

Commitment to Quality Report for 2009

Mount Carmel Health Partners Report on Clinical Integration



MOUNT CARMEL
Health Partners, Inc.

Contents

Table of Contents

Letter from the Medical Director	4
Letter from the Executive Director	5
Mount Carmel Health Partners Organizational Information	6-7
Clinical Integration: Definition and Vision	8-9
2009 Clinical Integration Programs.....	10
2010 Clinical Integration Programs.....	11
NCQA Diabetes Physician Recognition Program	12-13
Diabetes Quality Improvement in an Employer-Sponsored Health Plan	14-15
NCQA Heart-Stroke Physician Recognition Program	16-17
Employer-Sponsored Health Plan: Quality and Cost Evaluation	18-19
Physician-Led Quality Improvement in the Hospital Setting	20-21
Diabetes and Cardiovascular Disease Control in an Elderly Population.....	22-24
Physician Credentialing and Board Certification	25
Emergency Room Utilization Reduction	26
Generic Prescribing	27
Patient Management and Outreach	28
Improvement in HEDIS Measures for a Medicare Advantage Health Plan	29

Medical Director

From the Medical Director

Dear Colleague,

The year 2010 will surely be one of great changes in healthcare, not only in Central Ohio, but in the entire country. This document displays the progress made by CareNet and Health Partners in the past and outlines the exciting future plans of the new Mount Carmel Health Partners organization.

On behalf of the Mount Carmel Health Partners board and staff, I would like to thank Health Partners member physicians and the staff of the Mount Carmel Health System for their delivery of high quality patient care, and for their efforts towards improving patient care during the past year. As one will see from the following pages, we have continued to make great progress.

Also during the last year, we moved one step closer to the goal of Clinical Integration when the two physician organizations of Mount Carmel, CareNet and Health Partners, joined with the Mount Carmel Health System to form a single organization, Mount Carmel Health Partners. Mount Carmel Health Partners is an organization that is sponsored by practicing physicians, both primary care and specialist, and Mount Carmel, with an organizational mission of assisting and supporting physician practices and the patients they serve, ultimately providing an integrated health delivery system.

What is Clinical Integration? Why is Clinical Integration important to practicing physicians? How does Clinical Integration improve patient care? How can Clinical Integration help a physician's practice succeed financially? These are all legitimate questions a physician, patient, employer or health plan might ask when presented with the words "Clinical Integration." Simply put, Clinical Integration is primary care physicians, physician specialists and hospitals working together, using proven protocols and measures, to improve patient care.

Many individuals who will read this publication may have a firm understanding of Clinical Integration while others may have never heard of the concept. This publication will explain Clinical Integration to a broad audience, demonstrate how Mount Carmel Health Partners physician members are improving patient care, and discuss the outcomes of these efforts.

The initiatives discussed in this, the Health Partners *2009 Commitment to Quality Report*, form the "bedrock" of our Clinical Integration effort. New quality initiatives will begin, past programs will be expanded, physician specialists will increase their involvement, and the organization will reach out to the community, to health plans and to employers for support.

I look forward to working with our diverse stakeholders to improve patient care in Central Ohio.

Sincerely,

Daniel Wendorff, M.D.
Medical Director
Mount Carmel Health Partners

Executive Director

From the Executive Director

It is a pleasure to inform you that as a result of your assistance and support, Mount Carmel Health Partners has undergone tremendous change and growth since the *2008 Commitment to Quality Report* was published. The 2008 report was our first edition referencing Clinical Integration and laid the groundwork for the achievements of the past twelve months.

I am pleased to announce that on July 1, 2009, CareNet and Health Partners became one Physician-Hospital Organization (PHO). The new organization is called Mount Carmel Health Partners and is a collaboration between primary care physicians, specialty physicians and Mount Carmel Health System. The organizational change which took place this spring is the most comprehensive transformation the two organizations have experienced since being founded in 1994. At a time when capitalization and managed care were new payor initiatives and physicians and hospitals were not certain how they could benefit in this new and challenging environment, it became increasingly more important for physicians and hospitals to work together to assure they could respond to new payor demands. It was the insight of Mount Carmel's hospitals and their medical staffs to form CareNet and Health Partners and to enable the networks to realize the importance of coming together to meet the challenges of 2010 and beyond.

The newly-formed PHO and its organizational structure enable us to be better prepared for the future healthcare environment, which is poised for another sea change: one that rewards physicians and hospitals who demonstrate high quality coordinated care and positive patient outcomes. Health Partners is structured to meet these challenges through its Clinical Integration vision and related work plans.

This *2009 Commitment to Quality Report* details the achievements and efforts of Health Partners and CareNet physicians during the past year. You will find that many of the performance improvement programs from 2008 have continued and at the same time we have launched a number of new clinical quality programs. This report is written for a broad audience and meant to educate the reader about the clinical quality achievements of the organization.

The year 2010 will be a growth period for our Clinical Integration program. We look forward to launching new physician-led quality programs and reporting their successes to you. The staff of Health Partners and Board of Directors look forward to working with you to improve patient care and position each practice to be prepared for future changes in healthcare. Many thanks for your assistance in making this happen.

Sincerely,

Michele Helbig
Executive Director
Mount Carmel Health Partners

Mount Carmel Health Partners

Organizational Information

Contact Information

Main telephone number(614) 546-3000
Fax number.....(614) 546-4261
Websitewww.mchp.com

Mount Carmel Health Partners

Health Partners is a Physician-Hospital Organization (PHO) composed of 1,400 individual physician members and the Mount Carmel Health System. Mount Carmel Health System serves more than a half-million patients each year and is the second-largest healthcare system in Central Ohio. The physician members of Health Partners have an even larger number of patient visits each year. Mount Carmel Health System comprises four respected hospitals as well as outpatient facilities, physicians' offices, surgery centers, urgent care centers and community outreach sites. Physician members of Health Partners represent all specialty disciplines and practice sizes, and the very best in clinical training and expertise.

All physicians joining Health Partners are credentialed to ensure they meet the organization's standards for physician quality. The organization follows The National Committee on Quality Assurance (NCQA) credentialing standards. All physician members are reviewed first by a Credentialing Committee of practicing physicians, then by the Health Partners Board of Directors.

Health Partners provides its physician members with access to numerous health plan and payer contracts. Health plan contracts, their terms and credentialing services are analyzed and implemented by Health Partners, thus reducing the administrative burden on physician practices.

Mount Carmel Health Partners and CareNet Merger

Health Partners and CareNet became one PHO on July 1, 2009. Previously, Health Partners was composed of specialty physicians and CareNet was composed of primary care physicians. Health Partners and CareNet are now one organization with equal specialty and primary care ownership and representation on the Board of Directors.

While the legal structure of the organization was changed in 2009, the Clinical Integration and quality programs led by CareNet and Health Partners have carried over to the new Health Partners. Health Partners will expand upon the initiatives CareNet introduced and directed. We would like to thank all CareNet physicians who participated in and led the organization's quality initiatives. We look forward to working with you on new programs under the Health Partners name.

Mount Carmel Health Partners Board of Directors

- Michael J Cooney, M.D.: *Cooney, M.D., Ricaurte, M.D. & Associates, Inc.*
- James J Barr, M.D.: *Dublin Family Care*
- Franklin Bressler, M.D.: *Bressler & Schaeffer, Inc.*
- George Ho, M.D.: *Scioto Valley Urology, Inc.*
- William Morris, M.D.: *Family Physicians of Columbus, Inc.*
- Jackie Primeau: *Mount Carmel Health System Chief Financial Officer*
- Cindy Sheets: *Mount Carmel Health System Senior Vice President of Ambulatory Services and Chief Information Officer*
- Alan Papa: *Mount Carmel Health System, Mount Carmel West Chief Operating Officer*
- Richard Streck, M.D.: *Mount Carmel Health System Chief Medical Officer*
- Tammy Weidner, R.N.: *Mount Carmel Health System, Vice President of Patient Care Services, Mount Carmel St. Ann's*

Clinical Integration

Definition and Vision

Clinical Integration is primary care physicians, physician specialists and hospitals working together, using proven protocols and measures, to improve patient care.

The Federal Trade Commission defines Clinical Integration as:

An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians in order to control costs and ensure quality.

Commitment to Quality Report

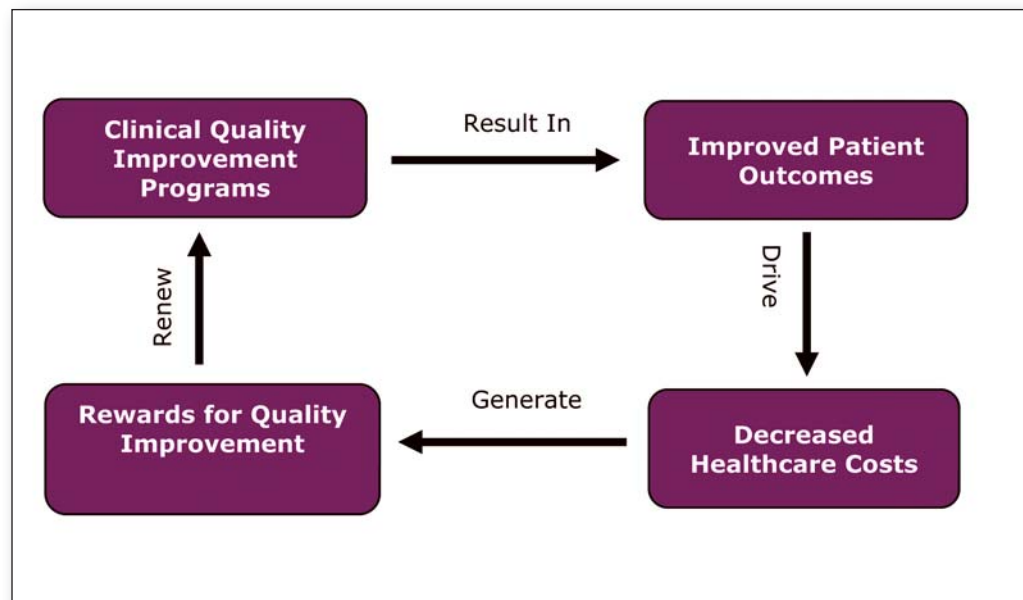
The goal of Mount Carmel Health Partners' second annual Commitment to Quality Report is to share the organization's Clinical Integration program and the program's impact on healthcare quality and cost. The report is written for a variety of audiences: Health Partners physician members, physician practice administrators, employers, health plans, hospitals, coalitions, pharmaceutical companies, and, of course, patients and the community.

Mount Carmel Health Partners' Mission

The mission of Mount Carmel Health Partners is for physicians and Mount Carmel Health System to venture collaboratively to provide high-quality, cost-effective, coordinated and innovative patient care in all healthcare settings and to be the premier healthcare provider network in Central Ohio.

Clinical Integration Vision

Clinical Integration is primary care physicians, physician specialists and hospitals working together, using proven protocols and measures, to improve patient care. Health Partners physicians, along with Mount Carmel Health System, will engage in physician-directed quality improvement with the focus on improving patient and clinical outcomes along with reducing the cost of health care. These efforts and their outcomes will be shared with health plans, employers and the community, allowing Health Partners physicians and hospitals to demonstrate and be rewarded for exceptional patient care.



Clinical Integration is:

- A physician led and driven quality improvement program.
- Primary care physicians, physician specialists and hospitals working together to demonstrate and improve clinical and quality outcomes.
- Collaboration among independent doctors and hospitals to increase quality and efficiency of patient care.
- Adoption of a comprehensive and reportable program of inpatient and ambulatory quality improvement that allows physicians to set organizational benchmarks for quality, which provides resources to physicians so they can excel in care delivery.
- Sharing of our physicians' and hospitals' quality track records with health plans, employers and patients, thus making Health Partners the preferred physician-hospital network in Central Ohio.
- Building of an infrastructure that supports quality and enables joint negotiations when beneficial to the parties.
- Physicians and hospitals receiving financial rewards for providing high quality care.

We should become *Clinically Integrated* in order to:

- Continually improve the quality of care our patients receive.
- Demonstrate and prove to health plans, employers, the government and patients that we deliver high-quality and cost-effective care.
- Reverse the tide of declining physician and hospital reimbursement through demonstrating value.

We become *Clinically Integrated* through:

- Physician leadership and involvement in Health Partners programs that demonstrate high quality and positive clinical outcomes in the physician practice and hospital settings.
- Physician leadership and involvement in health plan quality programs that demonstrate quality and improve care processes and clinical outcomes in a cost-effective manner. This demonstrates a willingness to work with our health plan partners to improve care.
- Physician leadership and participation in National Committee on Quality Assurance (NCQA) Physician Recognition Programs and other national and local physician and quality programs which demonstrate that Health Partner physician members provide care at or above national standards.
- Mount Carmel Health System and physicians forming partnerships in quality health plan programs which provide benefits to physicians, hospitals, and patients.

Clinical Integration is not:

- A loss of physician or practice autonomy
- A hospital or government mandate
- A means to “weed out bad physicians”
- A means to force physicians to purchase an Electronic Medical Record (EMR)
- “Cookbook medicine”
- Messenger model contracting

Clinical Integration Programs

Eleven unique and distinct quality programs were launched and maintained by Health Partners in 2009.

NCQA Diabetes Physician Recognition Program: The National Committee for Quality Assurance (NCQA) and The American Diabetes Association (ADA) developed the Diabetes Physician Recognition Program. Ninety-five physicians (22% of Health Partners' eligible physicians) are recognized through this program.

Diabetes Quality Improvement in an Employer-Sponsored Health Plan: This program's goal is to improve diabetic patient outcomes, decrease work absenteeism from diabetic-related illnesses, and decrease the costs of diabetic care by controlling the disease and reducing complications from diabetes.

NCQA Heart-Stroke Physician Recognition Program: The National Committee for Quality Assurance (NCQA) and the American Heart Association/American Stroke Association developed the Heart-Stroke Recognition Program. Thirty-nine physicians (9% of Health Partners' eligible physicians) are recognized through this program.

Diabetes and Cardiovascular Disease Control in an Elderly Population: Primary care physicians have been participating in a quality improvement program with a Medicare Advantage Plan since 2005. The objective of the diabetes and cardiovascular measures is to increase the number of elderly members who obtain appropriate diabetic screenings. A total of 41% of participating physicians met the measurement goals of the program.

Employer-Sponsored Health Plan Quality and Cost Evaluation: Provider groups received reports on key processes and utilization measures developed using the health plan's database. The reports showed these groups' performance compared to both Health Partners' primary care physician membership as a whole and to a national database.

Physician Credentialing and Board Certification: Health Partners' Credentialing Committee performs a complete review of physicians applying to join the organization and re-reviews all member physicians periodically. The committee obtains meaningful advice and expertise from participating physicians when making credentialing decisions.

Emergency Room Utilization Reduction in an Employer-Sponsored Health Plan: The initiative's goals are to encourage employees to have a primary care physician, improve continuity of care, and reduce lower-level complexity ER utilization.

Generic Prescribing: The goals of the initiative are to maximize medication compliance to improve health outcomes by ensuring patients are provided with affordable medications, and to reduce the health plan's costs for 13 selected brand name pharmaceuticals by 20% through appropriate use of generic alternatives.

Patient Management and Outreach: The program is designed to improve clinical outcomes, prevent or diminish the impact of chronic diseases, assist in care coordination and promote a healthier lifestyle for Health Partner physicians' patients.

Improvement in HEDIS Measures for a Medicare Advantage Health Plan: Mount Carmel Health Partners implemented a quality improvement program designed to improve selected publicly reported Healthcare Effectiveness Data and Information Set (HEDIS) measures for a Medicare Advantage Plan. In conjunction with other efforts, HEDIS rates for the plan increased from the previous year due to physicians increased involvement and commitment to the program.

Physician-Led Quality Improvement in the Hospital Setting: As members of Mount Carmel Health System's Medical Staff, Health Partners member physicians are actively involved in hospital outcomes measurement. Physicians provide the clinical leadership for patient care and clinical quality improvement in the hospital setting.

Clinical Integration Programs

KEY FOCUS AREA:***Specialist and Hospital-Based Quality Improvement***

Health Partners will engage and support specialty physician members and Mount Carmel Health System in developing quality improvement activities focused on clinical specialty areas and joint physician-hospital quality improvement programs.

KEY FOCUS AREA:***Primary Care Quality Improvement***

Health Partners will engage and support primary care physician members in providing comprehensive and high-quality patient care, improved outcomes for specific diseases, and enhanced patient coordination between primary care physicians, specialty physicians, and Mount Carmel Health System.

KEY FOCUS AREA:***Information Technology Adoption***

Health Partners will assist member physicians who are adopting or plan to adopt comprehensive information technology designed to coordinate care, facilitate improved patient outcomes and reduce inefficiencies and waste. Information technology will give physicians, physician groups, and Health Partners the ability to report the high level of quality patient care Health Partners physician members provide.

KEY FOCUS AREA:***Patient-Centered Medical Home***

Health Partners will engage and support primary care physicians in developing patient-centered medical homes in their practices. A medical home is a healthcare setting that facilitates partnerships between individual patients, their personal physicians, and, when appropriate, the patient's family. Care is facilitated through the use of registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner. (NCQA)

Diabetes Physician Recognition Program

Definitions

Diabetes: a group of diseases marked by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can lead to serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications.¹

NCQA: The National Committee for Quality Assurance (NCQA) is a private, 501(c)(3) not-for-profit organization dedicated to improving healthcare quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the healthcare system, helping to elevate the issue of healthcare quality to the top of the national agenda.²

Economic Impact

The estimated economic cost of diabetes in 2007 was \$174 billion. Of this amount, \$116 billion was due to direct medical costs and \$58 billion due to indirect costs such as lost workdays, restricted activity, and disability arising from diabetes.³

In order to provide physicians with tools to support the delivery and recognition of consistent, high-quality care, the National Committee for Quality Assurance (NCQA) and The American Diabetes Association (ADA) developed the Diabetes Physician Recognition Program. This is a voluntary program which helps physicians utilize evidence-based measures to provide excellent care to their patients with diabetes.

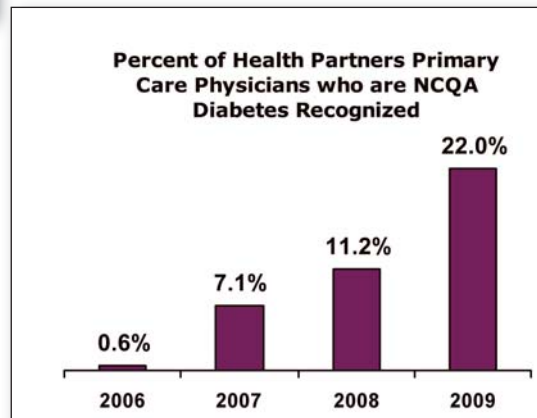
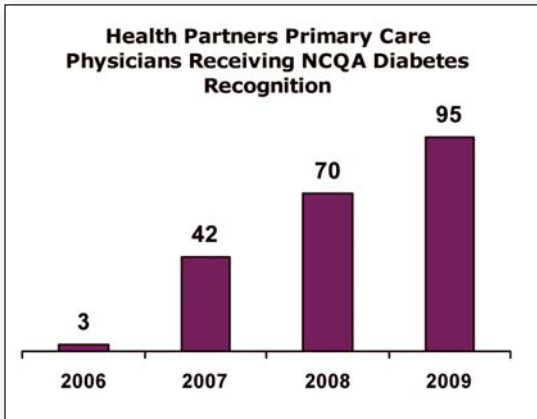
Physicians who participate in the program enhance their ability to deliver of high-quality diabetic care through the use of a physician and practice evaluation tool and individual physician benchmarking to national diabetic performance standards. Additional resources are provided to participating physicians which help them control diabetes in their patient populations.⁴

The program focuses on preventing diabetic complications by focusing on key diabetic clinical areas which include HbA1c control, blood pressure control, LDL control, eye examination, foot examination, nephropathy assessment and smoking cessation. When these clinical areas are managed properly in diabetic patients, clinical outcomes are improved dramatically.

Diabetes Recognition Measures ⁴	Threshold (% of patients in sample)	Measure Summary ³
Denotes poor control HbA1c Control $\geq 9.0\%^$	$\leq 15\%$	Every percentage point drop in measurement in a patient's HbA1c blood test results reduces the risk of microvascular complications by 40%.
HbA1c Control $\leq 7.0\%$	$\geq 40\%$	
Blood Pressure Control $\geq 140/90\text{mm Hg}^*$	$\leq 35\%$	Blood pressure control reduces the risk of cardiovascular disease among people with diabetes by 33% to 50%, and the risk of microvascular complications by approximately 33%.
Blood Pressure Control $< 130/80\text{mm Hg}$	$\geq 25\%$	
LDL Control $\geq 130\text{ mg/dl}^*$	$\leq 37\%$	Improved control of cholesterol or blood lipids (for example, HDL, LDL and triglycerides) can reduce cardiovascular complications by 30% to 50%.
LDL Control $< 100\text{ mg/dl}$	$\geq 36\%$	
Eye Examination	$\geq 60\%$	Detecting and treating diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50% to 60%.
Foot Examination	$\geq 80\%$	Foot care programs can reduce amputation rates by 45% to 85%.
Nephropathy Assessment	$\geq 80\%$	Detecting and treating early diabetic kidney disease by lowering blood pressure can reduce the decline in kidney function by 30% to 70%.
Smoking Status & Cessation Advice or Treatment	$\geq 80\%$	Diabetics who smoke are three times as likely to die of cardiovascular disease as are diabetics who do not smoke.

Program Results

Health Partners has 95 member physicians who have demonstrated high-quality diabetic care according to NCQA guidelines and are recognized by NCQA.



Program Impact

Bridges to Excellence is a not-for-profit organization developed by employers, physicians, healthcare service providers, researchers, and other industry experts with a mission to achieve significant leaps in the quality of care. It estimates that NCQA-recognized physicians who meet the standards of the NCQA diabetes program and who fully control diabetes in their patients:

- Save an estimated \$1,059 in health expenses per diabetic patient, per year, and
- When applied to a typical NCQA diabetes-recognized physician's patient population of over 100 diabetic patients, savings can be in excess of \$100,000 per year.

By improving the care diabetic patients receive, Health Partners physicians are contributing to reducing healthcare expenditures associated with diabetes and improving clinical outcomes for their patients with diabetes.⁶

Medical Impact

The medical complications of diabetes include: heart disease and stroke, high blood pressure, blindness, kidney disease, nervous system disease, amputations, dental disease, complications of pregnancy, sexual dysfunction, and illnesses such as pneumonia and influenza.⁵

Total prevalence of diabetes in the United States, all ages, in 2005 was 20.8 million people: 7.0% of the population has diabetes.¹

References

1. The Centers for Disease Control and Prevention. National Diabetes Fact Sheet, 2005.
2. The National Committee on Quality Assurance, www.ncqa.org
3. Diabetes Statistics and Research, CDC, www.cdc.gov.
4. The National Committee on Quality Assurance, *The Diabetes Physician Recognition Program*, www.ncqa.org
5. The American Diabetes Association, *Complications of Diabetes in the United States*, www.ada.org
6. Bridges to Excellence, *Diabetes Care Analysis – Savings Estimate*. www.bridgestoexcellence.org

Quality Improvement

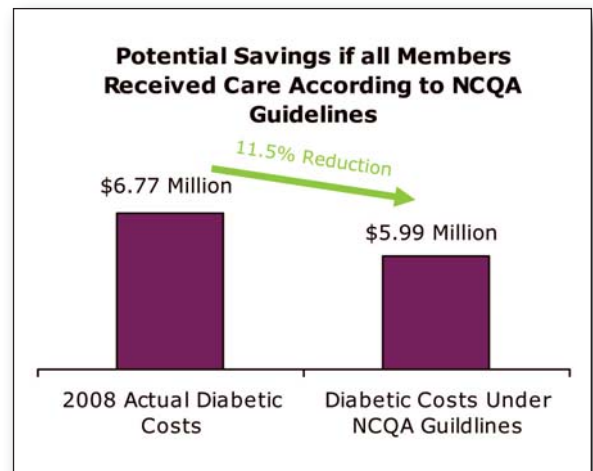
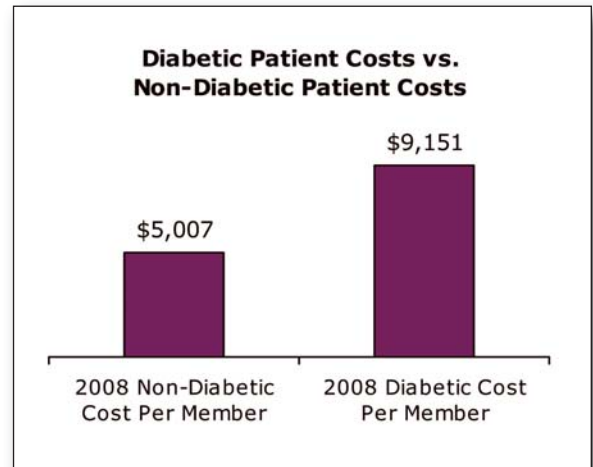
Diabetes Quality Improvement in an Employer-Sponsored Health Plan

Please see the NCQA Diabetes Physician Recognition Program section for definitions and for the medical and economic impacts of diabetes.

Building upon the success of the NCQA Diabetes Physician Recognition program, Health Partners is actively involved in a diabetic quality improvement program with an employer-sponsored health plan. The program's goal is to improve diabetic patient outcomes, decrease work absenteeism from diabetic-related illnesses, and decrease the costs of diabetic care by controlling the disease and reducing complications.

Of the 12,000 members in the partnering employer-sponsored health plan, there are over 740 diabetic members, or 6.2% of the membership. On average, the diabetic members have annual healthcare expenditures of \$9,151, compared to \$5,007 for a non-diabetic member. Over \$6.7 million was spent on healthcare services for diabetic members in the last year.

As stated earlier in this report, NCQA-recognized physicians who meet the standards of the NCQA diabetes program and who fully control diabetes in their patients save an estimated \$1,059 in healthcare expenses per diabetic patient per year. If all patients in the employer-sponsored health plan receive the recommended diabetic care based on the NCQA guidelines, the plan can expect to save over \$783,000 annually.



Results

The table on the following page outlines the program's goals and measures. The goals and measures have been established for the program, which will end on June 30, 2010. Re-measurement will take place at that time.

Several of NCQA's measures require a practice to monitor and evaluate diabetes care through population-based management of diabetic patients. Physician practices which have established and implemented Electronic Medical Records (EMR) or patient registries for diabetic patients have been able to monitor and impact their performance on these measures. For example, EMRs and registries provide a physician with the ability to identify which patients in their practice have not been seen for diabetic care in the last six months, did not have an HbA1c test in the last 12 months, did not have an LDL test in the last 12 months, and/or did not have annual screenings for nephropathy and retinopathy. Patient registries may be used as a tool to help drive systematic improvement in chronic disease management.

Diabetes Program	Measures	Measure Goal	Measure Importance
	Patient had a office visit for diabetes care in the last six months	90% of patients	Routine diabetic care is essential to avoid complications
	Patient had an HbA1c test in last 12 months	90% of patients	Every percentage point drop in measurement in a patient's HbA1c blood test results reduces the risk of microvascular complications by 40%.
	Patient had good diabetic control, HbA1c < 7.0%	40% of patients	
	Patient had poor diabetic control, HbA1c > 9.0%	≤15% of patients	
	Patient had an LDL screening in the last 12 months	90% of patients	Improved control of cholesterol or blood lipids (for example, HDL, LDL and triglycerides) can reduce cardiovascular complications by 30% to 50%.
	Patient's most recent LDL is < 100 mg/dl	36% of patients	
	Patient received an annual nephropathy screening	80% of patients	Detecting and treating early diabetic kidney disease by lowering blood pressure can reduce the decline in kidney function by 30% to 70%.
	Patient received a annual retinopathy screening	60% of patients	Detecting and treating diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50% to 60%.

Heart-Stroke Physician Recognition Program

Definitions

Cardiovascular disease: the conditions and illnesses that affect the cardiovascular system. Cardiovascular can be defined as those body systems that pertain to the heart and blood vessels. (“Cardio” means heart, “vascular” means blood vessels.) The circulatory system of the heart and blood vessels is the cardiovascular system.¹

Economic Impact

The economic cost of cardiovascular diseases and stroke in the United States for 2007 is estimated at \$431.8 billion. This figure includes health expenditures (direct costs, including the cost of physicians and other professionals, hospital and nursing home services, medications, home health care, and other medical durables) and lost productivity resulting from morbidity and mortality (indirect costs). By comparison, in 2004 the cost of all cancers was \$190 billion.²

Medical Impact

An estimated 79,400,000 (or, one in three) American adults have one or more types of cardiovascular disease, of whom 37,500,000 are estimated to be age 65 or older. Mortality data indicates that cardiovascular disease is the underlying cause of death in 36.3% of all deaths in the United States.³

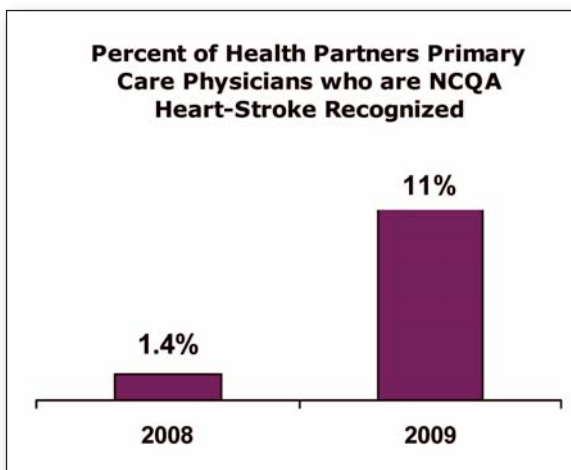
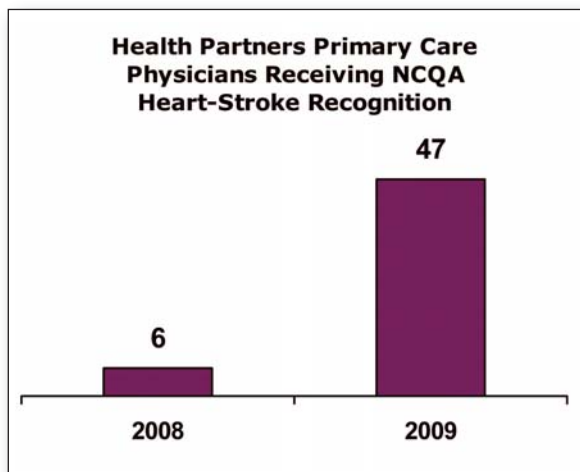
In order to provide physicians with tools to support the delivery and recognition of consistent, high-quality care, the National Committee for Quality Assurance (NCQA) and the American Heart Association/American Stroke Association developed the Heart-Stroke Recognition Program. This is a voluntary program to help physicians use evidence-based measures and provide excellent care to their patients with cardiovascular diseases.

Physicians who participate in the program enhance their delivery of high quality cardiovascular care through the use of a physician and practice evaluation tool and individual physician benchmarking to national cardiovascular performance standards. Additional resources are provided to participating physicians to help them monitor and control cardiovascular diseases in their patient populations⁴

Heart-Stroke Recognition Measures ⁴	Criteria	Measure Summary
Blood pressure control (<140/90 Hg) < 140/90 mm Hg < 145/90 or <140/95 mm Hg < 145/95 mm Hg ≥ 145/95 mm Hg	75% of patients in sample	About 69% of individuals who have a first heart attack, 77% who have a first stroke, and 74% who have congestive heart failure have high blood pressure (>140/90 mm Hg). ⁵
Complete lipid profile	80% of patients in sample	Low-density lipoprotein (LDL) is the major cholesterol carrier in the blood. LDL can slowly build up in the wall of the arteries
LDL Cholesterol control (<100 mg/dl) < 100 mg/dl 100-109 mg/dl 110-119 mg/dl 120-129 mg/dl ≥ 130 mg/dl	50% of patients in sample	feeding the heart and brain, resulting in atherosclerosis. A clot (thrombus) that forms near this plaque can block the blood flow to part of the heart causing a heart attack, or block the blood flow to the brain causing a stroke. Testing for LDL and controlling LDL can help prevent heart attack and stroke. ⁵
Use of aspirin or another antithrombotic	80% of patients in sample	Clinical trials have shown that aspirin helps prevent the recurrence of heart attacks, hospitalizations for recurrent angina, and second strokes. Studies show that aspirin also helps prevent these events from occurring in people at high risk. ⁵
Smoking Status & Cessation Advice or Treatment	80% of patients in sample	Cigarette smoking results in a two- to three-fold increased risk of dying of coronary artery disease. ⁵

Program Results

Health Partners has 47 member physicians who have demonstrated high-quality heart-stroke care according to NCQA standards and are currently recognized by NCQA. Over a two-year time period, Health Partners had a nearly six-fold increase in the number of primary care physicians recognized by NCQA for heart-stroke care.



Program Impact

Bridges to Excellence estimates that NCQA-recognized physicians who meet the standards of the NCQA heart-stroke program and control heart disease in their patients save an average of \$818 per patient per year in healthcare costs. These savings are compounded when factoring in that a typical heart attack or stroke has an average direct cost of \$11,755 per patient.⁶

References

1. The American Heart Association, *The Heart and How it Works*, www.americanheart.org
2. The American Heart Association, *Economic Cost of Cardiovascular Diseases*, www.americanheart.org
3. The American Heart Association, *Cardiovascular Diseases*, www.americanheart.org
4. The National Committee on Quality Assurance, *Heart-Stroke Recognition Program*, www.ncqa.org
5. *Circulation 2009*, American Heart Association, www.circ.ahajournals.org
6. Bridges to Excellence, *Cardiac Care Analysis — Savings Estimates*, www.bridgestoexcellence.org

Health Plan

Employer-Sponsored Health Plan Quality and Evaluation

Definitions

HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.¹

HbA1c: A test that measures the amount of glycated hemoglobin in blood. Glycated hemoglobin is a substance in red blood cells formed when blood sugar (glucose) attaches to hemoglobin.²

Lipoprotein: a chemical compound made of fat and protein.

LDL: low-density lipoproteins that have more fat than protein (HDLs are high-density lipoproteins that have more protein than fat).

Cardiovascular disease: the conditions and illnesses that affect the cardiovascular system.⁴

Mammography: Imaging examination of the breast by means of X-ray, ultrasound, and nuclear magnetic resonance; used for screening and diagnosis of breast disease.³

Colorectal Screening: Diagnostic screening for cancer of the colon or rectum. In the United States, colorectal cancer is the fourth most common cancer in men and women.²

Prostate Screening: Diagnostic screening for cancer of the prostate. In the United States, prostate cancer is the third most common cause of death from cancer in men of all ages.²

Cervical Screening: Diagnostic screening for cancer of the cervix.²

Health Partners is actively involved in quality improvement and cost reduction initiatives with an employer-sponsored health plan. A robust data repository containing claims information and other data is being used to measure and affect quality and cost trends for this health plan's population. The goals are to assist the health plan's members in successfully navigating the healthcare environment, to improve their health, and to assist in reducing the cost of care.

Health Partners has measured quality performance for selected medical conditions among 18 primary care provider groups that include a total of more than 250 physicians and represent 45% of Health Partners' total primary care membership.

These provider groups received reports on key processes and utilization measures that were developed using information obtained from the health plan's database. The reports showed the performance of these specific groups and compared them to other Health Partners physicians and to a national database. Measures were chosen because of their similarities to HEDIS¹ measures and their importance to other quality care standards.

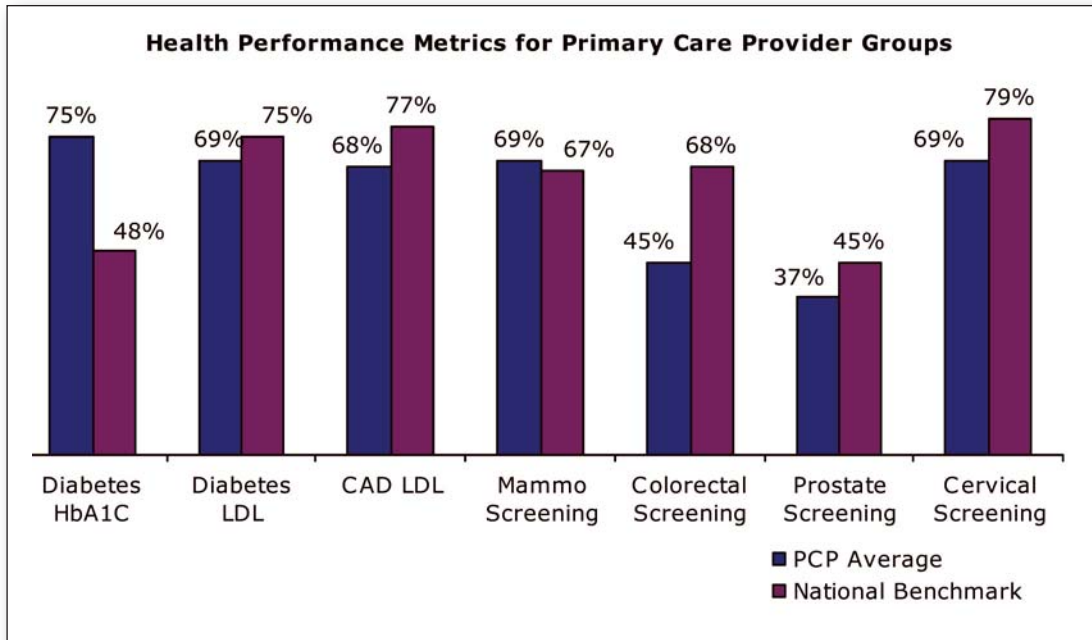
These reports were developed and shared with the primary care physician groups in order to provide their physicians with fair, open and objective data regarding quality and cost of care. Health plans throughout the nation are using similar data and programs to "grade" physicians based on cost and quality. Health Partners' program objective was to provide physicians with transparent data that provider groups can use to evaluate their performance compared to national and local benchmarks. This comparison gives the provider groups the ability to evaluate their practice's quality and cost performance and to make necessary performance improvement.

Other objectives included:

1. Each provider group was given the goal of improving their measured results to meet the 2008 Health Partners average, except in the areas of brand drug utilization, ER utilization, and inpatient utilization; the objective for these measures was to decrease their measured results in these areas.
2. Provider groups were asked to utilize the reports to provide their practice with data to help determine what clinical areas their practice would like to focus on for future improvement.
3. The reports provided local and national quality benchmarks for Health Partners' practices and will assist Health Partners in identifying what clinical areas will be the focus of quality improvement activities going forward.

Program Results

Primary care provider groups were given the following information regarding Health Partners performance on key clinical prevention areas:



Program Impact

The impact of measuring Health Partners primary care physicians and provider groups against national standards identified clinical areas in need of improvement. In many cases, individual physicians and practices are not aware of their performance in key clinical areas. These reports provide an evaluation tool for quality improvement.

Controlling HbA1C in individuals with diabetes and LDL levels in individuals with diabetes and cardiovascular disease will help to prevent the clinical complications and associated cost of these diseases.

Cancers that can be diagnosed early through screening include cancers of the breast, colon, rectum, cervix, prostate, oral cavity and skin. For cancers of the breast, colon, rectum and cervix, early detection has been proven to reduce mortality.⁷ Achieving high levels of cancer screenings is important because it has a direct impact on mortality.

Economic Impact

Diabetes and Cardiovascular Disease: Please see previous sections.

Cancer: The estimated overall cost of cancer in 2008 was \$228.1 billion.⁷

Medical Impact

Diabetes and Cardiovascular Disease: Please see previous sections.

Cancer Screenings: Regular screening examinations by a healthcare professional can result in the detection and removal of precancerous growths, as well as the diagnosis of cancers at an early state, when they are most treatable.⁷

References

1. The National Committee on Quality Assurance, www.ncqa.org
2. National Institutes for Health, Medline Plus, www.nlm.nih.gov
3. Stedman's Concise, Medical Dictionary for the Health Professions, 3rd Edition.
4. The American Heart Association, *The Heart and How it Works*, www.americanheart.org
5. Diabetes Statistics and Research, CDC, www.cdc.gov.
6. The American Heart Association, *Economic Cost of Cardiovascular Diseases*, www.americanheart.org
7. *Cancer Facts and Figures 2009*, American Cancer Society, www.cancer.org

Quality Improvement

Physician-Led Quality Improvement in the Hospital Setting

Definitions

St. Ann's: Mount Carmel St. Ann's hospital located in Westerville, Ohio

New Albany: Mount Carmel New Albany Surgical Hospital located in New Albany, Ohio

East and West: Mount Carmel East and West hospitals located in Columbus, Ohio. The two hospitals' data is reported together because of their hospital classification

Ohio: Average for all reporting hospitals in Ohio

US: Average for all reporting hospitals in The United States

Medical Impact

Medical research has demonstrated that patients who receive the appropriate care, as indicated by each individual measure, have better clinical outcomes.

Economic Impact

Appropriate clinical care has been proven to reduce re-admissions to hospitals, reduce a patient's length of stay and prevent additional clinical intervention. These factors are extremely costly to the US healthcare system.

References

CMS Hospital Compare:
www.hospitalcompare.hhs.gov

1. The number of cases is too small (<25) to reliably tell how well a hospital is performing.
2. This hospital treated patients in this condition but no patients met the criteria for inclusion in the measure calculation.

Physicians provide the clinical leadership for patient care and clinical quality improvement in the hospital setting. This leadership is becoming increasingly important as the Centers for Medicare and Medicaid Services (CMS) and Joint Commission enhance their outcomes measurements of hospitals and their medical staffs and publicly report this data.

Health Partners member physicians are actively involved in hospital outcomes measurement as members of Mount Carmel Health System's Medical Staff and as "partners" in the Health Partners organization. CMS and Joint Commission collectively monitor 58 measures for inpatient care provided at Mount Carmel Health System. These measures represent diverse patient care processes provided in the inpatient setting.

Program Results

The following tables provide information on Mount Carmel Health System's performance for selected CMS publicly-reported clinical measures. These measures are being reported by Health Partners because they demonstrate physician-provided or physician-directed care processes taking place in the Mount Carmel hospital setting. These measurements are important to the Health Partners organization because they demonstrate patient care quality measures that are directed by specialty physicians. Mount Carmel Health System is a partner in the Clinical Integration program, and the clinical outcomes of Mount Carmel are important to the physician members of Health Partners.

Program Impact

Mount Carmel and its medical staff invest extensive resources to follow CMS clinical measures. For the majority of these measures, Mount Carmel meets and exceeds Ohio and national benchmarks. Health Partners physicians, hospital clinical departments, Outcomes Management and Service Line Management have active programs in place to improve those measures where Mount Carmel is not at the national benchmark.

Physician-Directed Care Measure	St. Ann's	New Albany	East & West	Ohio	US
Percent of surgery patients who were given an antibiotic at the right time to help prevent infection	93%	99%	94%	91%	89%
Percent of surgery patients who were given the right kind of antibiotic to help prevent infection	99%	99%	99%	95%	94%
Percent of surgery patients whose preventive antibiotics were stopped at the right time	94%	96%	91%	89%	87%
Percent of all heart surgery patients whose blood sugar (blood glucose) was kept under good control in the days right after surgery	NA ²	NA ²	89%	86%	85%
Percent of surgery patients needing hair removed from the surgical area before surgery, who had hair removed using a safer method	100%	100%	100%	98%	96%
Percent of surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries	91%	85%	92%	91%	87%
Percent of patients who received treatment at the right time to help prevent blood clots after certain types of surgery	89%	85%	87%	88%	84%
Percent of heart attack patients given aspirin upon arrival	100%	NA	99%	97%	94%
Percent of heart attack patients given aspirin at discharge	NA ¹	NA	100%	93%	93%
Percent of heart attack patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD)	NA ¹	NA	99%	92%	90%
Percent of heart attack patients given smoking cessation advice/counseling	NA ¹	NA	100%	94%	95%
Percent of heart attack patients given beta blocker at discharge	100%	NA	100%	95%	93%
Percent of heart attack patients given PCI within 90 minutes of arrival	NA ²	NA	89%	76%	77%
Percent of pneumonia patients given oxygenation assessment	100%	NA	100%	100%	99%
Percent of pneumonia patients assessed and given pneumoccal vaccination	83%	NA	84%	89%	84%
Percent of pneumonia patients whose initial emergency room blood culture was performed prior to administration of the first hospital dose of antibiotics	94%	NA	94%	93%	91%
Percent of pneumonia patients given smoking cessation advice/counseling	100%	NA	100%	94%	89%
Percent of pneumonia patients given initial antibiotic(s) within 6 hours post arrival	98%	NA	97%	94%	93%
Percent of pneumonia patients given the most appropriate initial antibiotic(s)	96%	NA	96%	90%	87%
Percent of pneumonia patients assessed and given influenza vaccination	91%	NA	76%	86%	82%
Percent of heart failure patients given discharge instructions	100%	NA	100%	82%	76%
Percent of heart failure patients given an evaluation of left ventricle systolic (LVS) function	100%	NA	100%	95%	89%
Percent of heart failure patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD)	98%	NA	100%	90%	89%
Percent of heart failure patients given smoking cessation advice/counseling	100%	NA	100%	94%	91%
How often did doctors communicate well with patients?	77%	84%	78%	78%	80%
How often was patients' pain well controlled?	68%	78%	67%	68%	68%

Disease Control

Diabetes and Cardiovascular Disease Control in an Elderly Population

Definitions

Medicare Advantage Plan: Medicare Advantage Plans are health plan options that are approved by Medicare but run by private companies. They are part of the Medicare Program, and are sometimes referred to as "Part C."¹

Lipoprotein: a chemical compound made of fat and protein.

LDL: low-density lipoproteins that have more fat than protein (HDLs are high-density lipoproteins that have more protein than fat).

HbA1c: A test that measures the amount of glycated hemoglobin in blood. Glycated hemoglobin is a substance in red blood cells formed when blood sugar (glucose) attaches to hemoglobin.³

Economic Impact

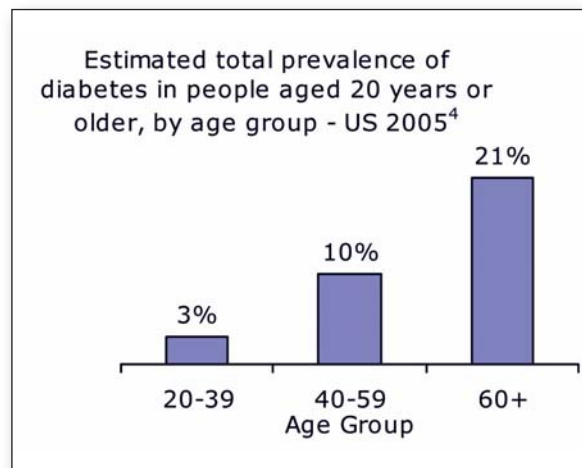
The estimated economic cost of diabetes in 2007 was \$174 billion. Of this amount, \$116 billion was a result of direct medical costs and \$58 billion due to indirect cost such as lost workdays, restricted activity, and disability due to diabetes.⁶ The economic cost of cardiovascular diseases and stroke in the United States for 2007 is estimated at \$431.8 billion.⁷ In addition, the prevalence of diabetes and cardiovascular disease is greater among older Americans. Among Americans aged 60 years or older, 23.1% (12.2 million people) have diabetes.⁶

Primary care physicians have been participating in a diabetes quality improvement program with a Medicare Advantage Plan since 2005. The program was expanded in 2008 to include cardiovascular disease management.

Diabetes Control in an Elderly Population

The medical impact of diabetes is especially burdensome among individuals 60 years or older, the vast majority of Medicare Advantage plans' member population. In 2005, 10.3 million or 20.9% of all people aged 60 years or older had diabetes.⁴

The objective of the diabetes measures was to increase the number of elderly members with diabetes who obtain appropriate diabetic screenings. The program measured a physician's diabetic patients' HbA1c and LDL levels. As stated in the previous section on diabetes, the proper management of glucose and blood lipids will dramatically improve clinical outcomes for diabetic patients.



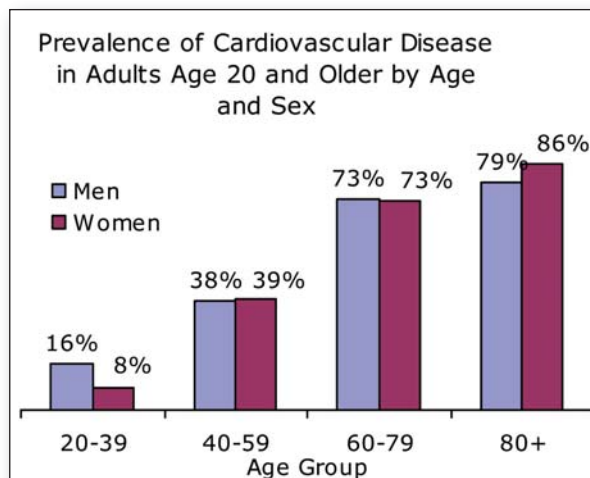
Diabetes Program Measures:

1. 55% or more of a physician's diabetic patients should have good diabetic control with a HbA1c control value of < 7.0% as determined by the most recent HbA1c at the end of the reporting year.
2. 59% or more of a physician's diabetic patients should have evidence of good LDL control of < 100 mg/dl as determined by the most recent LDL at the end of the reporting year.

Cardiovascular Control in an Elderly Population

Over 70% of all individuals age 60 and older have cardiovascular disease. The prevalence of cardiovascular disease nearly doubles when comparing individuals aged 40-59 and individuals aged 60-79.⁵ The treatment of cardiovascular disease is extremely important in an elderly population due to the prevalence of the disease.

The objective of the cardiovascular measures was to increase the number of elderly members with cardiovascular disease who obtain appropriate cardiovascular screenings. The program focused on LDL testing and LDL levels in individuals with cardiovascular disease. The proper management of blood lipids will dramatically improve clinical outcomes for patients with cardiovascular disease.



Cardiovascular Program Measures:

1. 66% or more of a physician's patients with cardiovascular disease should have evidence of good LDL control of < 100 mg/dl as determined by the most recent LDL at the end of the reporting year.
2. 85% or more of a physician's patients with cardiovascular disease should have evidence of an LDL cholesterol test in the reporting year.

Medical Impact

Controlling LDL: By reducing a patient's LDL levels, atherosclerosis, a condition in which fatty material collects along the walls of arteries, can be avoided. This fatty material thickens, hardens, and may eventually block the arteries.³

Controlling HbA1c: High levels of HbA1c will increase a patient's risk of developing problems such as eye disease, heart disease, kidney disease, nerve damage and stroke. This is especially true if HbA1c remains high for a long period of time. The closer a patient's HbA1c is to normal, the less risk there is for these complications.³

References

1. Medicare, www.medicare.gov
2. Stedman's Concise, Medical Dictionary for the Health Professions, 3rd Edition.
3. National Institutes for Health, Medline Plus, www.nlm.nih.gov
4. The Centers for Disease Control and Prevention. National Diabetes Fact Sheet, 2005.
5. *Heart Disease and Stroke Statistics 2009*, American Heart Association, www.heart.org.
6. Diabetes Statistics and Research, CDC, www.cdc.gov.
7. The American Heart Association, *Economic Cost of Cardiovascular Diseases*, www.americanheart.org

Disease Control

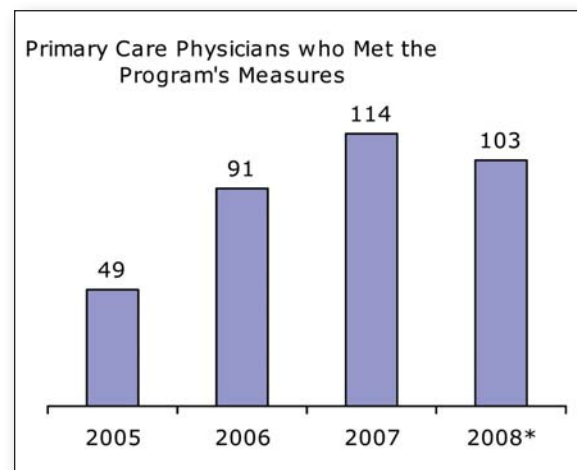
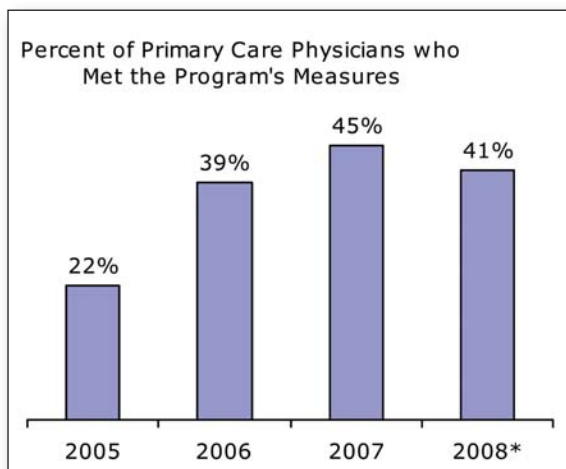
Diabetes and Cardiovascular Disease Control in an Elderly Population *cont'd*

Program Results

41% of participating physicians met the measurement goals of the diabetes and cardiovascular disease control in the elderly population. Since the program was implemented in 2005, the number of physicians who have met the program's goals has doubled.

Patients of the 103 participating physicians who met the program's goals receive evidence-based care for their diabetic and cardiovascular conditions. Evidence has demonstrated that by providing the appropriate diabetic and cardiovascular screenings, advanced complications from these illnesses can be prevented or restricted.

**Please note: in 2005, 2006 and 2007, the program measured only diabetic control in an elderly population. The cardiovascular disease measurement was introduced in 2008.*



Physician Credentialing and Board Certification

Health Partners' Credentialing Committee, composed of practicing Health Partners member physicians, performs a complete review of physicians applying to join the organization, and uses credentialing and recredentialing guidelines from The National Committee for Quality Assurance (NCQA) for this review. The Committee reviews all member physicians periodically as well. Health Partners' credentialing policies ensure these national credentialing standards are followed to ascertain compliance.

The committee obtains meaningful expertise from participating physicians when making credentialing decisions. The committee reviews each physician's medical education and residency completion dates, medical licensure expiration date, DEA expiration date, Medicare/Medicaid sanctions, hospital privileges (to ensure they are in good standing), malpractice limits and expiration date, settlements reported to the National Practitioner Data Bank, and verifies all work and education gaps. Also reviewed are inability to perform the essential functions of the position with or without accommodation, history of substance abuse (alcohol or drugs), history of felony convictions, history of loss or limitation of privileges, or any disciplinary activity (hospital, professional society, group practice, managed care organization). If at any time a physician does not meet any of the standards, the credentialing committee will review these instances on a case-by-case basis and make recommendations.

Health Partners Measurement and Results

The impact of credentialing Health Partners applicants and periodic re-credentialing of physician members, along with setting Board Certification as a criterion for membership, results in the establishment of a physician network that is high quality, minimizes risks to patients, and establishes the means to ensure physician quality is maintained and measured. The credentialing process ensures patients are treated by physicians who meet a national standard of care and who are continuously held to national standards.

** Per Health Partners policies, there are a limited number of Health Partners physicians who are not Board Certified because they completed their residencies prior to 1985.*

References:

1. The American College of Medical Quality, www.acmq.org
2. Health Partners Organizational Policies and Procedures

Definitions

Credentialing or re-credentialing: The processes of formal recognition and attestation of current medical or technical competence and performance by evaluating and monitoring a physician's clinical or medical review decision-making via adherence to applicable professional standards for direct medical care or peer review.¹

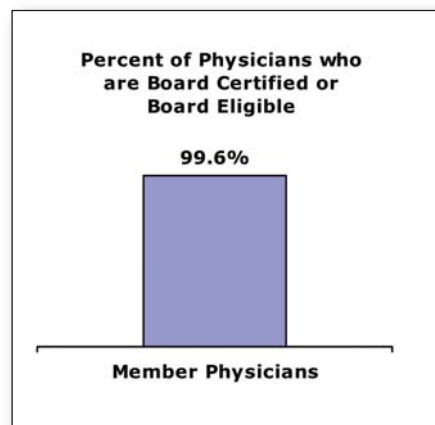
Board certification: Demonstrates a physician's expertise in a particular specialty and/or subspecialty of medical practice through certification by a recognized accredited Board, accepted by Health Partners, that involves a rigorous process of testing and peer evaluation designed and administered by specialists in the specific area of medicine.

Medical Impact

Credentialing and Board Certification of physicians ensures that patients served through contracts held by Health Partners receive care from physicians who are appropriately qualified and experienced in their medical specialty and whose past performance and behavior are in keeping with acceptable medical professional standards.

Economic Impact

Credentialing and Board Certification of physicians assists in the mitigation and intervention with physicians who may not perform to the standards of their medical specialty. Credentialing and ensuring Board Certification of physicians may assist in the reduction of medical malpractice and medical errors, and ensures medical standards are upheld, all of which contribute to reducing healthcare costs.



Health Plan

Emergency Room Utilization Reduction in an Employer-Sponsored Health Plan

Economic Impact

In 2003, nearly 114 million visits were made to hospital ERs, more than one for every three people in the United States. About one-quarter of those visits were for unintentional injuries, the leading cause of death for people aged 1 through 44; indeed, traumatic injury has surpassed heart disease as the most expensive category of medical treatment, resulting in \$71.6 billion dollars in expenditures per year.¹

Between 1993 and 2003, ER visits increased from 90.3 million to 113.9 million, a 26% increase. During this same period, the United States experienced a net loss of 425 hospital ERs.¹

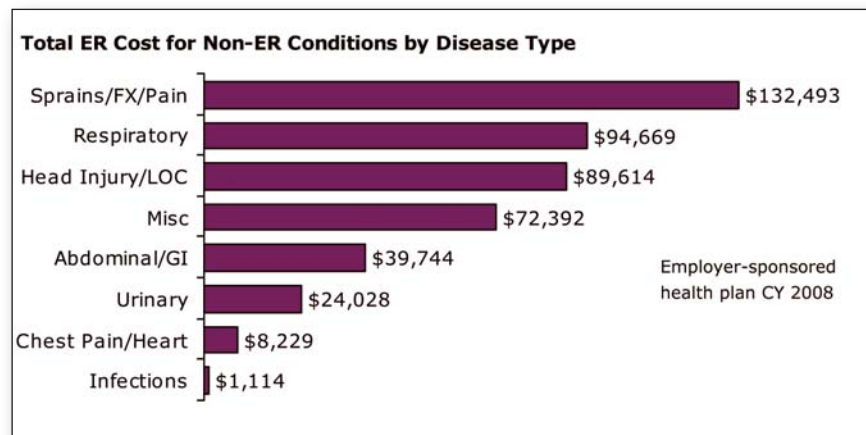
Medical Impact

ERs have become a key component of the healthcare safety net, providing a considerable volume of care to uninsured patients and Medicaid beneficiaries who often cannot access health services elsewhere. ERs are often high-risk, high-stress environments fraught with opportunities for error.¹

References

1. *Hospital Based Emergency Care: At the Breaking Point*, The National Academies Press.

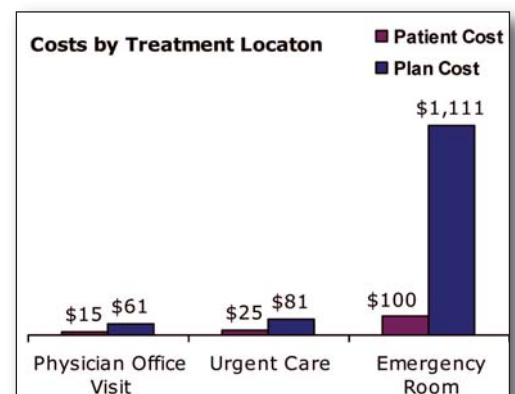
Health Partners is actively involved with an employer-sponsored health plan in a quality improvement and cost reduction initiative focusing on Emergency Room (ER) utilization. The health plan spent over \$3.6 million on ER and its associated treatment in calendar year (CY) 2008. Approximately half of the ER visits were for diagnoses that had the potential to be treated at a physician's office or urgent care center. Treatment for these diagnoses in the appropriate setting is less costly than at the ER.



The initiative's goals are to:

- Encourage employees to have a primary care physician.
- Improve continuity of care by increasing utilization of primary care physicians and urgent care centers by employees and their dependents, rather than the ER for non-emergent care.
- Reduce lower level complexity ER utilization by 20% for the selected "non-emergency" diagnoses in 2009 in comparison to the 2008 baseline. A 20% reduction would result in a savings of more than \$100,000 yearly in ER costs.

The initiative will end on December 31, 2009 and results will be shared with physicians and be reported in the *2010 Commitment to Quality Report*.



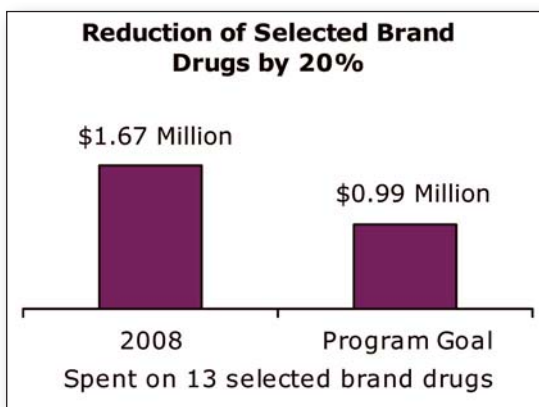
Health plans, employers and patients can realize substantial cost savings from generic prescriptions. It is estimated that every percentage point increase in generic utilization reduces overall drug spending by nearly a percentage point.⁴ Extensive research demonstrates the effectiveness of generic medications in treating patients. In addition, all generic drugs have safety data that is often not available with newer, branded medications. This combination of long-term efficacy and data combined with their lower cost makes generic pharmaceuticals a cost-effective option for physicians and their patients.⁵

Health Partners, in partnership with an employer-sponsored health plan, launched a generic prescribing initiative in 2009. The health plan spent \$2.5 million on 13 brand name drugs with generic alternatives in calendar year 2008. Spending on these 13 brand name drugs represents 23.8% of the health plan's pharmacy costs in 2008. Over 13,000 scripts were written for these 13 drugs in 2008. These drugs were selected because they have a generic alternative and/or alternatives that can be purchased over the counter. The goals of the initiative are to:

1. Maximize medication compliance to improve health outcomes by ensuring patients are provided with affordable medications.
2. Reduce the health plan's costs for 13 selected brand-name pharmaceuticals by 20% through appropriate use of generic alternatives.

The program lays the foundation for future programs that will implement costs savings measures without compromising the clinical effectiveness of pharmaceutical or medical treatment.

The initiative will end on December 31, 2009 and results will be shared with physicians and be reported in the *2010 Commitment to Quality Report*.



Definitions

Generic Pharmaceuticals: A generic drug is a copy that is the same as a brand-name drug in dosage, safety, strength, how it is taken, quality, performance and intended use.¹

Medical Impact

A generic drug provides the benefit and is identical, or bioequivalent, to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.²

Economic Impact

Spending in the US for prescription drugs was \$216.7 billion in 2006, more than 5 times the \$40.3 billion spent in 1990.³ According to the Congressional Budget Office, generic drugs save consumers an estimated \$8 to \$10 billion a year at retail pharmacies.²

References

1. *Frequently Asked Questions about Generic Drugs*, www.fda.gov
2. Federal Food and Drug Administration, www.fda.gov/cder/ogd/#Introduction
3. *Prescription Drug Trends*, Kaiser Family Foundation, www.kff.org/rxdugs/upload/3057_07.pdf
4. *Generic Drugs First for Millions*, Express Scripts, <http://phx.corporate-ir.net/phoenix.zhtml?c=69641&p=irolNewsArticle&ID=860127&highlight>
5. 2009 Value Report, Advocate Health Partners.

Patient

Management and Outreach

Economic Impact

The average cost in 2008 of a member in the Care Management program was \$13,300 while the average member cost was \$5,007. Care Management has the potential to save the health plan over \$8,293 in yearly health expenditures.

Medical Impact

Care Management can provide the following services to members:

- Assisting patients to make lifestyle choices that improve their health and quality of life.
- Assisting patients to identify risks for medical conditions and changes necessary to prevent them.
- Developing care plans to assist a patient in living well even with a chronic health condition.
- Assisting patients to understand and better manage their chronic health condition.
- Recognizing early warning signs and symptoms of illness.
- Addressing health or medication questions and concerns.
- Coordinating multiple services such as homecare, medical supplies or medical equipment.
- Helping with home safety concerns.

Mount Carmel Health Partners, in partnership with an employer-sponsored health plan, has assisted in the development of a comprehensive patient management and outreach program. The "Care Management Program" is designed to improve clinical outcomes, prevent or diminish the impact of chronic diseases, assist in care coordination and promote a healthier lifestyle for the health plan's members. The Care Management Program is a free, voluntary service for members of the health plan. A registered nurse works in conjunction with Health Partners member physicians to assist patients in controlling their health conditions.

As of December 2009, 880 health plan members have been engaged by the Care Management Program. Medical conditions and chronic diseases affecting these members include diabetes, cardiovascular disease, obesity, smoking cessation, hypertension, hypercholesterolemia and cancer. On average, members involved in the care management program had an annual healthcare expenditure rate of \$13,300 in 2008. The average healthcare expenditure rate per member in the health plan was \$5,007 in 2008.

Twenty-eight plan members have also been enrolled in a comprehensive care management program for weight loss designed to medically assist obese members to lose weight and reduce the cost of secondary conditions such as diabetes and cardiovascular disease. The program lasted a total of 13 weeks. Summary statistics of this program include:

- Average weight loss of 31 pounds per member
- 924.6 pounds lost among all 28 members
- Five bariatric surgeries avoided for a savings of \$143,110
- 35 medications were discontinued
- 9 medications decreased dosage levels
- Medication reductions and discontinuations resulted in an annual savings of \$31,716
- 10% reduction in blood pressure levels per member
- 10% reduction in blood glucose levels per member
- 18% reduction in HbA1c levels per member
- 12% reduction in total cholesterol levels per member

The Care Management Program also monitors all Inpatient, ER, and Observation admissions. A real-time report of all admissions is used and calls are placed to help with discharge planning and symptom management, with the goal of decreasing future ER visits.

A member website was implemented by Care Management to provide education, programs, resources and announcements for all associates. Education regarding migraine headaches, back pain and screening services has also been published with the goal of decreasing absenteeism.

Health Partners member physicians and the employer sponsored health plan, benefit from this program through the involvement of an additional resource to help manage chronically-ill patients. The nurse care manager is in contact with a member's physician to provide the patient with coordinated care that benefits the patient, physician and health plan by reducing unnecessary costs, managing chronic diseases, and in engaging patients in their health care.



Health Plan

Improvement in HEDIS Measures for a Medicare Advantage Health Plan

Mount Carmel Health Partners has implemented a quality improvement program designed to improve selected publicly reported Healthcare Effectiveness Data and Information Set (HEDIS) measures for a Medicare Advantage Plan. The quality improvement program provided Health Partners physicians with data regarding their individual performance on select HEDIS measures. The expectations of the program were to acquire physician assistance in improving the Plan's HEDIS measures. The Health Plan also implemented new HEDIS software and performed a medical record review to abstract data for several of the HEDIS measures. This had not been done in the past.

Program Results

The combination of these interventions assisted in the improvement in HEDIS rates for the Plan. Steps for further improvement include outreach by Case Managers to non-compliant members, quarterly reports to physicians from the HEDIS software to show progress on compliance and additional initiatives based on HEDIS measures.

This program is an ongoing initiative and Health Partners physicians will be engaged in monitoring and improving the health plan's HEDIS scores.

Improvement in HEDIS Measures Results	2007 result	2008 result	2009 result	2009 benchmark
<i>Staying Healthy: Screenings, Tests and Vaccines</i>				
Breast Cancer Screening	66%	67.2%	68.5%	67.3%
Colorectal Cancer Screening	51%	51%	53.4%	50.4%
Cholesterol Screening for Patients with Diabetes	84%	82.7%	90%	85.7%
Cholesterol Screening for Patients with Heart Disease	82%	84.2%	84.4%	87.9%
<i>Persistent beta-blocker treatment for six months after discharge for an Acute Myocardial infarction (AMI).</i>	85.8%	87%	87.8%	84.8%
<i>Comprehensive Diabetes Care - HbA1c Control (HEDIS requirements changed from <7.0% in 2007 and 2008 to <8.0% for the 2009 reporting year for HbA1c control)</i>				
HbA1c control (<7.0%)	23.7%	30.7%		
HbA1c control (<8.0%)			70.8%	45.2%
Osteoporosis Management in Women Who Had A Fracture	19.1%	17.9%	18.6%	20.4%

* All results represent the percent of the eligible patient population who received the recommended care.

* Results reflect prior year data.

Definitions

*Healthcare Effectiveness Data and Information Set (HEDIS)*¹: a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.¹

Medical Impact

Improvement in HEDIS measures represent improvements in care being delivered to patients. For every increase in a HEDIS measure, additional patients are receiving the recommended care for their particular disease, condition, age or sex.

Economic Impact

HEDIS measures focus attention on the prevention of illness and/or complication resulting from a disease. Illness prevention and disease control are two fundamental methods to control healthcare costs.

References

1. The National Committee on Quality Assurance, www.ncqa.org



MOUNT CARMEL
Health Partners, Inc.