



SOCIETY OF ACTUARIES

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Health Watch

Behind Clinical Integration

by Steve Tutewohl

Clinical integration is a term that is thrown around a lot these days. It is not a new concept, but health care reform and the Health Information Technology for Economic and Clinical Health (HITECH) Act have made clinical integration a household term. We all can conceptually understand what clinical integration means and why there is value in it, but yet the specifics are fuzzy for most of us.

What Does It Mean?

The Department of Justice and the Federal Trade Commission have stated that clinical integration can be evidenced by a network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.¹ They expanded on their definition and provided these four signs of clinical integration.²

- Use of common information technology to ensure exchange of all relevant patient data
- Development and adoption of clinical protocols
- Care review based on implementation of protocols
- Mechanisms to ensure adherence to protocols



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¹ "Statements of Antitrust Enforcement in Health Care," Department of Justice and Federal Trade Commission, August 1996

² "Improving Health Care: A Dose of Competition," Department of Justice and Federal Trade Commission, July 2004

The key to clinical integration is measuring clinical performance objectively.

Why Do It?

A logical question is why are the Department of Justice and Federal Trade Commission commenting on clinical integration. Intuitively clinical integration is about quality, but there are two main reasons for becoming clinically integrated.

- Improve quality, safety and efficiency of patient care
- Leverage clinical integration when negotiating with payors and in reimbursement strategies

The impacts on quality and efficiency have been well documented. They include, but are not limited to,

- Better chronic disease management
- Reduced adverse drug events
- Reduced medical errors
- Increased adherence to evidence based medicine and preventative care
- Reduced misuse of services
- Better coordination of care across providers

Because the FTC believed strongly in the possibility of improved quality, safety, and efficiency they created an incentive for practices to become clinically integrated. In 1982 in the case of Arizona v. Maricopa County Medical Society, the Supreme Court ruled that physicians in independent practices are supposed to compete. When they don't compete, by collectively setting the prices at which they sell their individual services, they can be guilty of illegal price fixing. The FTC has clarified that joint contracting and negotiation of fees

is permitted for organized provider groups (IPAs/PHOs) only under the following two circumstances.

- The providers have at least 15 percent of their fees at risk
- The providers are clinically integrated

For provider groups that don't meet the criteria, a messenger model must be utilized in fee schedule negotiation. In this model each individual physician must review and either accept or refuse the proposed fee schedule independently. For groups that do meet the criteria, the collective group can negotiate with the payor thus greatly increasing their leverage.

As a collective group, the providers can push for higher fee schedules and they can work with the payor to design pay-for-performance incentives that build off the data they are tracking with their clinical integration program. The later is an appealing option for all parties because it creates a direct monetary incentive to support the quality initiatives that the provider group has defined as important to them. The quality initiatives will theoretically provide better patient care at a lower cost thus aligning the incentives of the providers and the payors.

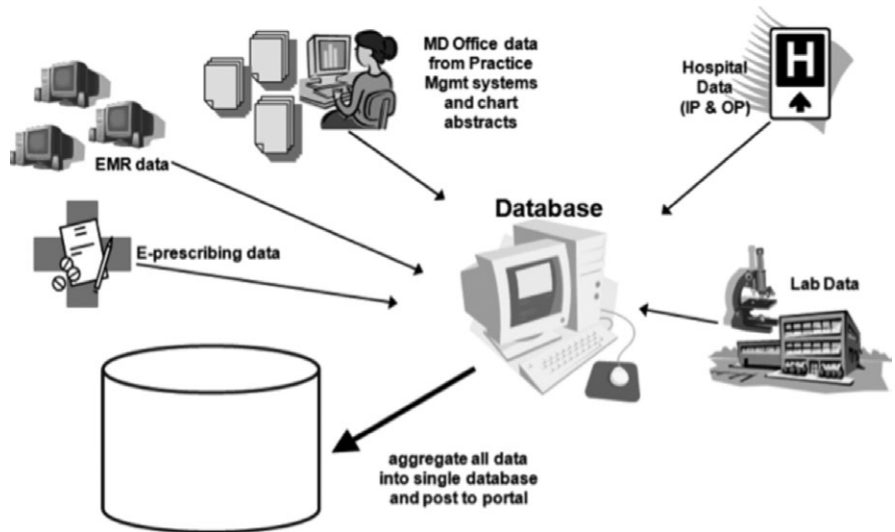
How to Create the Database?

The key to clinical integration is measuring clinical performance objectively. This cannot be done without various forms of data. Access to the required data can be difficult. Many believe that the only way to become clinically integrated is through a full Electronic Medical Record (EMR)

solution. There are actually multiple ways to create the database necessary to become clinically integrated and each has its pros and cons. They vary greatly in cost and complexity, time to implementation, impact on physician offices, and the scale of the data integration. The objectives and resources of the provider organization should determine the approach taken.

Approach	From Payors	As Payor	EMR	Health Information Exchange	Practice Management Systems	Paper Medical Record
Timing	6 months	6 months	Years	Years	6 months	6 months
Cost	Inexpensive - ~\$250K/yr	Inexpensive - ~250K/yr	Very Expensive - Millions	Very Expensive - Millions	Moderate - ~ \$80-\$120/physician/month	Cheap to moderate - ~\$300-400K/yr
Physician office Effort	Almost no effort	Almost no effort	Extensive set up time	Set up time	Almost no effort	Significant effort
Magnitude of Data	Limited to Payor's data	Limited to Payor's data	Most extensive	Extensive	Extensive	Sampling

The first two options are to work with the payors (either independently or as provider sponsored payor) to acquire the data. While these options are quick, inexpensive, and put little burden on the physicians, it is limited to data only from the payors that participate. The EMR solution is the Cadillac version that clinically integrates as well as provides a point of care tool that contains patient information and practice protocols at the hands of the physicians. However, the cost, implementation time, and burden on physicians are significant. A Health Information Exchange is an organized effort across providers and payers to collect data for an entire region. While this approach can be the most comprehensive, it is very difficult to coordinate and implement. Pulling data from the Practice Management Systems is challenging because a large provider organization will likely have many different Practice Management Systems and programs must be written for each to pull the data. The last option is to build the database manually with data samples. The lack of data robustness is a critical issue with this approach.



An End-to-End Example

A Midwestern PHO with approximately 500 physician members implemented a clinical integration solution. The database was created by combining data from 25 different physician practice management systems, their hospital data, and lab data (Quest and Labcorp). This approach exceeds the requirements of clinical integration, at a reasonable cost, puts no burden on the physician office, and has a short implementation. The backbone of the process is an application that is installed remotely on the physician practice computers which extracts and transmits encounter data on a scheduled basis. Furthermore it offers minimal disruption to practice workflow and requires no hardware investment.

As the database was being created the physicians worked together to determine what they would like to measure and what could be measured. Much has been written on various ways to measure quality. The more data sources that are collected, the more robust the measurements can become. The PHO selected about 40 different clinical guidelines to measure and an example of one follows.

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS	
REFERENCE	HEDIS 2007, American College of Cardiology/American Heart Association
PATIENT POPULATION	Adults age 18 and older
PROTOCOL	Patients who were discharged from the inpatient setting with the diagnoses of Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG) or Percutaneous Transluminal Coronary Angioplasty (PTCA) - or - who have a diagnosis of Ischemic Vascular Disease (IVD), should have the following test: - Full lipid profile
COMPLIANCE MEASUREMENT	Those patients with diagnoses listed above that were discharged from the hospital between January 1 and November 1 of the year prior to the measurement year and Those patients with a diagnosis of IVD (at least one outpatient/non acute inpatient or acute inpatient/ED visit with any diagnosis of IVD) between January 1 and November 1 of the year prior to the measurement year will have the following test completed during the measurement year: - Full Lipid Profile

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