Advocate Health Partners Clinical Integration Program

A Core Strategy to Enhance Value for Patients, Providers, and Purchasers

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Presentation Overview

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

Clinical Integration: Definition

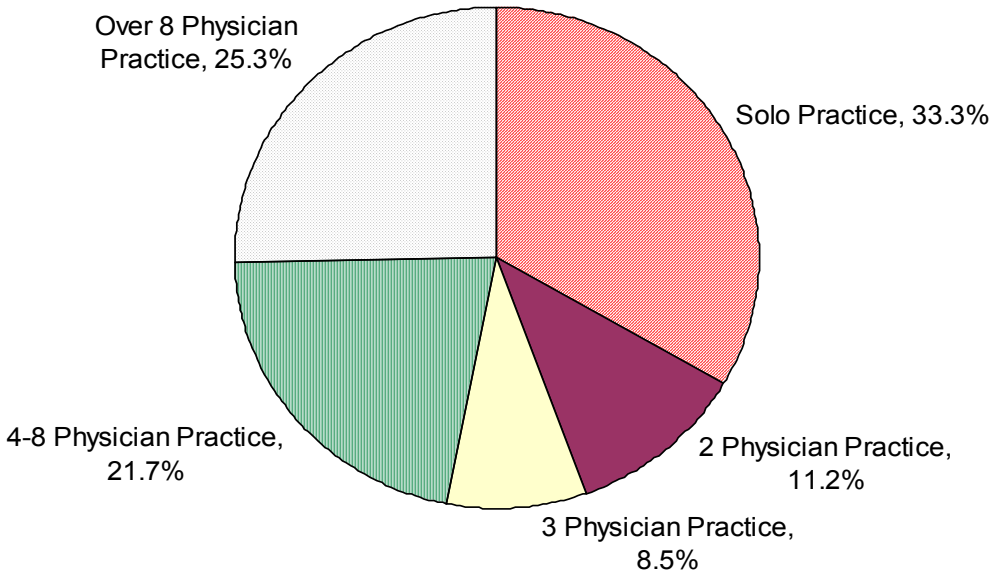
"A set of programs and infrastructure including joint contracting among physicians to improve the care and its efficiency for all the organization's patients and to demonstrate the organization's value to its patients, employers, insurance companies and government regulators."

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

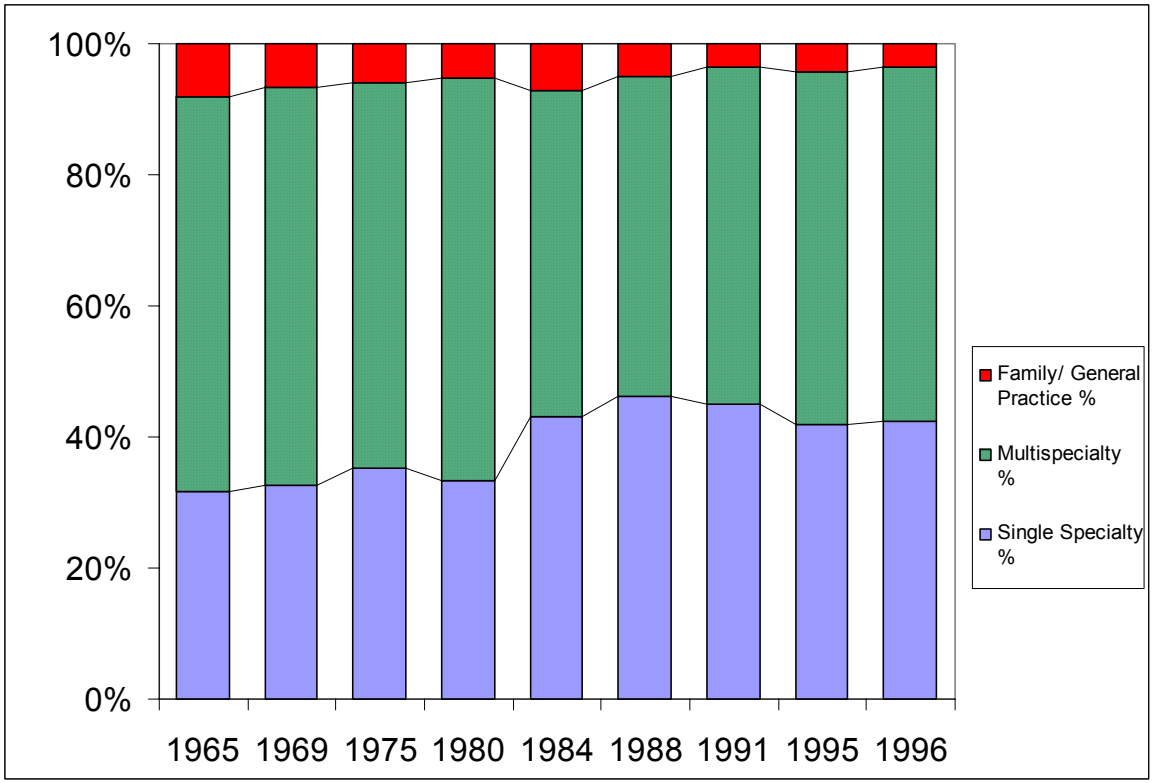
Distribution of Physicians by Size of Practice, 2001*

All Physicians in Noninstitutional Settings



*Percentages may not sum to 100 because of rounding.
Source: 2001 Patient Care Physician Survey of nonfederal patient care physicians, American Medical Assoc.

Distribution of Group Physician Positions, by Specialty Composition of the Group, 1965-1996



Source: Table 5-7, 1999 Edition, Medical Group Practices in the US, American Medical Association, Penny L. Havlicek

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

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
- Over 10 years experience with risk contracts
- Central verification office certified by NCQA

Advocate Health Partners at a Glance

- 356,000 Capitated Lives
  - Commercial: 310,000
  - Medicare: 30,000
  - Medicaid: 16,000
- 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

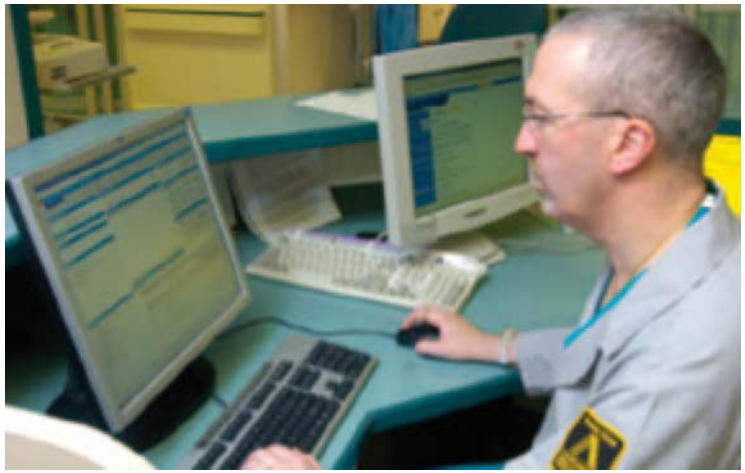
Case Study: Advocate Health Partners (AHP) Clinical Integration Program (CI)

- 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

Physician participation criteria in 2004:

- 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



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 CPOE**	CareConnection access IP and OP 50% use CPOE (PHO)
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**	75% LDL performed as indicated on flow sheet cardiac

Clinical Integration Program Overview

PCP	SCP	Clinical Integration Program	Outcome Criteria
X	X	**Diabetic Care Outcomes**	75% HgbA1c, 50% LDLs and 40% eye exams performed as indicated on diabetic flow sheet
X	X	**Asthma Outcomes**	75% completion of asthma action plans. < 6% readmission rate, < 7% 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

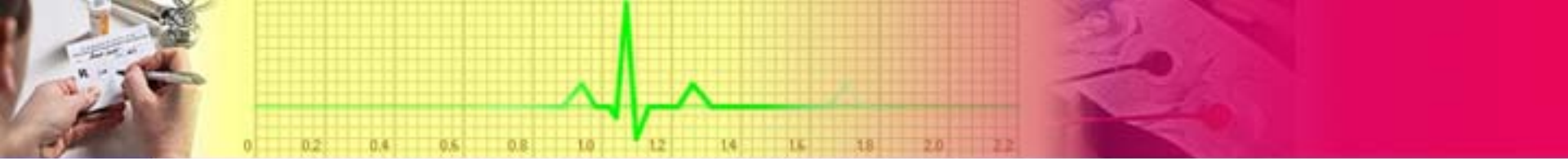
PCP	SCP	Clinical Integration Program	Outcome Criteria
X	X	**Physician Roundtables**	75% attendance at AHP/PHO educational meetings
X		**Inpatient Rounding**	Physicians meet rounding criteria 50% for PHO
X	X	**Depression Screening for Cardiovascular patients**	30% of patients have depression screening completed
	X	**OB Risk Initiative**	80% of medical record elements in place Completion of Advocate CME on fetal monitoring

Clinical Integration Program Overview

PHO Measures

(Includes below and all individual physician measures)

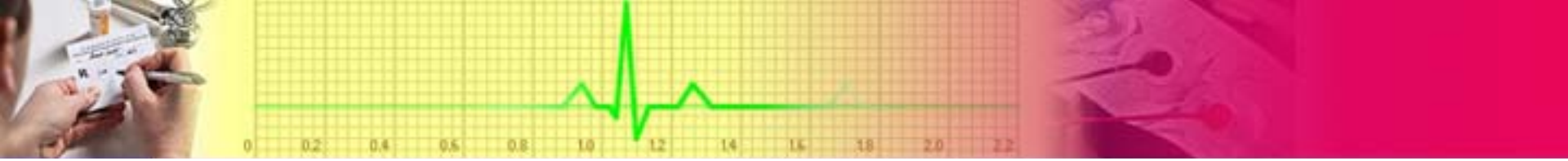
Clinical Integration Programs	Outcome Criteria
Formulary usage (inpatient)	Maintain baseline compliance rate to Advocate Hospitals Inpatient Formulary
Smoking cessation counseling	45% documented assessment and counseling of smoking cessation in office record, 5% hospital record
Hospital QI projects Heart Failure Deep Vein Thrombosis Acute Myocardial Infarction Community Acquired Pneumonia	Use of Advocate Hospital Congestive clinical practice guidelines for patients with CHF, MI's, Pneumonia and DVT's when clinically appropriate
Supply Chain Initiative	98% use of Advocate's preferred orthopedic primary implants



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

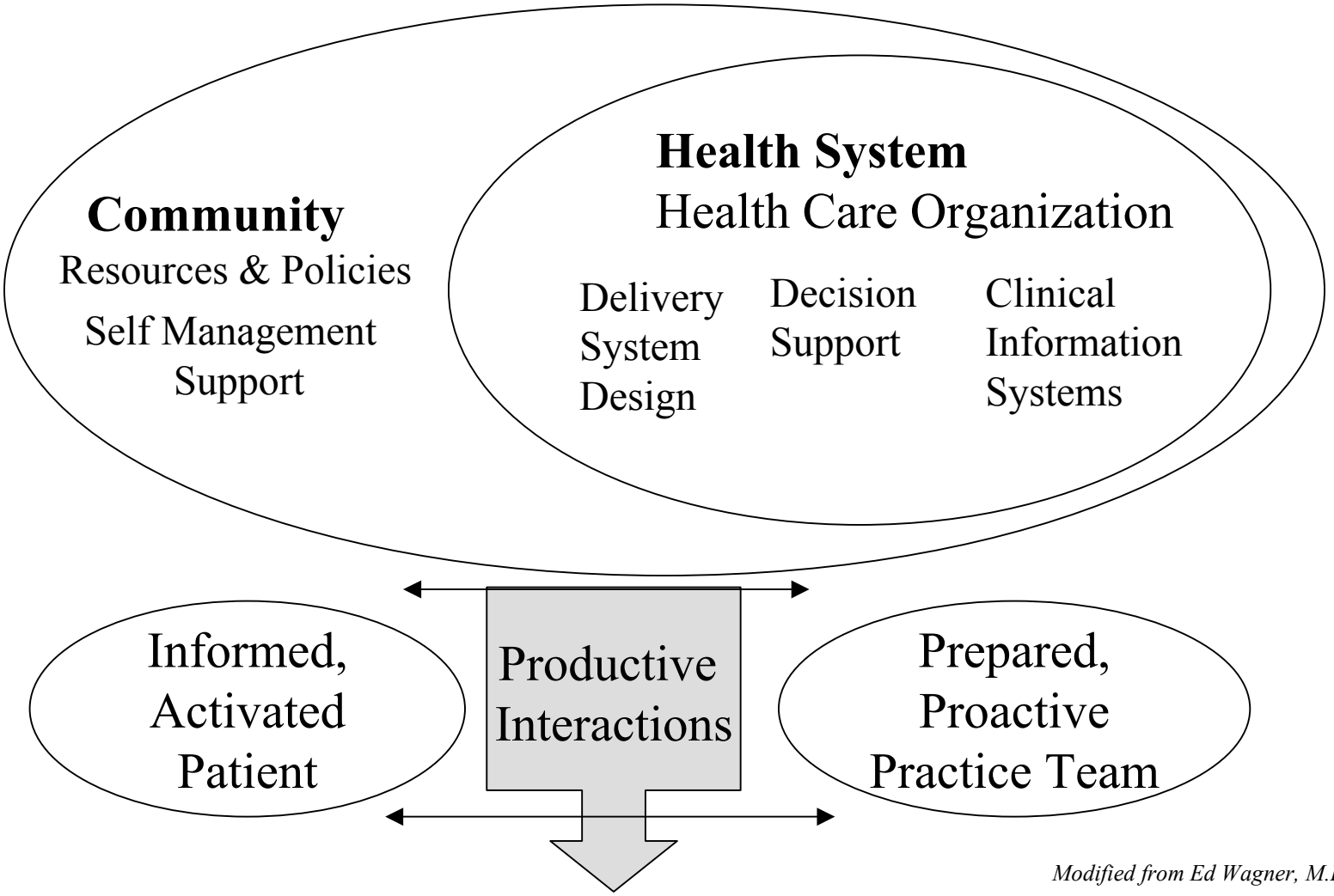


Clinical Integration Program Overview

Hospital Measures

Clinical Integration Program	Outcome Criteria
Hospital Quality Indicator	Clinical effectiveness Hospital Ratio. (Mortality, Readmission and Infection Rates)
Effective Use of Resources	Resource utilization including length of stay compared to M&R

Chronic Care Model



Modified from Ed Wagner, M.D. et al

Techniques of Improvement

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

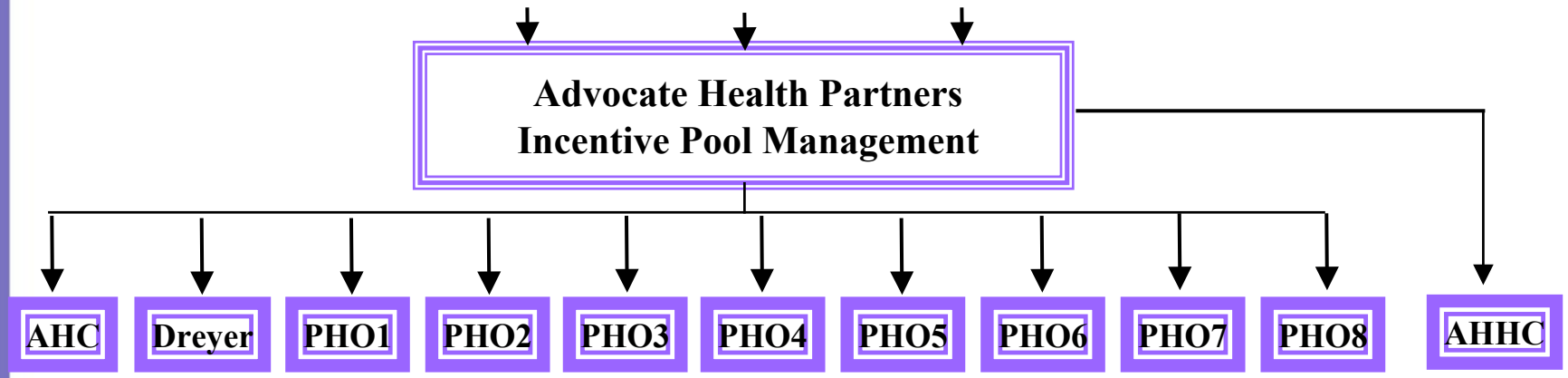
Incentive Design

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



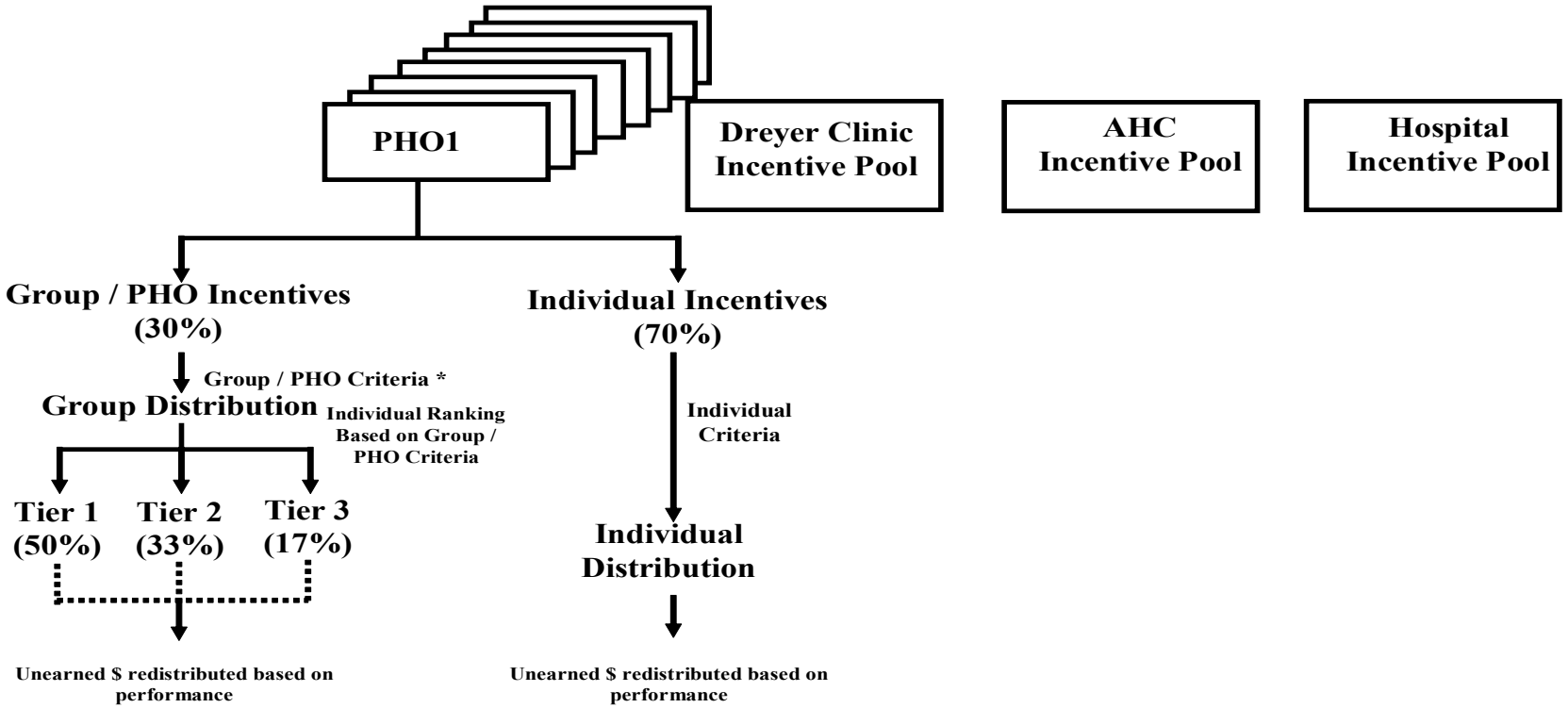
Basic Plan Elements

- ✓ 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)

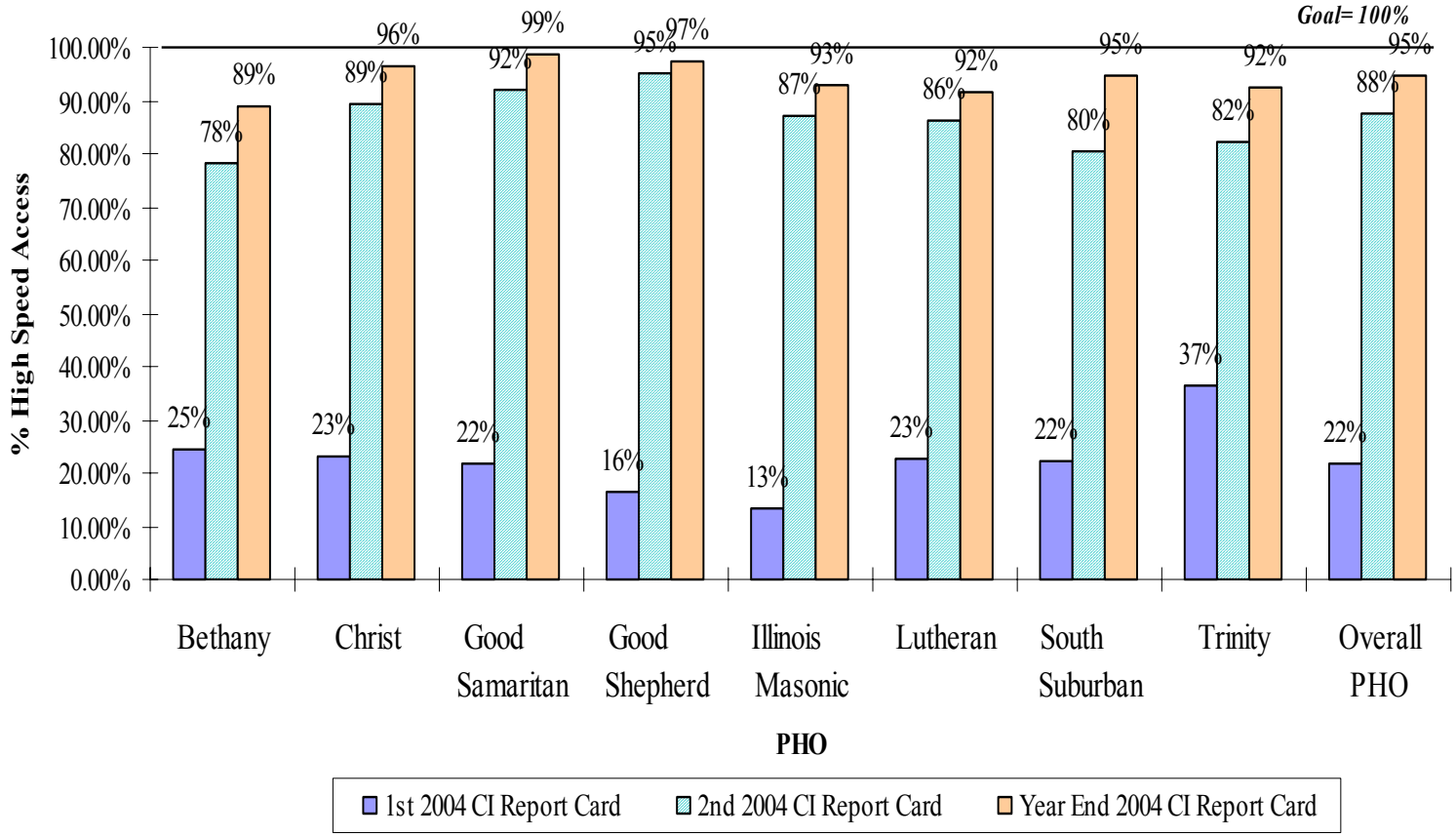
Incentive Fund Design

Source of Funds:
Future Rate Increases
Cost Savings
Capitation

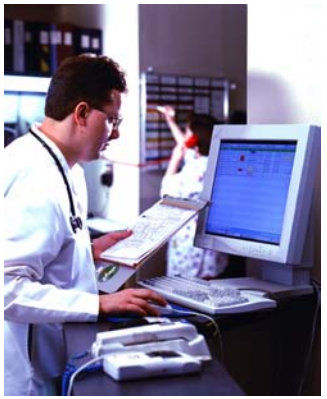
AHP Functions:
Accounting
Performance Measurement
Incentive Fund Distributions



High Speed Access Comparison



High Speed Internet



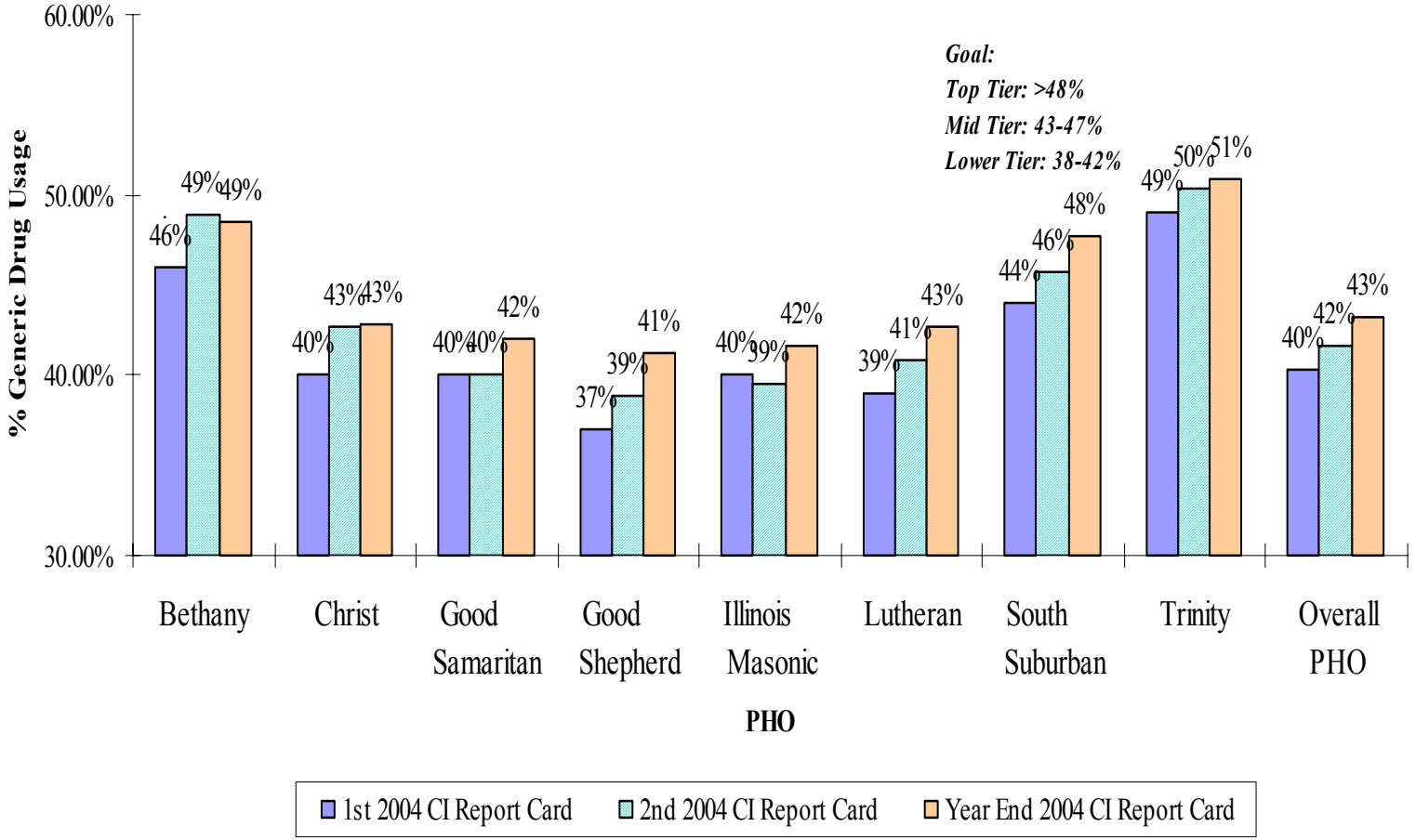
- 100% with high speed internet connection
- Implications for over 2,700 physicians
  - Electronic Referral Module
  - AHP Website
  - Carrier connections
  - Clinical protocols and patient education material available on-line

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

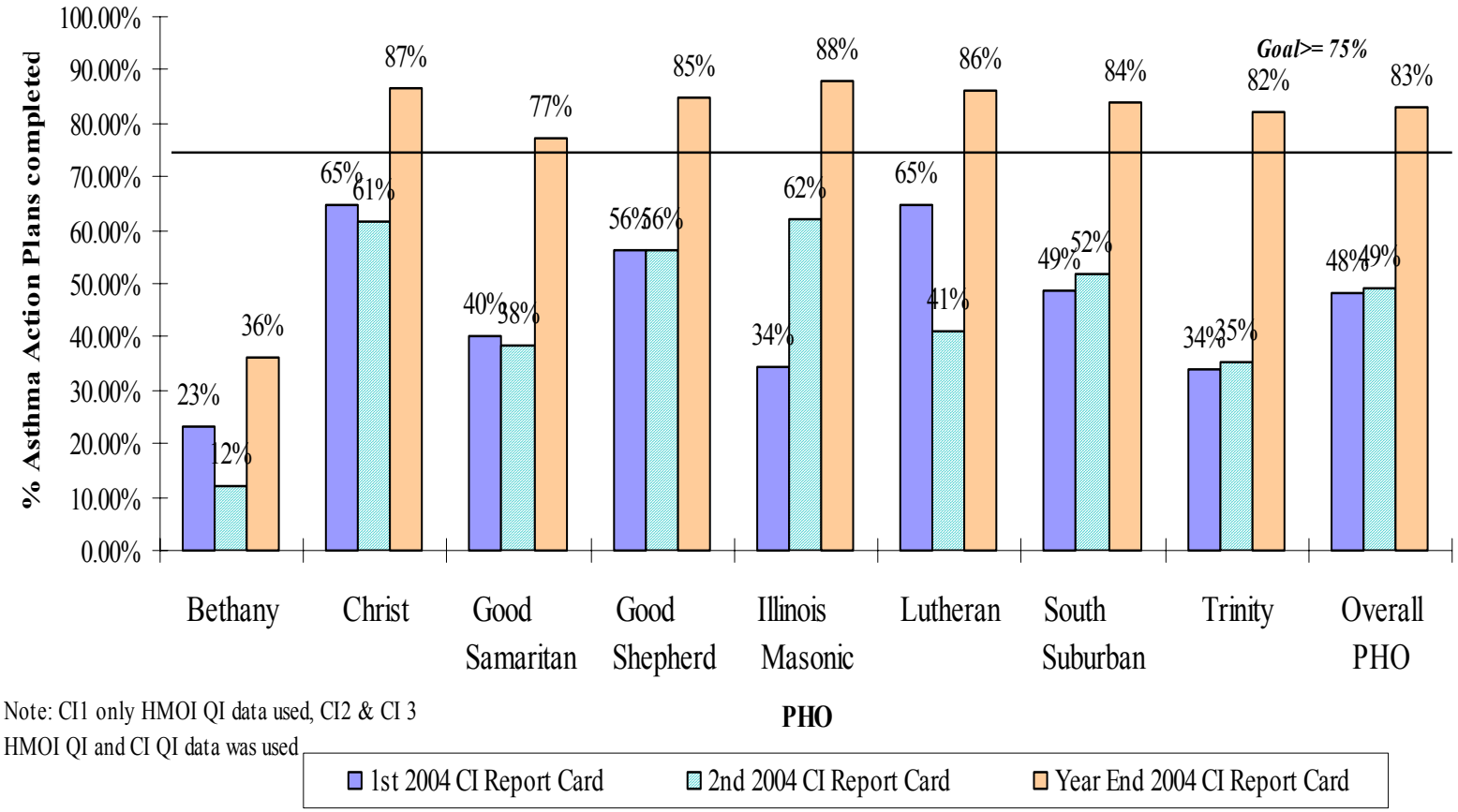
The increase in Generic Prescribing by AHP physicians in 2004 resulted in additional savings of at least $8.3 million to health plans, employers and patients.

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

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The Value Report

Benefits from Clinical Integration

Advocate Health Partners