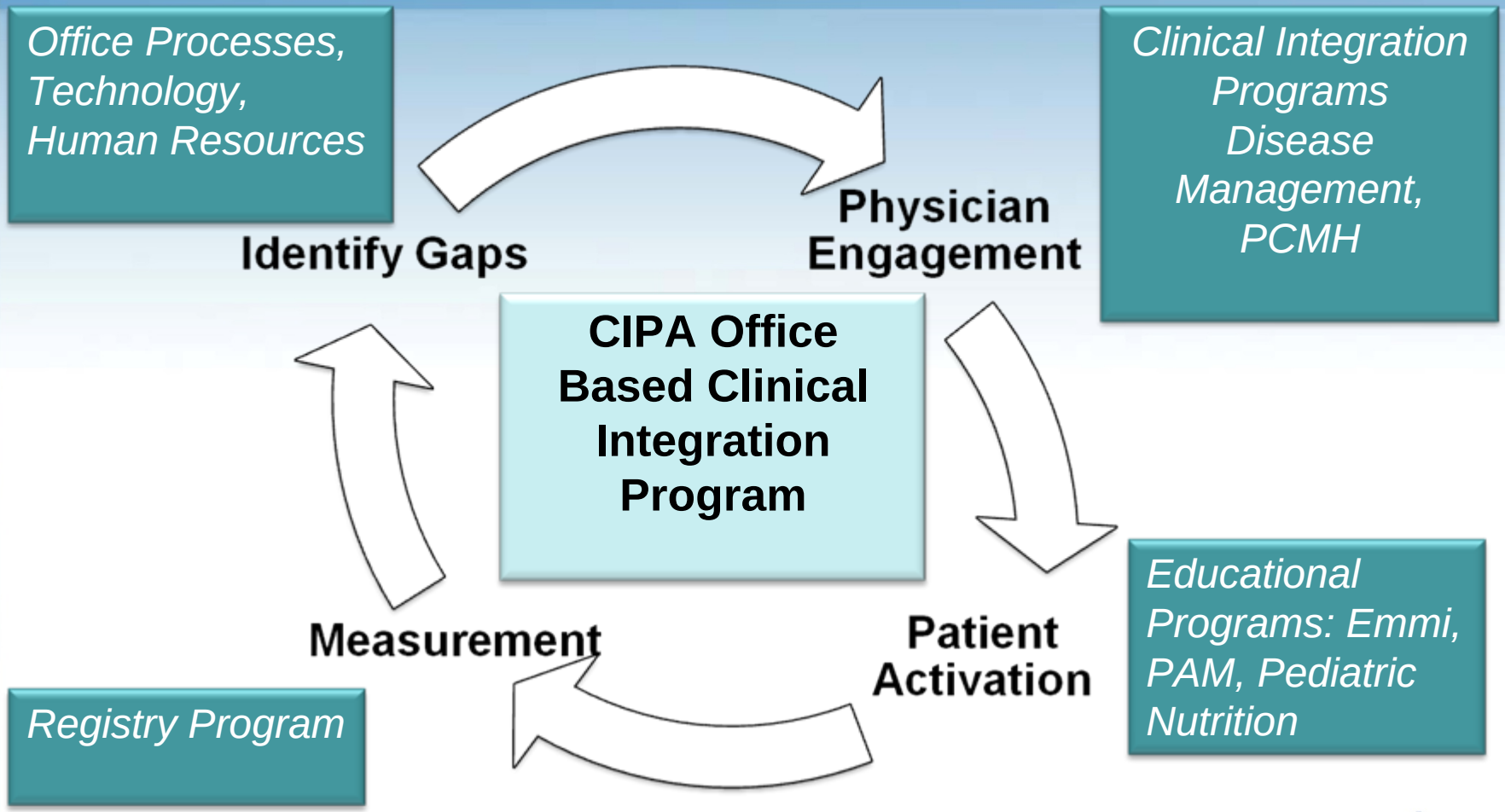
- Programs need to follow the patient
- Need to be coordinated with effective communication
- Need integration with office (primary and specialty), acute facilities, home care, sub-acute etc
- Service Lines and Technology
- Whole System Measures (IHI)

Closing Quality Gaps: Patient Centric

Background: Over 20% of Medicare discharges have readmission within 30 days

- Care Transitions Program
  - -Nurse visit within 48 hours of discharge
  - -Coordinate with office Care Coordinator to schedule appointment
  - -Medication reconciliation
  - -Family engagement
  - -Activate community resources
  - -Re-assess discharge plan to reduce potential risk for readmission

Disease Management: NCQA



The role of CIPA is to provide all the necessary resources for successful Clinical Integration

Alignment of Clinical Integration with Patient Centered Medical Home

- Electronic Health Record adoption and move to meaningful use
- Patient registries and office based Disease Management
- Referral and lab tracking
- Patient Education and self Management
- Performance Reporting and Action Plans
- Patient Facing EHR*

Transition to an Accountable Care Organization

- Moves to more formal relationship between physicians and hospital system
- Shift to taking greater amount of direct financial risk
- Greater opportunity to impact care and change

Transition to an Accountable Care Organization

- Need to understand the needs of community, government and employers
- Need to develop expertise in managing this broad delivery system

Questions