Elements

Clinical Integration *Newsletter*

Valence Health

THE *Power* TO *Combine*

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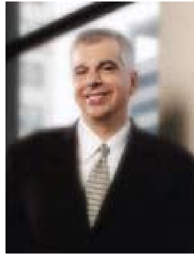
Message from Phil Kamp, CEO of Valence Health



The meaning of "meaningful use"

In recent months, much attention in the health care industry has centered on Health IT incentives described in the American Recovery and Reinvestment Act (ARRA). Medicare-participating physicians who adopt EHR technology and use it in a way the government deems "meaningful" could receive up to $44,000 in stimulus plan funds over a period of up to five years.

The definition of "meaningful use" is emerging as the critical element in the policy debate. Various associations and industry groups are advocating their preferred definitions. A common theme is that the focus should be on end goals of improving quality and cost, regardless of the specific technology used.

A broader definition of "meaningful use" would support the innovative solutions forward-looking IPAs and PHOs are pursuing, such as enterprise data warehouse and health information exchange models. Several of our clients believe the Valence technology they are using to support clinical integration may be eligible for ARRA funds; we will support their efforts and continue to follow developments closely.

In this issue we welcome Pamela Ballou-Nelson, RN, Clinical Quality Manager, Adventist Health Network, who writes about best practices in patient outreach, to improve compliance with evidence based medicine protocols and make a real difference in patient care.

We are also following discussion of payment reform models such as Primary Care Medical Home and Accountable Care Organization models. As we see it, clinically integrated provider organizations are well positioned for these developments, and have great opportunity to proactively shape the debate rather than wait to react. What do you think? We welcome your feedback. Please call or email us with your questions or comments.

– Phil Kamp

LEGAL NEWS – FAVORABLE FTC ADVISORY OPINION FOR TRISTATE HEALTH PARTNERS

On April 29, 2009 the Federal Trade Commission released an Advisory Opinion letter regarding TriState Health Partners, a physician-hospital organization in Hagerstown, Maryland. TriState becomes the third organization in the country to receive a favorable FTC advisory opinion, joining MedSouth (2002) and Greater Rochester IPA (2007).

TriState Health Partners comprises more than 200 physicians and one hospital, serving patients in western Maryland, southern Pennsylvania and northern West Virginia. In TriStates' program,

Upcoming Events

Clinical Integration Webinars: Valence will continue our popular series of information webinars on topics of interest to clinically integrated organizations, as well as IPAs and PHOs considering clinical integration.

August 20 – Save the Date!

Institute for Clinical Quality and Value – Chicago, June 18-19
Valence will once again be a sponsor of the Institute for Clinical Quality and Value, a forum for clinically integrated provider organizations to share knowledge and experiences, while hearing from regulators and other organizations from around the country. For more information and to register, go to www.icqv.org. We hope to see you there.

Georgia Society for Managed Care, Summer Meeting, King & Prince Resort, St. Simons Island, GA, July 8-11
Valence is pleased to again be an exhibitor and sponsor at this annual conference. Please stop by our table and get information on Valence's newest products and services. www.gha.org

Messenger Model demos: Automate your messenger model processes! Valence's vElect tool allows physicians to log into a secure web site to view fee schedules and make their elections in a safe and compliant manner. Lori Fox Ward, VP Clinical Integration will conduct web demonstrations of the Valence vElect tool on the second Thursday of every month. If interested, please register here or call Lori Fox Ward at 312-277-6304 for more information.

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physicians collaborate to produce a superior system for high quality health care through use of technology and value-based purchasing and performance incentives. The program will provide physician members with access to electronic health records, development of evidence based quality indicators, and case management and pharmacy benefit management programs to control costs.

The FTC found that the program "…appears to have the potential to create substantial integration among its participants, with the potential to produce significant efficiencies, including both improved quality and more cost-effective care". The FTC further found that joint contracting would be "reasonably related" and "reasonably necessary" to achieve the benefits of the program, and would therefore not be summarily condemned as price fixing, allowing TriState to contract on behalf of its members with self-insured and fully insured employers.

To read the full Advisory Opinion, go to http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf

IS THERE ROI FOR CLINICAL INTEGRATION?

Clinical Integration programs are perceived as complex and often costly to implement. But can a physician organization expect a return on their investment in clinical integration? At the recent AAIHDS Spring Managed Care Forum in Atlanta, Liz Simpkin, VP of Consulting Services, Valence Health, identified a number of ways in which physician organizations can recoup their investment and realize a positive return.

Return on Investment is a function of total program costs, revenue growth opportunities, and opportunities for offsetting cost reductions. Other "intangibles" have value to the IPA or PHO and physicians, but may be difficult to quantify.

• **Program costs** include the obvious categories of Information technology at both the IPA/PHO and practice level, and related staffing costs due to the likelihood of requiring additional staff to implement and manage the effort. Additionally, most organizations incur legal and other outside services particularly in the startup phase. Costs that groups may not think about include increased committee/work group activities and associated stipends to encourage physicians to participate; and certain programmatic costs such as mailings, phone outreach to patients and other activities to engage physicians and patients in improving care management.

• **Revenue growth** – clinically integrated groups may pursue collective negotiation with payers, including enhanced fee schedules as well as P4P programs and other incentive opportunities. Other sources of new revenue growth include increased patient visits and other services associated with improved chronic care patient

Looking for a speaker for your next Physician Membership Meeting, or a facilitator for a Board Strategic Planning retreat? Valence team members can address a wide range of strategic, operational and clinical topics, and provide useful insight for your physicians and administrative team. Please contact Liz Simpkin, VP of Consulting Services, for more information. She can be reached at 312-277-6340 or esimpkin@valencehealth.com

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management, gainsharing programs with hospital partner(s), and the opportunity to grow market share by promoting quality programs. Another area to explore is healthcare IT stimulus funds under the HITECH act, if your IT investments qualify.

• **Direct and indirect cost savings** can also contribute to a positive return on investment for a Clinical Integration program. Possible savings include: Improved performance on risk contracts, if you have them; decreased LOS; and operational efficiencies from automated data sharing and use of other online tools. Other areas of savings can certainly be significant, even if the savings do not directly accrue to the provider – such as reduction in inappropriate overutilization, decrease in avoidable adverse events, and overall improvement in population health for the community.

• **Intangibles** such as helping physicians remain independent if they desire and providing other value to IPA/PHO members are also important measures and should be weighed in any evaluation of program value

At the end of the day, no one can put a price tag on improving quality or doing the right thing for patients. But making the effort to quantify benefits of a well-designed clinical integration program can help make the decision to invest easier for physicians. As you consider the value of a clinical integration program, be sure to think broadly enough to capture the full ROI potential.

IDENTIFYING AND REACHING OUT TO PATIENTS USING CLINICAL INTEGRATION PROGRAM DATA

By Pamela Ballou-Nelson
Clinical Quality Manager,
Adventist Health Network, Illinois

A recent article in the British Medical Journal (March 2009) regarding predicting risk of Type 2 diabetes in an ethnically and socioeconomically diverse population raised my level of enthusiasm for the mission of partnering with Valence Health for data collection within our PHO. The article references the “routinely” collected data, indicating the routine as a “usual pattern of activity”. Our PHO is slowly growing into the concept that routinely collecting data can and will be a powerful tool as we enter a new era of “evidence based medicine.”

Current trends call for research to be more relevant, context based and actionable. Our PHO, with the support and expertise of Valence, now has the capability of collecting analyzing and translating the data to patient intervention programs and physician office practices in a manner that makes evidence more practical and relevant, a position Medicare and insurance companies dream about. This has truly become a reality at the local level.

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In our PHO, we have collected data to develop a community based intervention for hypertensive patients, by geographic areas (over 30,000 patients), to improve guideline compliance with the objective of controlling blood pressure and reducing cardiovascular incidents. We have also used the data to identify COPD patients who are non-compliant with flu and pneumococcal vaccines. Each fall, a post card will be sent to this population of patients to remind them to receive the appropriate vaccines. Our data collection efforts will then assist us in identifying other possible sources for these immunizations outside the doctor's office and help determine patient barriers to compliance.

Other physician office interventions that the PHO has undertaken, such as coding practices and raising awareness to the number of patients actually following through with tests, (like colonoscopies and mammograms) have provided critical feedback to assist physicians provide relevant patient care at the local level and at the point of care.

References

Cox, J., Coupland, C., Robson, J., Sheikh, A., Brindle, P. (2009). Predicting risk of type2 diabetes in England and Wales: prospective derivation and validation of QDS score. BMJ, 338:b880. Retrieved March 18, 2009 from www.bmj.com/cgi/content/abstract/338/mar17_2/b880

Green, L., (2006). Public Health asks of systems science……, American Journal Public Health, 96

Presentation April 28, 2009 at Adventist Midwest Health CME, Oakbrook, Illinois.

If you'd like to learn more about the Adventist Health Network Clinical Integration program, contact Pam at Pamela.Ballou-Nelson@AHSS.ORG

ACCOUNTABLE CARE ORGANIZATIONS – A SOLUTION TO FRAGMENTED HEALTH CARE?

The Accountable Care Organization (ACO) model is becoming an increasingly popular topic in policy discussions, particularly around cost control and quality improvement in the Medicare program. Generally the Accountable Care Organization is characterized as a group of physicians and possibly a hospital that are held responsible for both quality and cost of care for a defined population of patients. A spending benchmark is established for that population, based on expected spending from prior experience, and the ACO shares in any savings if actual spending is less than the target, provided quality standards are also met. Various payment methods could be consistent with an Accountable Care Organization model; one of the

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most commonly mentioned is fee-for-service payment less a withhold, with bonuses for meeting resource use and quality targets, and/or penalties for failing to meet targets.

The Accountable Care Organization model is more comprehensive than a Primary Care Medical Home (PCMH) model which focuses on recognizing primary care physicians for care coordination and related services, but does not provide incentives for other specialists or facility providers to also participate in the program. Elements of PCMH model complement and could certainly be incorporated into an ACO model to properly reward PCPs' coordinating efforts within the organization.

MedPAC, the Medicare advisory body, has been considering both voluntary and mandatory ACO scenarios.

1. Voluntary ACO - wherein an existing organization volunteers to take responsibility and payment. MedPAC recognizes it may be difficult to find or attract sufficient organizations to deliver any real savings to the Medicare program using only those who volunteer

2. Mandatory or virtual ACO - in which providers would be "assigned" to an ACO based on patterns discerned from past Medicare claims data. Questions with this approach include - Will providers accept "assignment" to a group? And can a virtual organization achieve a sufficient degree of coordination to yield savings?

Clinically integrated organizations are already building the infrastructure and making the necessary culture changes to embrace ACO. Key elements that influence the organization's effectiveness and ability to manage quality and costs of care include:

• Structure and scope of the organization (PCP, SCP, hospital, other)

• Traditional referral patterns and services that can be provided within the organization

• Historical cost and quality performance

• Size and stability of the patient population

• Internal payment methodology and agreement on how to distribute shared savings

In considering whether your organization might be a good candidate for ACO, consider whether you have sufficient information to establish spending and quality targets, as well as how to apply the information to manage and coordinate care for a population within a targeted spending budget. With planning and forethought, the same tools an IPA or PHO is developing for clinical integration can also hold the key to managing costs and quality measures for a population as an Accountable Care Organization.