Clinical Integration in Health Care: a Check Up

Federal Government Initiatives to Improve Health Care Delivery through Collaboration among Health Care Providers

The Veterans Health Administration Experience

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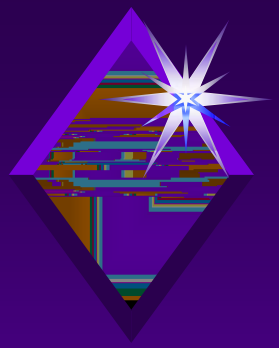
Executive VP & Chief Medical Officer
Catholic Health East

Under Secretary for Veterans Affairs, 1999-2002
Deputy Under Secretary for Veterans Affairs, 1995-1999



"All organizations are perfectly designed to get the results they get."

David Hanna

Designing Organizations for High Performance

1988

VA Structural Advantages

- ü IT focused on Care not Billing
- ü 108 Medical School Affiliations (10,000 Residency slots): Faculty, Fellows, Residents, Students
- ü Strong Clinical and Health Services Research
- ü Employed physicians
- ü Saved $$'s stay in VA

BUT these were true pre-1995, what ELSE changed

The Environment (1994)

- **President/Vice President**
  - **Healthcare agenda**
  - **Reinventing Government Initiative**

***USH* / Policy / Planning => VISION**

Public Accountability to Veterans & USA

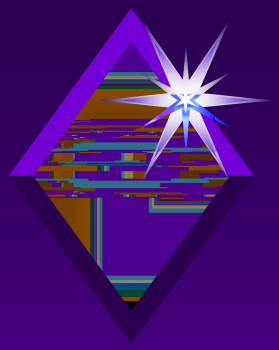
OMB Accountabilities (GPRA)
Congressional Accountabilities

VA Mission & Goals

VHA Mission => Strategic Goal Areas

Measure Alignment, Vetting, Priority Reconciliation
Creation of Director's Performance Contract

Performance Mgmt Work Group



1. ACCESS:

“ . . . Overall, VA patients receive better care than patients in other settings”

PROVING PATIENT CARE

roving Patient Care is a special section within *Annals* supported in part by the U.S. Department of Health and Human Serv

Quality of Care for Patients in the Veterans Health and Patients in a National Sample

Summary fo
Figures/Tables List
Appendix Table
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21 December 2004 | Volume 141 Issue 12 | Pages 938-945

Background: The Veterans Health Administration (VHA) has introduced an integrated electronic medical record, performance measurement; and other system changes directed at improving care. Recent comparisons with other delivery systems have been limited to a small set of indicators.

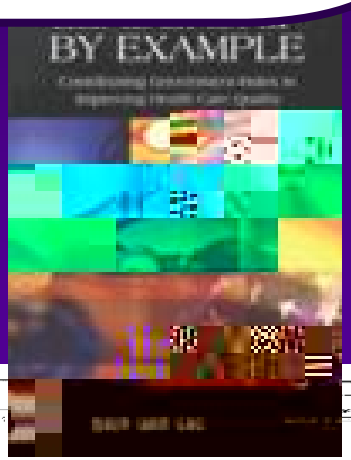
nparison.

systems and 12 communities.

and 992 patients identified through random-digit dialing. All were men older than 35 years of age.

997 and 2000, quality was measured by using a chart-based quality instrument consisting of 348 in
age, number of visits, and medical conditions.

HA scored significantly higher for adjusted overall quality (67% vs. 51%; difference, 16 percentage
s. 59%; difference, 13 percentage points [CI, 10 to 17 percentage points]), and preventive care (64%
nts]), but not for acute care. The VHA advantage was most prominent in processes targeted by VHA



The Veterans Health Administrati
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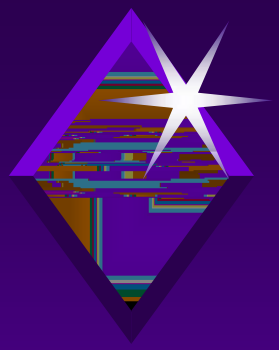


5. EFFICIENCY:

Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices

Nugent GN, Hendricks A, Nugent L, Render ML

This analysis compares VA medical care expenditures with estimates of total payments under a hypothetical Medicare fee-for-service payment system reimbursing providers for the same counts of each service VA medical centers provided in fiscal 1999. At six study sites, hypothetical payments were more than 20 percent greater than actual budgets. Nationally, this represented more than ***$3 billion in 1999 and more than $5 billion in 2003****. Data limitations suggest the estimate is conservative. Less than half of the difference is due to VA's low pharmacy costs. The study demonstrates the potential savings to patients and taxpayers of the VA health care system.*

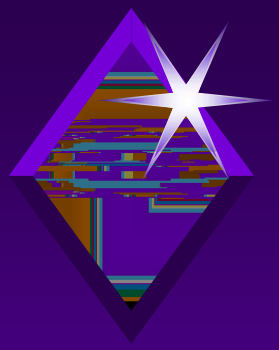
Medical Care Research and Review, Vol. 61, No. 4, 495-508 (2004)

VA's Electronic Health Record

- VistA in all VA's
- Images
- CPOE >95%
- Bedside Medication

Summary

- Right Environment
- Right Leadership & Support
- Right Structural Design
  - A system focused on a population
  - Performance measurement focused on quality
  - Aligned funding & incentives
  - Employed physicians
  - Automation of the care process
  - Patient - centered care model
  - Evidenced based guidelines
  - Quality Improvement as a System Property (IHI Collaboratives, QUERI)



Relevance to Non

Catholic Health East

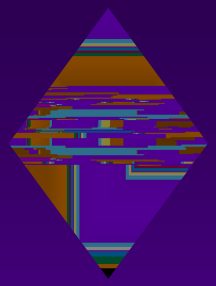
Catholic Health System, Buffalo

Catholic IPA (CIPA)

- ü Joint Venture: Catholic Health System and its Practice Community
- ü 750 Unique Physicians
- ü 60% Specialists/40% Primary Care
- ü Aim to Close Clinical Quality Gaps and Integrate Care
- ü Concerned about how to do it right from an antitrust perspective

Clinical Integration

- A 3 part test for clinical integration of a physician network based on advisory opinions of FTC for other models (Advocate Health, Health South and Greater Rochester IPA):
  - Is the networks' clinical integration program real?
  - Are the initiatives of the program designed to achieve likely improvements in health care quality and efficiency?
  - Is joint contacting with fee-for-service health plans "reasonably necessary" to achieve the efficiencies of the clinical integration program?



CIPA Initiatives

- Registry and Quality Improvement
  - Registries
  - Provider Reviews, Audits, Tracking of Care
- Care Coordination Program
  - Care Managers (primarily RNs) supported by contract $'s
  - Building an integrated team with physicians
- Patient Education & Self Management Support
  - Emmi program – completion reported to physicians
  - Health Buddy program
- Technology Support
  - Up to $300/physician/month for EMR from contract $'s

CIPA EMR Initiative

- Electronic Medical Record Initiative
  -

Alignment of Incentives

(Designed to Promote Efficiency & Quality)

- ü

Governance of the Integration Effort

Board of Directors Checklist
Components of the Clinical Integration Program

Infrastructure:	2007	2008
Medical Director	R Yes	R Yes
Information System	R Yes	R Yes
Credentialing Process:	* Yes	R Yes
Clinical Protocols	R Yes	R Yes
Quality and Cost Benchmarks:	R Yes	R Yes
Performance Monitoring	R Yes	R Yes
Corrective Action:		
Formal Plan	* Yes	R Yes
Monitoring	R Yes	R Yes
Disease/Case Management	* Yes	R Yes
Patient Education	* Yes	R Yes
Payor Involvement	R Yes	R Yes