UPA . 9000 Executive Park Drive . C 200 . Knoxville, TN 37923

ISSUE 1 | SPRING 2013

Publishers
Trey La Charité, MD
Jerry B. Willis, MBA

Contributors
Blaine L. Enderson, MD
Jill Martinez

Design & Editing
Donna Mowery

CI impact

YOUR INSIGHT TO LIGHT THE WAY.

IF IT'S HEALTHCARE WE'LL BE THERE.

A physician led system of care dedicated to improving patient outcomes through the real time coordination of an individual patient's care delivery amongst all of their providers regardless of service setting or life stage.

The Right Directives

UPA Clinical Integration Medical Director Named

Special Announcement
by Kim Friar,
UPA Executive Director

Today's healthcare presents numerous demands and finding the right physician to champion the necessary role of Clinical Integration Medical Director has been a priority for UPA.


Trey La Charité, MD

The UPA Board of Directors has recently named **Trey La Charité, MD** as the UPA Clinical Integration Medical Director. He has been a UPA Shareholder since 2007 and UPA is privileged to have Dr. La Charité in this capacity. He has begun setting forth the appropriate directives that will help UPA continue to advance in any direction in which healthcare leads.

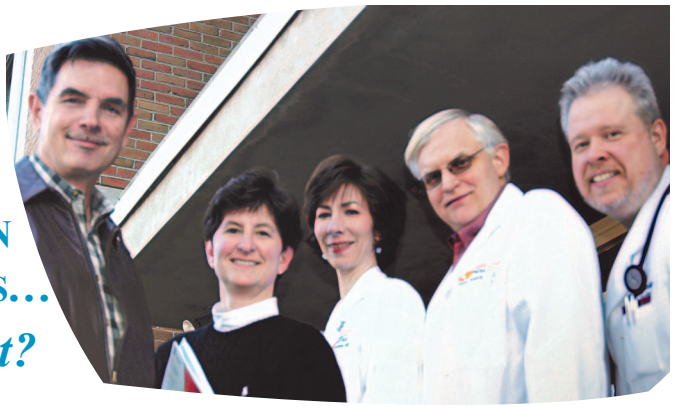
Clinical Integration Doesn't Affect Surgeons…

…Does it?

by Blaine L. Enderson, MD

You may think that Clinical Integration is simply the latest buzzword to try to impact payments for primary care physicians who manage patients with chronic diseases, but it is much more than that. It refers to integrating care for patients across their whole episode of care, including hospitalization, surgery, and outpatient care. Payments for all providers — physicians, hospital, rehab, and others will be bundled and will depend upon how efficiently and safely we can deliver that care and by how well we coordinate that care.

The initial payment initiatives are involving rewards and punishments for the quality of care you deliver. The Affordable Care Act directed CMS to establish a website (http://www.medicare.gov/find-a-doctor) to provide information on providers—including YOU!



Advocating UPA Board Members left to right: Daniel Cox, MD; Stephanie Cross, MD; Amy Barger-Stevens, MD; David Eakes, MD and Trey La Charité, MD

Currently, this site has basic practice information but will soon include whether you have satisfactorily participated in the Physician Quality Reporting System (PQRS) or electronic prescribing. The next step will be listing your quality and patient experience metrics.

So, Where do they get that data?
…From billing submissions.

To see how you look in that data and to begin to learn how to impact that information, review your data in Crimson. To help with the journey toward improved patient care, get involved with UPA's Clinical Integration initiative.

Don't think it can't happen to you—
…it *already* is!

CI Examined. *What is it?*

by Trey La Charité, MD, Medical Director of Clinical Integration

The basic problem with today's model of healthcare delivery is that it is episodic in nature. Unfortunately for our patients, each office appointment, emergency room visit, or hospitalization is treated as an isolated, independent patient care encounter. What if direct patient care delivery continued once they left your office, ER, or hospital? Should we not monitor our patients after they have given us their co-pay and gone home? Did they get that prescription filled that you wrote?

-continued page 2

—Continued
What is Clinical Integration?

PRODUCING THE BEST POSSIBLE OUTCOMES.

A coordinated team of healthcare providers.

Did they actually stop taking the other medications as you instructed? Are they carrying out the dressing changes as you had ordered? What did their cardiologist or oncologist recommend to them yesterday?

Clinically integrating our healthcare delivery system means that patients are actively and continually managed by a coordinated team of healthcare providers. While not an exhaustive list, this team would include primary care physicians, specialist physicians, pharmacists, nurses, inpatient and outpatient case managers, physical therapists, home health agencies, skilled nursing facilities and even hospices.

"Did they get that prescription filled that you wrote?
DID THEY ACTUALLY STOP TAKING THE OTHER MEDICINES AS YOU INSTRUCTED?"

To be effective, this new approach must also occur regardless of the patient's physical residence (for example, a hospital, their home, or a SNF) or their distance from our offices.

While this sounds daunting and will take a tremendous amount of resources and work to create, **it *is* obtainable**. Developing care delivery systems that continually and consistently provide for our patient needs is paramount if we are to produce the best possible outcomes. Currently, our healthcare providers are very good at their particular field of concentration. Traditionally, we tend to function in a systems vacuum focusing on only what we manage individually —ignoring the other pieces of the complete patient puzzle.

The ultimate goal of clinical integration, however, is to treat the individual patient as a whole by providing more actual health as opposed to just more healthcare.

MONEY IS LOST UNLESS METRICS ARE ACHIEVED WITH THE PAYER

by Mitzi L. Vaughn, Director of UPA Managed Care

Risk Based Contracting is a type of contracting that has risk and reward based language. The majority of Risk Contracts have both financial risks and metrics that must be closely monitored to insure success. It is very important to understand where UPA is positioned and that we continue to search for opportunities that close gaps in performance and help minimize our risk. By having a firm understanding of where UPA is positioned today, we can limit our risk of failure in the future.

Clinical Integration allows UPA to do just that.

Capturing UPA's performance today enables us to enter into agreements for a stronger financial tomorrow. CI helps UPA close those gaps in performance by exposing where they exist as well as insure that the data supplied to us by our carriers is both accurate and meaningful. We must leverage this information to gain the full financial benefits from these contracts and at the same time quantify and balance the incentives.

UPA's strategic plan must prioritize our clinical indicative and use advanced analytics to quantify our current and future agreements, including patterns of care, to *better* prepare and support performance improvement; thus capitalizing on the financial reimbursements for these improvements. Close monitoring and tracking is crucial to change our course of action so we can navigate toward better performance, leading to advanced rewards. As an organization, UPA must be flexible and open to change and examine where we don't perform to the best of our ability. Problems are not always bad, it is what you do with them that counts. If we look at these gaps in care as an opportunity to improve; then apply our energies TO improve, we can- and WILL be successful in the future.

UPA
Clinical Integration

PRIMARY CARE: Reward for Performance

The Division of Clinical Integration is pleased to announce that Dr. Cynthia Newton of University Internal Medicine was chosen as a winner of the Humana Close-the-Gaps Sweepstakes for the period of October through December 2012. On March 8th, as an acknowledgment of Dr. Newton's efforts, she was rewarded with a pre-paid VISA gift card worth $1,000.00.

Congratulations to Dr. Newton!

There were two criteria for a physician to be eligible for entry into the contest. The first was to close a recognized care delivery gap found within a physician's patient population. Humana, as all other carriers are now doing, constantly monitors provider performance. More specifically, for primary care physicians, Humana and others follow certain quality indicators such as the proportion of patients that have had appropriate colon cancer screening or the proportion of diabetic patients that have HbA1cs that are controlled. ***Impressively, Dr. Newton closed no less than 7 different gaps for her patient population during the eligibility period.***

The second criteria Dr. Newton met to enter the contest was to enroll a patient into Humana's My Diabetes Path program. This is a chronic disease management initiative designed to reduce the incidence of diabetic complications that frequently result from long-term, uncontrolled diabetes.

While this particular contest has officially ended, we have been informed that Humana will have similar contests in the near future. We expect other payers to provide incentive programs of a similar nature as well. When asked about her win, Dr. Newton was unaware that this contest was even occurring.

Obviously, this lends credence to the idea that *you never know who is watching you (or your performance).*

CI impact
IF IT'S HEALTHCARE WE'LL BE THERE.

Our response to health care reform

by Joe Landsman
President and CEO, The University of Tennessee Medical Center

March 2013

The Affordable Care Act (PPACA) is creating significant change in the healthcare industry. The way we are operating as care providers is shifting. The amount of money we are paid for providing that service is shrinking.

Although payment cuts from the Affordable Care Act are on a much larger scale than what we have seen in previous "healthcare reform" over the years, the method of achieving those cuts is the same—reducing the amount that is paid to the providers of care. But that said, we need to act to respond to these changes, because it is clear to me that the political process is not going to change the essence of PPACA.

Our response will be to ensure that we are a high service, high quality and high efficiency provider.

The most effective way we can implement our response is to remove the variation from our process of care. Standardized process is a tried and true means of improving efficiency and increasing quality and safety. And the time has come for us to do so in healthcare… and to do so at **The University of Tennessee Medical Center**. This is one of the critical steps in achieving our system wide objective of Clinical Integration.

"WE NEED TO ACT,

to respond to these changes, because it is clear to me that the political process is not going to change the essence of PPACA."

We have set a goal to develop and implement in 2013 care pathways around the first third of the 140 DRGs most commonly used at the medical center. We will implement the remaining of these DRGs in 2014. Also in 2013 we are developing a Chronic Disease Management process and implementing it around three of our most common chronic diseases.

We all saw the tremendous impact of implementing a standard process when we worked together to implement a house wide method to eliminate CLABSI.

What a great outcome for our patients and our medical staff and for our operational efficiency. I am confident that the medical staff and team members of the Medical Center will be successful in achieving this valuable and important goal of developing standard processes in the care we provide.

"I AM CONFIDENT,

that the medical staff and team members of the Medical Center will be successful in achieving this valuable and important goal of developing standard processes in the care we provide."

The Magnitude of Clinical Integration

by Jerry B. Willis, MBA
Director of Clinical Integration

Clinical integration is a term that providers are hearing more often, especially with passage of the Patient Protection and Affordable Care Act (PPACA). Often providers may understand the care aspect of why it is important, but what about the legal ramifications? Under Federal Trade Commission (FTC) Antitrust laws, separate groups of physicians that practice in the same or related specialty and are in the same geographic market are considered "competitors". Therefore, if individuals and different physician groups come together and engage in certain concerted activities, such as collective negotiation of fees with individual payers, such action would be considered illegal collaboration among competitors and could be held to be a per se violation of the antitrust laws. In 1996 the FTC and Department of Justice (DOJ) issued a statement that created the term "Clinical Integration". That statement reads **"Physician network joint ventures that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies. Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies."** While not defining clinical integration, it gives clear examples of how IPA's can jointly contract, but must improve care and reduce costs to do so. This is exactly why the UPA has embarked on this path and is working diligently to accomplish the above mandates.

LEGAL RAMIFICATIONS

Providers may understand the care aspect of why it is important, but what about the legal ramifications?

Have You Viewed Your Outpatient Practice Data?

by Jill Martinez
Clinical Integration Data Analyst

Currently, data for Clinical Integration comes from claims files or billing data. For most practices, UPA installed a service on your billing computers that sends the claims data directly to Crimson. This data is displayed in Crimson under the "Clinical Integration" tab of your profile. Under this tab, there is a "PQRS "section. This area reveals any PQRS measures that apply to your specialty. By clicking on the "more" button beside each measure, you have the ability to drill down into each metric and see the patients that meet each metric's qualifications. There is also the ability to follow the patient through the continuum of care to see things such as frequent fliers to the Emergency Room and Hospital stays.

Another section of the Clinical Integration tab is the "CI Overview". This section allows you to see your top CPT codes and ICD-9 codes for the time period selected. Please have your office manager review this data on a monthly basis to verify that it matches your records. This will assist in confirming your claims data is being captured correctly.

Providers are encouraged to look at their profiles on a monthly basis. Initially, since many quality metrics are tracked from coding, you may show lower numbers of compliance. This is due to quality tracking codes or CPTII codes not being submitted via electronic claims. The UPA Clinical Integration staff will gladly discuss your data with you and assist you in how to most accurately code your data.