21st Annual AHA Leadership Summit
July 25, 2013

From Clinical Integration to Accountable Care: A Case Study with Advocate Physician Partners

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Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Agenda

• About Advocate
• APP response to healthcare reform
• Clinical integration
  – Key drivers of success
• Population health management
  – Clinical programs
  – Key metrics
• Lessons learned
• Strategic considerations
• Critical success factors
13 Hospitals
- 9 acute care hospitals
- 1 children’s hospitals
- 5 level 1 trauma centers
- 3 major teaching hospitals
- 2 specialty hospitals

2 Physician Groups
- 1,100 employed

Home Care Company
- 3.4 Million Patients Served
- 34,000 Associates
- Total Revenue $4.6B

AA Rating
ADVOCATE 2020
Mission, Values, Philosophy
To be a faith-based system providing the best health outcomes and building lifelong relationships with the people we serve

Vision

Strategies

Key Result Areas

Foundation

Advocate Experience
Safety Quality Service

Access and Affordability
Growth Funding our Future

AdvocateCare
Coordinated Care

Strong Physician Engagement
Advocate Physician Partners

- 9 PHOs, 2 medical groups
- 4,112 physicians
- Employed & independent physicians
- 200,000 capitated lives/700,000 PPO lives
- 270,000 shared savings lives

MSO Operations

Clinical Integration Program

AdvocateCare Programs

APP Advisors Consulting
Advocate Physician Partners

**Vision**
To be a faith-based system providing the best health outcomes and building lifelong relationships with those we serve.

**Our Role**
To drive improvement in health outcomes, care coordination and value creation through an innovative and collaborative partnership with our physicians and the Advocate system.
Pluralistic Physician Approach

Active physicians on medical staffs (5,673)

Total APP physicians (4,112)
25% PCPs – 75% specialists

Employed/affiliated (1,135)
- Advocate Medical Group (952)
- Dreyer Affiliated (183)

Independent APP (2,977)

Independent non-APP (1,561)
APP Physicians By Practice Group Size

33% of PCPs Are Solo Practitioners, 25% In Offices of 2-3
## APP Response To Health Care Reform

### Key Dates
- **February 17, 2009**
  - Recovery Act and HITECH Funding
- **March 23, 2010**
  - Patient Protection and Affordable Care Act Signed
- **2012**
  - 153 Pioneer and MSSP ACOs Launch
- **January 1, 2014**
  - Health Insurance Exchanges (HIX)
  - Medicaid and Federal Subsidy Coverage to Uninsured

### Programs and Initiatives

#### 2010
- **2004-Current**
  - Nationally recognized CI program
- **2010-Current**
  - SynAPPs EMR incentive

#### 2011
- BCBSIL ACO
- AdvocateCare programs
- CI collaboratives
- Meaningful use

#### 2012
- AdvocateCentered plans
- MSSP ACO
- Practice coaches
- Population analytics

#### 2013
- PCP and specialist value pools
- Advanced medical practice
- 0.5% PQRS Medicare incentive for APPAC, Inc.
- Employer partnerships

#### 2014
- New disease registry
- IT connectivity
- Increasing transparency and public reporting
- Health Insurance Exchange (HIX)

### Outstanding Issues
- SGR and Budget Cuts

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**9**
Key Drivers Of Success

- Culture
- Governance
- Infrastructure
- Incentives
- Transparency of Results
- Feedback Loop
Creating a Culture of Engaged Physicians

• Physician engagement in governance
• Physician leadership development
• Shared identity and values → “membership”
• Infrastructure investment to enable success
• Appeals to pride and sense of excellence
  – Recognition for quality and efficiency
  – Consistent use of evidence-based medicine
  – Power of the outcomes of the group
More Than 100 Physicians Involved In APP Governance

APP Board of Directors
Class A - Physicians
Class B - Advocate

PHO Boards

Contract Finance Committee
Utilization Management Committee
Credentialing Committee
Quality & CI Improvement Committee
Audit Committee

Pharmacy & Therapeutics Committee
Clinical Integration Measures Committee
Clinical Integration Is The Foundation Of An ACO

• Overcomes problems seen within the fee-for-service model
  – Incentives to providers drive improvement
• Creates business case for hospital and doctors to work for common goals
• Allows one approach for commercial and governmental payers
• Builds on success of APP and the CI Program
What Clinical Integration Looks Like

Jane Smith, Patient with Diabetes

Primary Care Physician

Pharmacy

Lab Test Results

Endocrinologist

OB-GYN

Mammography

APP Data Warehouse and Disease Registries

Primary Care Physician • OB-GYN • Endocrinologist
Clinical Integration 4.0: Increasing Physician/System Integration

- **Primary Care/Ambulatory Measures**
  - Early Years: 2004 - 2006

- **Increasing Specialist Measures**
  - Middle Years: 2007 - 2009

- **Increasing Physician/System Integration**
  - Maturing Years: 2010 - 2011

- **Clinical Integration to Accountable Care**
  - Health Reform: 2012 -
## Change In Domains

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Technology</td>
<td>Chronic Disease</td>
</tr>
<tr>
<td>Infrastructure</td>
<td></td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td>Health and wellness</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Efficiency</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient Experience</td>
</tr>
</tbody>
</table>
Advancing Evidence-Based Medicine and Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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 collaborative  
 | Patient coaching program  
 | Hospitalists |
| 2009 | Diabetes wellness clinics  
 | Asthma and HF/CAD collaborative |
| 2011 | Access & COPD collaborative |
| 2012 | Patient experience CME & coaching  
 | Practice coaching (data sharing) |
## Physician Support: Advancing Technologies

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
</table>
| 2004 | High speed internet access in physician offices  
       Centralized longitudinal registries  
       Access to hospital, lab & diagnostic test information through a centralized clinical data repository (Care Net & 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 |
| 2011 | Care management software plus analytics |
| 2012 | Advocate/Cerner collaboration |
## Strategy For Transparency

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>External via Annual Value Report</td>
</tr>
<tr>
<td></td>
<td>Internal via Annual Value Report and Organizational Level Reporting</td>
</tr>
<tr>
<td>Year 2</td>
<td>Blinded Comparative Overall Organizational Level Reporting</td>
</tr>
<tr>
<td>Year 3</td>
<td>Blinded Comparative Overall Physician Level Reporting with Outstanding Physician Performance Recognition</td>
</tr>
<tr>
<td>Year 4</td>
<td>Unblinded Overall Physician Scores within Metrics</td>
</tr>
<tr>
<td>Year 5</td>
<td>Unblinded Across All Organizations and Physicians</td>
</tr>
</tbody>
</table>
Mechanisms To Increase Compliance

• APP QI/Credentials Committee
• Membership criteria
• Peer pressure/local medical director
• Mandatory provider education/CME
• Physician’s office staff training
• Financial incentives/report cards
• Targeted programs
2013 APP Incentive Design

Professional HMO Surplus
Facility HMO Surplus
CI Funding
AdvocateCare Shared Savings

Minus Infrastructure Costs, Deficits and 120% Fee Schedule

PCP CI Value Pool
Specialist CI Value Pool
Hospital Value Pool
Change In Incentive Distribution

• Increase relationship between value contribution and incentive distribution
  – Continue transition from pay-for-performance

• Value contribution has several key components
  – CI Score
  – Care coordination
  – Number of patients managed
2013 Value Report

To download a copy of the 2013 Value Report, go to: advocatehealth.com/valuerreport
From Clinical Integration To Accountable Care

Editorial

Clinical Integration Provides: Quality Improvement: Structural Change

Caring the quality, costs, and other factors have determined the short-term and long-term sustainability of clinical integration programs. Nevertheless, for the sustainability and success of clinical integration programs, it is essential to understand the relationship between the clinical integration programs and the health care delivery systems.

The traditional quality improvement models focus on the process of care and the outcomes of care. However, the success of clinical integration programs depends on the ability to improve the quality of care, reduce costs, and improve patient satisfaction. It is essential to understand the relationship between the clinical integration programs and the health care delivery systems.

The traditional quality improvement models focus on the process of care and the outcomes of care. However, the success of clinical integration programs depends on the ability to improve the quality of care, reduce costs, and improve patient satisfaction. It is essential to understand the relationship between the clinical integration programs and the health care delivery systems.
Some Key Issues To Address

- Improving PCP access
- Reducing avoidable admissions
- Intensive outpatient management
- Achieving “hospitalism”
- Affecting “perfect transitions”
- Increasing alignment with independent physicians
- Real time clinical decision support
Implications For Primary Care

• Renaissance of primary care
• Appropriate incentive structures
  – Access/avoidance of ER
  – Medical Home
  – Managing ambulatory sensitive conditions
  – Admission rates & LOS
  – Readmissions
  – Specialist & ancillary efficiency
• Greater alignment with single system
Implications For Specialists

- Specialists are **Integral** to success
- Structures needed to unlock creativity
- “Pay for Work Done” will work for you
- Greater transparency around efficiency
- In-network care strategy will work for you
- Efficacious specialists will thrive
Implications For IDNs

- Communicating a complex message
  - Management & Physicians
- Building a climate of trust
- Ensuring physician access (both employed & independent)
- Less volume from existing sources
- “Re-purposing” parts of the enterprise
  - Business Development, Physician Relations, UM, Operations Management
  - Refocus on in-network care and marketing to physicians
  - Hospitals re-energizing business development teams to sell benefits of in-network care to physicians
  - Partner with physicians to enhance care
Advocate Population Health Vision & Roadmap

- Commercial & Governmental Payer Contracts
- Clinical Integration Program
- ACO Infrastructure
- Advocate Centered Health Plans for Associates
- Advocate at Work
- Advocate Cerner Collaborative: IT Population Health
Advocate’s Infrastructure Investments

<table>
<thead>
<tr>
<th>Physician Office</th>
<th>Hospital</th>
<th>Post-Acute</th>
<th>Ambulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Disease Registries</td>
<td>• Enhanced IP CM and ED CM Roles</td>
<td>• Hospital to home transition coaches</td>
<td>• Telephonic OP CM</td>
</tr>
<tr>
<td>• Patient Access</td>
<td>• Standardized Readmission Risk Tool</td>
<td>• “SNFists” &amp; advanced Practice Nurses Facility-Based teams</td>
<td>• OP Palliative Care</td>
</tr>
<tr>
<td>• Embedded OP CMs</td>
<td>• Follow-up appointments with PCP office</td>
<td>• Post-acute network built of preferred providers (SNF, inpatient rehab, LTACH)</td>
<td>• Advocate/Cerner collaborative</td>
</tr>
<tr>
<td>• Medical Home/ Advanced Medical Practice</td>
<td>• IP Care Coordination Redesign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Field Operations/ Practice Coaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• EB prescribing; high cost ancillary referrals</td>
<td></td>
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</tr>
</tbody>
</table>
Population Health Approach

- Catastrophic CM
- Actionable High Risk CM
- Acute/Chronic Disease Management
- Registry Management/Patient Outreach
- Patient Wellness Programs/Self Management
- Advanced Medical Practice
- PCP Practice
- Team Model of Care
- Medical Home
- Data/Analytics
- Health Risk Assessment
- Risk Stratification
- Disease Registries
Reimbursement Model Is Shifting

2010
- 82%
- 12%
- 5%

2012
- 59%
- 23%
- 5%
- 12%
- 1%

2014
- 55%
- 15%
- 5%
- 24%

Legend:
- Part B Capitation HMO
- Global Capitation HMO
- Fee-for-Service (FFS)
- FFS Population Management
- Bundled Payment
## Value Based Agreements

<table>
<thead>
<tr>
<th>Contract</th>
<th>Lives</th>
<th>Total Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross</td>
<td>340,000</td>
<td>$2.4 B</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>32,000</td>
<td>$0.3 B</td>
</tr>
<tr>
<td>Advocate Employee</td>
<td>21,000</td>
<td>$0.1 B</td>
</tr>
<tr>
<td>Medicare ACO</td>
<td>114,000</td>
<td>$1.3 B</td>
</tr>
<tr>
<td>Total</td>
<td>507,000</td>
<td>$4.1 B</td>
</tr>
</tbody>
</table>
What Results Have We Seen?

• Bent the cost curve in 2011 and 2012 while maintaining or improving performance on quality and service metrics outcomes and satisfaction

• 2% HMO membership growth; market dropped >10%

• PPO In-network use up 3.4% points

• APP physician membership growth
Clinical Program Results

- Outpatient care management
  - Early results for managed vs. control group showing reduction in ED and inpatient
- In-network care coordination (% days at Advocate hospitals) increased 6.9%
- SNF readmissions have decreased from 22% to 13%
- SNF LOS has decreased from 30 to 20 days
- Referrals to Advocate at Home from partnered SNFs increased from 35% to 70%
Key Measures Of Success

Purpose
• Aid transformation to population health management
• Create organizational alignment across sites
• Simplify and focus on five measures of success

Key Metrics
• ER visits/1000
• Admits/1000
• LOS
• Readmission rate
• Care Coordination (% of admissions within Advocate)
Lessons Learned

• Commercial PPO and Medicare lack benefit plan design to create alignment by patients with the ACO

• Timely and accurate data is critical

• Communication to the caregivers, focused messages and actionable items drive change

• Getting critical mass of “attributable” patients in a practice and across a system is integral for success
Lessons Learned (continued)

• MSSP can facilitate getting past the “tipping point” of critical mass
• A “locked cohort” of attributable commercial patients will be easier to manage and drive results
• Having same attribution logic across all payers in market will facilitate adoption
• This is an evolution that takes time
Biggest Challenges Moving Forward

- Redesigning primary care-advanced medical practice
- IT connectivity
- In network care coordination
- Discipline to create a standard approach
- Management/governance succession planning
- Patient experience
Strategic Considerations

• Pace of reimbursement shift
• Shared savings as a transitional model
• Leverage infrastructure investments in managing risk
• Balance the ideal clinical model with available financial resources
• Align incentives for high performing & strategic practices
  – Care coordination and value creation
Questions & Answers
For Additional Information

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