Catholic Medical Partners
INDEPENDENT PRACTICE ASSOCIATION

ACO CASE STUDY

CATHOLIC MEDICAL PARTNERS: *BUFFALO, NEW YORK*

January 2011

American Hospital Association

McManis Consulting

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CATHOLIC MEDICAL PARTNERS: *BUFFALO, NY*

Prepared by:
Keith D. Moore / kmoore@mcmanisconsulting.com & Dean C. Coddington / dcoddington@mcmanisconsulting.com

Catholic Medical Partners is a not-for-profit independent practice association (IPA) serving western New York. The IPA's members include 900 physicians, the Catholic Health System (three hospitals and four locations in Erie County), and Mount St. Mary's Hospital in Niagara County. Exhibit 1 shows the locations of hospitals in the Buffalo area and the location of Catholic Medical Partners practices.

Catholic Medical Partners is the largest IPA in the Buffalo area. It has performance-based contracts, plus agreements to invest in infrastructure, with seven health plans.

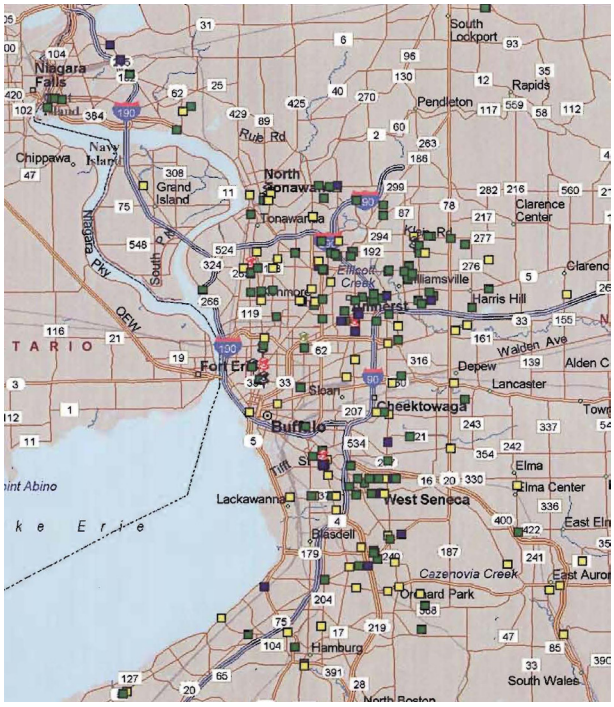
This is one of four case studies of organizations that are relatively far along in preparing for population health management and value-based reimbursement.

The case studies have been prepared by McManis Consulting, under the sponsorship of the American Hospital Association (AHA).[1]

Catholic Medical Partners was selected as a case study because: (1) it presents a model for cooperation and mutual investment between multiple private physician groups, hospital-affiliated physician groups, hospitals, and health plans; and (2) it has made major advances in developing the infrastructure required for a group of private practices to manage the health care of a defined population.

[1]Two white papers based on this case study, and the other case studies, are available at www.aha.org/ACOcasestudies.

1 LOCATION OF HOSPITALS AND CATHOLIC MEDICAL PARTNERS PRACTICE LOCATIONS IN THE BUFFALO AREA, FALL 2010



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SUCCESS FACTORS

Key factors in positioning Catholic Medical Partners for success in a performance and/or risk-based contracting environment include:

- Credible leadership and clear strategic vision.
- Financial support from health plans for care coordination infrastructure.
- A staged approach to building a "high performing health system."
- Successful deployment of electronic health records (EHR) and progress on the health information exchange (HIE).
- Integrated leadership teams across care settings.
- Effective strategies to engage physicians.

Each of these factors is discussed below.

Credible leadership and clear strategic vision.
In 2005, the IPA that would later become Catholic Medical Partners was experiencing serious financial difficulties. The recruitment of a new chief executive, a well-respected executive from a local health plan, brought credibility to the entity and marked a new start. Soon thereafter, a chief medical officer (CMO) with experience in managing a staff model HMO was added.

These two new leaders worked closely with the Catholic Medical Partners board, the Catholic Health leadership and the local health plan community in establishing a new direction: to move from an organization focused on contract negotiations to one capable of managing care to improve quality, patient service and cost effectiveness.

Catholic Medical Partners physician membership increased by 40 percent between 2006 and late 2010. Exhibit 2 shows the growth, since 2006, of primary care and specialty physicians. Leadership attributes this growth to Catholic Medical Partners' vision, and to the commitment of its hospital sponsors and participating health plans in providing the resources and time it has needed to develop. Most member physicians are part of one- to three-physician practices.

CATHOLIC MEDICAL PARTNERS

HISTORY AND EVOLUTION

The predecessor organizations to Catholic Medical Partners – five physician-hospital organizations (PHOs) – were founded in the mid 1990s during the peak in interest in tightly managed care and capitated payment. In 1999, the five PHOs merged and formed Catholic IPA (CIPA). This coincides with the formation of the Catholic Health System in Buffalo an organization that currently includes three acute-care hospitals, seven long-term care facilities, home health care, continuing care and palliative (hospice) care. Catholic Health is a founding member and has provided continuous support.

In 2005, Dennis Horrigan was recruited from a local health insurance company, IHA, where he had served for 10 years as vice president of health services, to head the reorganization of the IPA. Horrigan recruited Dr. Michael Edbauer in 2006, a physician leader with experience in heading a staff-model HMO, to serve as chief medical officer.

In 2008, CIPA was reorganized as a not-for-profit but taxable membership organization and in January, 2011, CIPA WNY IPA began doing business as Catholic Medical Partners.

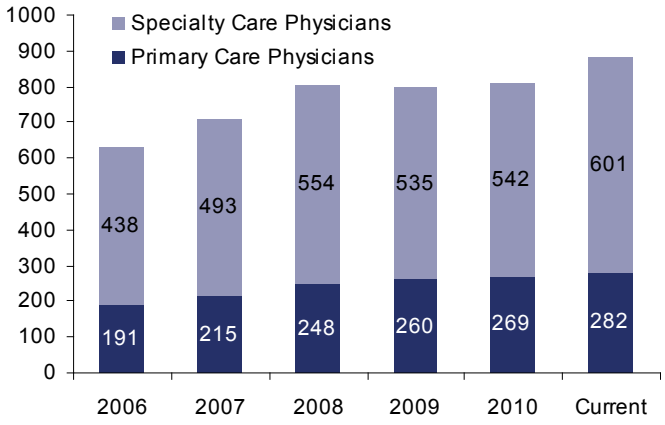
Catholic Health competes with the Great Lakes Health System, which includes, Kaleida Health (with three hospitals and a total of 1558 beds), and Erie County Medical Center (with 1200 beds).

Buffalo's health plan market is unique in that the three major health plans – HealthNow (owned by Blue Cross Blue Shield of New York), Independent Health Association (IHA), and Univera – are not-for-profit. Together these three plans had a total membership, both private and government, of 1.2 million individuals.

These and other health plans have entered performance-based contracts with Catholic Medical Partners; the health plans have also provided significant support for infrastructure development.

The Catholic Medical Partners model is based on developing partnerships with independent entities linked by information technology and clinical guidelines that cooperate to deliver health care services on a population basis.

2 NUMBER OF PRIMARY CARE AND SPECIALIST PHYSICIANS, CATHOLIC MEDICAL PARTNERS, 2006 TO FALL 2010

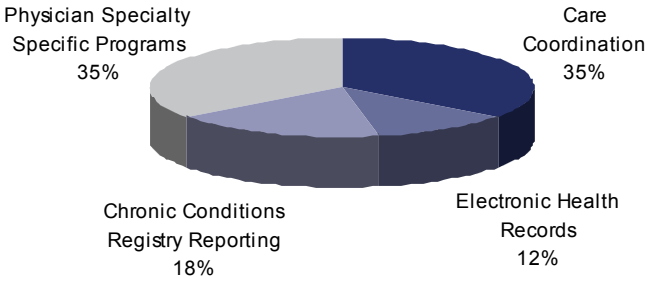


Financial support from health plans for care coordination infrastructure. The health plans that operate in Western New York have provided financial support for Catholic Medical Partners' clinical integration programs – including disease-specific registry reporting, accelerated electronic health record (EHR) adoption at the physician practice level, care coordination and disease management, specialty-specific quality improvement programs, and other clinically-integrated programs that are designed to engage physicians in population health initiatives. There is a recognition that, although substantial funds have been contributed by specific health plans, all Catholic Medical Partners' patients benefit. The health plans have also entered performance-based contracts with Catholic Medical Partners. Exhibit 3 shows the allocation of these funds for 2010.

Health plan leaders cite their regional ownership and their focus on Western New York in explaining their interest in working closely with physicians and health systems in the area, and with each other, on new care delivery models. At this point, most of these investments have been made based on health plan leaders' confidence that Catholic Medical Partners is on the right path. The data necessary to demonstrate success are just now becoming available. Plan leaders noted that continued investments in infrastructure will be contingent upon Catholic Medical Partners' success in moderating the cost curve and improving population health.

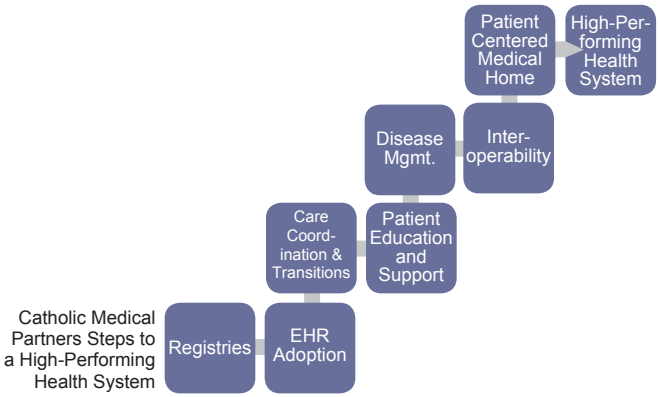
> *"[Catholic Medical Partners] has a clear vision of what it needs to do to be successful … We have a good sense of where our money is going. We have a seat at the table in deciding which initiatives to support and how our money is spent."*
>
> ***— Thomas Foels, MD, Medical Director, Independent Health Association***

3 CATHOLIC MEDICAL PARTNERS 2010 CLINICAL INTEGRATION DOLLAR ALLOCATION



A staged approach to building a high-performance health system. Catholic Medical Partners has taken a step-by-step approach to implementing the required infrastructure to improve quality, care coordination, and cost effectiveness to be successful in a new payment environment. (See Exhibit 4 on the following page.)

4 STEPS TO INTEGRATION AND HIGH PERFORMANCE



Catholic Medical Partners began its clinical integration program in 2005 with the introduction of chronic disease registries. The goal was to have registries in every primary care office and to stimulate physician-directed quality improvement.

The second phase of the clinical integration program was to accelerate the adoption and use of the EHR. As of 2010 Catholic Medical Partners had a 78 percent EHR adoption rate (595 out of a potential 795 physician users). In addition 30 practices (out of 235 potential practices) were reporting on preventive health measures via the EHR and six practices were reporting on their patients with diabetes, congestive heart failure and cardiovascular disease. The board has set a goal to triple these numbers in 2011.

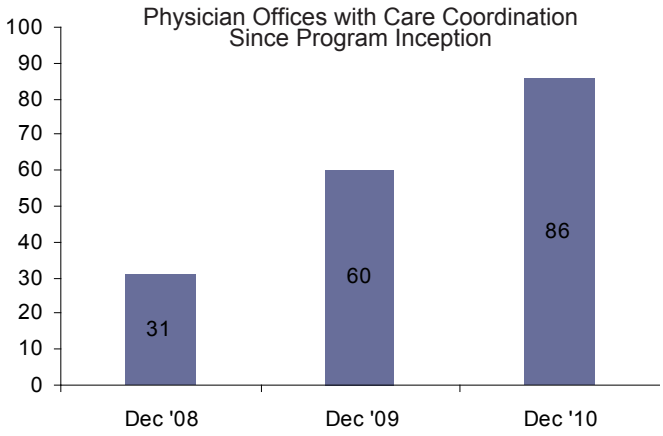
The third phase, the introduction of care coordinators in physician offices, is viewed as critical to Catholic Medical Partners' success. The care coordination program developed as a result of the chronic disease registry findings. There were clear gaps in care, and the offices needed trained staff to close the gaps and engage patients in their own care.

The care coordination program, started in 2008, is the largest of the clinical integration initiatives, funded at $3 million per year. Coordinators, usually registered nurses, are employees of the practices. The practices are reimbursed from clinical integration program funds. In addition to working with individual patients, the care coordinator is responsible for spreading the principles of care coordination and proactive patient care within the practice. This work is foundational to the patient-centered medical home.

Catholic Medical Partners leaders also report that communication among medical practices, and between the medical practices and Catholic Medical Partners, has improved significantly since the addition of care coordinators in the practices. Practices now have three points of contact – the physician leader, the practice manager and the care coordinator.

For planning purposes, Catholic Medical Partners assumes one full-time equivalent care coordinator is required for every 350 patients with a chronic disease (e.g., congestive heart failure, diabetes). Catholic Medical Partners' care coordination program currently supports 164 care coordinators located in 86 practices (these include 13 specialty and 73 primary care practices). Many of the care coordinators are part-time. Many physicians elect to begin with a part-time coordinator and then expand the role over time. Exhibit 5 shows the growth in care coordination at the medical office level since the inception of the program.

5 GROWTH OF THE CARE COORDINATION PROGRAM



From the beginning, care coordinators played key roles in re-designing work flow in the medical practices and in patient communications. Recently, the care coordinators have taken on a new role: assisting in managing care transitions from hospital to home for key patient populations in order to reduce hospital readmissions. This includes a home visit within 24 hours of discharge and a primary care physician (PCP)

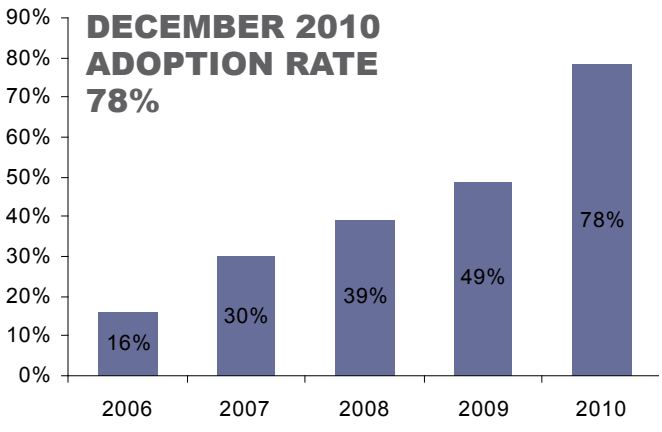
office visit within seven days. Pharmacy services are integrated into the treatment process to enhance medication reconciliation. Catholic Medical Partners employs a full-time pharmacist (supported by health plan funding), plus several associates, to support this function and to improve physician management of medications to manage chronic diseases.

Emphasized care coordination initiatives to date have addressed:

- Disease management for congestive heart failure, coronary artery disease, asthma, high-risk pregnancies, diabetes, COPD and pediatric obesity.
- Abdominal aortic aneurysm screening.
- Care transition support to reduce readmissions using nurse home visits and medication reconciliation.
- Palliative care referral program.
- Behavioral health coordination.

Medical homes are seen as a logical step in the care coordination and integration process. Nine Catholic Medical Partners primary care practices have received National Committee on Quality Assurance (NCQA) recognition as patient-centered medical homes (PCMH), and nine more are working toward receiving this designation.

6 EHR ADOPTION RATE



Successful deployment of EHRs and progress on the health information exchange (HIE). Catholic Medical Partners has achieved widespread adoption of EHRs but has elected not to establish a single EHR throughout the organization. Instead, practices select from several options and negotiate their own arrangements with EHR vendors. Catholic Medical Partners currently has EHRs from 20 different vendors within its member practices. The most common are Medent, Allscripts and eClinical Works. Catholic Health System hosts eClinical Works through an application service provider (ASP) model for 150 physicians. (Catholic Health System also implemented the Soarian inpatient EHR in 2005, at a cost of $5 million per year. The system also implemented the McKesson EHR for its certified home health organization.)

Catholic Medical Partners provides a stipend to its practices to defray the expense of purchasing, installing and beginning to use an EHR. Payments of $350 per month are made for a period of 36 months (for a total of $12,600) to practices that install a Certification Commission for Health Information Technology (CCHIT)-certified EHR. Exhibit 6 shows the growth in EHRs among Catholic Medical Partners members since the program's inception in October, 2006.

As practices come on-line with EHRs, Catholic Medical Partners staff assists in the transition. With EHR installation comes work flow redesign. The overall effect is to shift staff time from manual data entry tasks to care coordination. This eventually allows for improved quality reporting and interoperability.

Catholic Medical Partners is addressing the challenge of linking disparate EHRs through a regional HIE that involves numerous health care organizations in the greater Buffalo area, including both major health systems. In the planning stages since 2004, HEALTHeLINK (also known as the Western New York Health Clinical Information Exchange) was launched in January, 2006.

7 INTEROPERABILITY MODEL FOR WESTERN NEW YORK (THROUGH HEALTHELINK), OCTOBER 2010

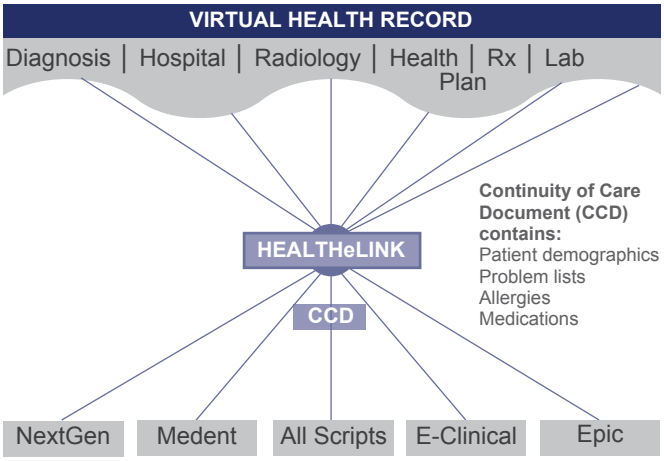


Exhibit 7 illustrates how data from multiple EHR platforms at the physician practice level are expected to come together for the exchange of clinical information and to provide data for analysis. Continuity of care documents (CCD) will be generated for each patient interaction; these will be moved throughout the system.

Integrated leadership teams across settings of care. To facilitate physician-hospital coordination, Catholic Health and Catholic Medical Partners have focused on integrating the leadership teams, strategies and care management approaches within the system and the physician network. Catholic Health has a 12-person leadership group, which has a standard four-hour meeting every week. The group includes four physicians, plus Catholic Medical Partners' chief executive. In addition, the medical directors of Catholic Health, each hospital and Catholic Medical Partners meet for several hours each week. Catholic Health System's CEO also meets frequently with Catholic Medical Partners' chief executive and medical director.

Catholic Medical Partners is the key element of Catholic Health physician alignment strategy. Catholic Health also employs 24 primary care physicians and 40 specialists in 11 locations. All physicians employed by Catholic Health are members of Catholic Medical Partners.

"In essence, Catholic Medical Partners is our physician strategy. It's traditional to think about a health system providing thought leadership; in this model, a major challenge is to align physicians with the direction of the system. Here, we have reversed the process. We want to align the system with the physician thought leaders. … You might think, 'How important is a $3 million per year business (Catholic Medical Partners) to an $800 million per year business (Catholic Health)?' The answer is 'very important.'"

— Joe McDonald, CEO, CHS

Effective strategies to attract and engage physicians. Catholic Medical Partners uses a number of strategies to attract physicians to the network and engage them in leadership and care management activities. Because most of the financial support for the network comes from the health plans, annual dues per physician are only $500 per year.

Physicians are more open to new care management practices because the bulk of the funding comes from Catholic Medical Partners rather than their practice revenue. Catholic Medical Partners also provides compensation for time devoted to training activities and board participation.

The board (see below) of Catholic Medical Partners is composed of roughly equal parts hospital, primary care and specialty physicians.

Management (Horrigan)	1
Catholic Health System	5
Mount St. Mary's Hospital	2
Primary Care Physicians	8
Specialist Physicians	7
Total	**23**

Recent board chairs have all been primary care physicians; this pattern is likely to continue for at least another three years.

CHALLENGES AHEAD

After four years of focused effort, the leadership of Catholic Medical Partners, its hospital and health system members/partners, and its health system sponsor/partners and physician practice members are convinced they are moving in the right direction. The infrastructure, leadership and key relationships are in place. Evidence of improvements in clinical quality is beginning to flow in.

Key challenges on the horizon relate to moving from the strategic and developmental stage to transitioning operationally to a new payment environment. Specific areas yet to be addressed include:

- Demonstrating value to payers and employers by care coordination, improving quality and moderating cost trends
- Aligning capacity with demand;
- Delineating the roles and responsibilities for care management between Catholic Medical Partners and participating health plans;
- Improving health literacy and developing a proactive approach that engages patients in improving their health; and
- Developing an acceptable model for sharing the financial gains associated with effective population health management.

"All this requires a new way of thinking. It is old school vs. new school, traditional reimbursement and payment reform vs. innovative population based payment – The speed of change and the transition strategy from the current to the future state will be extremely important. This is where we are focusing the majority of our efforts. Preserving the status quo is clearly not an option."

— Jim Dunlop, Executive VP, Finance, Catholic Health

Prepared for:

American Hospital Association
325 7th Street, NW
Washington, DC 20004
202-638-1100
www.aha.org

Prepared by:

Keith D. Moore
Dean C. Coddington

McManis Consulting
6021 South Syracuse Way, Suite 207
Greenwood Village, CO 80111
kmoore@mcmanisconsulting.com
720-529-2110