Clinical Integration and the Baptist Physician Alliance

Physicians at Baptist Health System will soon have the opportunity to decide whether to participate in the development of a clinically integrated physician network, entitled Baptist Physician Alliance (BPA). The term “Clinical Integration” (CI) refers to an intense, collaborative effort among a hospital system and its independent physicians to develop and maintain ongoing clinical initiatives that are designed to control costs and improve the quality of patient care.

Through participation in BPA, independent physicians can contract collectively with employer groups, PPOs and other fee-for-service health plans in a forthright and legally appropriate manner. BPA will require physicians at BHS hospitals to hold each other accountable for performance against agreed-upon clinical performance and efficiency standards.

Collectively-negotiated contracts under CI do not involve capitation or other forms of financial risk-sharing. Instead, CI contracting seeks to negotiate physician fees and bonus payments from payers. Participation in BPA does not require physicians to own an electronic medical record or electronic health record system.

The concept at BHS is for BPA to be entirely physician-driven, physician-led and physician-managed at the local hospital campus level. BPA will involve the “3 Cs,” of CARE, CONNECTIVITY and CONTRACTING.

*Care: BPA physicians will commit to uphold standards of quality that are recognized by the physicians themselves as best practices, consistent with scientific evidence and “the right thing to do.”

*Connectivity: BPA physicians will use technology to communicate with one another regarding individual patient care and the performance of the group as a whole. This will ensure high standards are upheld and that care is delivered in the most efficient manner possible.

*Contracting: BPA physicians will gain the ability to participate jointly in contracts with payers and employers based on quality performance and outcomes of the entire group.

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Representatives of the Baptist Physician Alliance have contacted BHS hospital medical staff members over the past few months to provide information about Clinical Integration, and to give physicians the opportunity to commit to the program through an Opt-In Agreement. This agreement basically serves as a commitment to receive and review the BPA Participation Agreement. The goal will be to engage the majority of the hospital medical staffs through the Opt-In process and provide Participation Agreements by late summer to those physicians that have opted-in.
CI: Frequently Asked Questions

Q: What is “Clinical Integration”?

A: Clinical Integration is an effort among physicians, often in collaboration with a hospital or health system, to develop active and ongoing clinical initiatives that are designed to control costs and improve the quality of health care services. Participation in an effective Clinical Integration program will provide independent physicians on Baptist Health System hospital medical staffs the ability to contract collectively with PPOs and other fee-for-service health plans without violating antitrust laws and to participate in hospital-sponsored Hospital Efficiency programs with BPA physicians.

Q: Why do a growing number of physicians and hospitals believe Clinical Integration to be a good business and health care strategy?

A: Physicians and hospitals nationwide are implementing Clinical Integration programs not merely for reasons of antitrust compliance, but rather because they believe in its value proposition:

1. Clinical Integration allows physicians to: (a) demonstrate their quality to current and future patients; (b) choose the clinical measures against which they will be evaluated and avoid measures imposed by health plans; (c) enhance revenue through better management of chronic patients; (d) gather collective support for building necessary infrastructure; and (e) engage in group contracting.

2. Clinical Integration gives hospitals the ability to:
   (a) demonstrate their quality to current and future patients; (b) enlist physician support for hospital initiatives, including compliance with “core measures,” clinical pathways, standardized order sets and supply chain management initiatives; (c) develop a better, more collaborative relationship with their medical staff; (d) improve performance on hospital pay-for-performance measures; and (e) position themselves at an advantage in the market on the basis of quality.

3. Clinical Integration provides patients with:
   (a) a better value for their health care dollar; (b) more effective care management and outreach from a trusted source, their physician; (c) more reliable information to support their choice of health plans, physicians and hospitals; (d) more accurate and meaningful provider ratings; and (e) greater stability in their relationship with their doctor and hospital, and less likelihood that they will need to choose new health care providers every year.

4. Clinical Integration gives employers:
   (a) the ability to more effectively manage the health care costs of employees and their dependents through the purchase of better, more efficient health care services; (b) increased employee productivity and reduced absenteeism through the better management of chronic disease; (c) lower health care costs over the long term through the reduction of variation in physician practice patterns; and (d) more reliable information to support conversion to consumer-driven health insurance products.

Q: In “real life,” what does a clinically-integrated network of independent physicians look like?

A: In many instances, Clinical Integration has involved independent physicians on the medical staff of the same hospital or hospital system who join together in an organization that allows them to: (1) identify and adopt clinical protocols for the treatment of particular disease states; (2) develop systems to monitor compliance with the adopted protocols on both an inpatient and outpatient basis; (3) collaborate with the hospital or hospital system to encourage compliance with inpatient performance improvement processes and protocols; and (4) enter into physician-directed “pay-for-performance” and
other contractual arrangements with health plans in a way that financially recognizes the physicians’ efforts to improve health care quality and efficiency.

Q: At Baptist Health System, will physicians be involved in the development of Clinical Integration and the leadership of this endeavor?

A: Yes. Baptist Health System and a number of physician leaders are now actively engaged in the process of developing a new independent physician network called Baptist Physician Alliance. This physician network will be governed by a board comprised predominantly of physicians, and will operate for the explicit purpose of developing and implementing a Clinical Integration Program. This would be the basis on which the network would negotiate “pay-for-performance” arrangements and related provider contracts with PPOs and other fee-for-service health plans.

Q: By agreeing to participate in the Baptist Physician Alliance Clinical Integration Program, will physicians be required to abandon medical staff appointments at non-Baptist Health System hospitals or admit patients only to Baptist Health System hospitals and ambulatory care facilities?

A: No. The Baptist Physician Alliance Clinical Integration Program will be established as a non-exclusive organization, making no limitations whatsoever on a physician’s ability to admit patients to non-Baptist Health System sites of care or a physician’s ability to maintain contracts with health plans on an individual basis or through another non-Baptist Physician Alliance Clinical Integration Program or IPA affiliation.

Q: What clinical initiatives will the Baptist Physician Alliance Clinical Integration Program include?

A: Although the Baptist Physician Alliance Clinical Integration Program is still in the process of development, it is likely that it will include efforts designed to facilitate and improve:

- inpatient EMR and CPOE adoption
- ambulatory EMR adoption
- chronic disease management
- care episode management
- PQRI reporting
- communication among primary care physicians and specialists
- community case management
- quality-based credentialing
- inpatient practice efficiencies

The goal is that the Baptist Physician Alliance Clinical Integration Program will enhance the value of the services we provide the patient and payor communities. The measuring of compliance with the initiatives would use data from various sources, including: claims processing and adjudication systems, practice management and scheduling systems, disease registries, pharmacy benefit systems, and hospital and ambulatory EMR systems.

Q: Will participation in the Baptist Physician Alliance Clinical Integration Program require physicians to change the way they practice medicine?

A: Yes. Participation in the quality and care management initiatives of the Baptist Physician Alliance Clinical Integration Program will require significant time and attention from physicians and their office staff. But, in return, participating Baptist Physician Alliance physicians will be eligible to obtain financial rewards for their achievements through the Clinical Integration Program, funded by contracted health plans and by BHS through Hospital Efficiency initiatives. The amount of incentive payments will depend on both the physician’s personal score and the overall score of the organization. This latter component highlights the importance of physicians working together to improve care.
Q: What role does an EMR play in Clinical Integration?

A: An ambulatory EMR is not a prerequisite for the development of Clinical Integration. While a common ambulatory EMR across all participating physician practices can certainly accelerate and strengthen a Clinical Integration program, most (if not all) successful models of Clinical Integration nationwide do not depend on an ambulatory EMR for data on physician performance. Ultimately, a network of independent physicians may wish to implement an ambulatory EMR that is designed in a manner that assists in the capture and extraction of the data necessary to continue to operate their Clinical Integration program. One opportunity offered by the anticipated Baptist Physician Alliance Clinical Integration Program is the ability of the health system to underwrite a physician office EMR. But still, the Baptist Physician Alliance Clinical Integration Program will likely begin its efforts to measure, analyze, and evaluate physician performance through claims data, existing hospital data, disease registries, and chart audits.

Q: How is it lawful for a network of clinically-integrated physicians to collectively negotiate with health plans when the FTC is actively investigating and prosecuting physician networks for negotiating PPO contracts?

A: The FTC views clinically integrated physician networks as an opportunity to create efficiency and quality in care that outweighs any restraint on trade. However, the FTC will continue to prosecute those networks that fail to demonstrate the elements of true Clinical Integration.

Q: What benefit do hospitals provide in the development of Clinical Integration programs?

A: Partnering with a hospital can provide distinct advantages to a network of independent physicians in the development of Clinical Integration. In instances where the hospital shares the same quality vision as the physicians, the hospital can be a powerful ally in program development by: (1) collaborating with the physicians in the development of Clinical Integration initiatives based on existing inpatient quality measures, (2) lending financial assistance and personnel in the implementation of inpatient and outpatient initiatives that provide true community benefit and are not tied to the volume or value of referrals, and (3) demonstrating to payors and the community as a whole that the Clinical Integration program is both legitimate and valuable.

Q: How is a Clinical Integration project organized?

A: There are a series of logical steps that physicians can take, with the assistance of competent legal counsel, in order to design, implement and operate a true Clinical Integration program, including:

1. conducting a readiness assessment, whereby existing infrastructure, programs and organizational structures (i.e., hospital technology, personnel and other resources; the existence of current IPAs or PHOs) are evaluated to determine the preparedness of the physicians to engage in Clinical Integration;

2. establishing an organizational framework, in order to create a flexible “joint venture” business entity through which the physicians can collaborate with each other and with their hospital to develop clinical quality and efficiency initiatives;

3. developing commitment and consensus among all stakeholders – physicians, hospital administration and even employers, health plans and patients – that Clinical Integration is
an ideal solution for the demands of improving health care quality, enhancing health care consumerism, and increasing health care efficiency;

4. designing Clinical Integration programs and initiatives that (a) leverage existing data, technology, and human capital at the respective physician practice, physician network and hospital levels; (b) provide the highest likelihood for accelerated implementation; (c) offer the greatest impact on health problems and disparities in the community; and (d) create the most probable case for overall health care cost reduction, based on better care rather than lowest unit price;

5. engaging regulators, primarily the FTC but also relevant state and local officials, usually in the context of “informal” dialogue rather than a formal advisory opinion process, wherein the network of physicians is readily able to answer likely questions regarding program initiatives, the efficiencies anticipated from the CI program and the reasonable necessity of joint negotiations to achieve efficiencies of the program;

6. implementing the Clinical Integration program through the execution of initiatives designed in step 4, the alignment of data collection and reporting systems to effectively measure physician performance, the delivery of feedback to network physicians about that performance, and the remediation of poor performance; and

7. contracting with fee-for-service health plans as a network in a manner that adequately compensates for the “new product” developed by the physicians through Clinical Integration, and rewards physicians under “pay-for-performance” and other incentives.

Q: How can I receive more information regarding the details of the Baptist Physician Alliance Clinical Integration Program?

A: During the next few months, physician leaders developing the Baptist Physician Alliance Clinical Integration Program and Baptist Health System representatives will be available for you to obtain detailed information regarding your participation in the program, the clinical quality initiatives of the Clinical Integration program, and the pay for performance and incentive opportunities.
An Interview with Jim Lasker, M.D.

Q: How would you describe the current general relationship between the physician community and the hospital community?
A: Over the last two to three years, Baptist Health System has worked very closely with the physician community to develop and promote physician leadership with individual physicians. Physicians, hospital administration and health care executives at Baptist Health System value greatly the partnership that we have developed over the last three to five years and are looking forward to continuing this relationship as we develop our Baptist Health Alliance.

Q: How did you become involved in the development of the Baptist Physician Alliance?
A: As president of the medical staff here at the Princeton Baptist campus, over the last two years I have developed an excellent working relationship with the health care executives as pertains to our campus and our issues. I was approached at the conclusion of my term as president of the medical staff regarding the development of the Baptist Physician Alliance. After reviewing the goals and mission of this alliance, I feel convinced that it is in the interest of our physician community and our health system to commit time and energy to develop this alliance for the betterment of our campuses and our communities.

Q: Why do a growing number of physicians and hospitals believe Clinical Integration to be good business in health care strategy?
A: As a result of the Healthcare Reform Act of 2011, both hospitals and physicians will be required to work closely together to produce and promote better quality, more efficient, less costly health care. Reimbursements for hospitals and physicians will be based on the quality of care they provide rather than for the number of procedures or patients they see. Clinical Integration is a process and relationship between Baptist Health System and the physicians in our community that allows us to develop a partnership with the health system that will identify quality measures and help promote quality care within our community. The Baptist Physician Alliance is a physician-led, physician-driven and physician-governed organization that is aligned with Baptist Health System to provide physicians with both a more integrated role in patient care and quality program implementation, and a greater say in the business and clinical strategy of the health system. This should, in turn, aid in our ability to obtain managed care contracts with payers and employers.

Q: Will participation in the Baptist Physician Alliance Clinical Integration program require physicians to change the way they practice medicine?
A: Yes, it will and for the better. By becoming a member of our Baptist Physician Alliance Clinical Integration program, physicians will be able to choose quality measures and goals that are aligned with those of payers, insurers and employer groups. In practicing along these lines and producing quality care, hospital admissions will hopefully be reduced and quality care will be provided to our community.

Q: Within the Baptist Physician Alliance, will physicians be involved in the development of Clinical Integration and the leadership of this endeavor?
A: Yes. The Baptist Physician Alliance is to be transparent and allow input from physicians in all areas of the organization’s decision making. Again, it is a physician-led, physician-driven and physician-governed organization aligned with Baptist Health System to promote an integrated role in the strategic planning, patient care and quality program implementation.

Q: How can physicians learn more about Baptist Physician Alliance?
A: Baptist Physician Alliance Board members at the individual hospital campuses are available to provide additional information regarding BPA. I am available at the Princeton Baptist campus to discuss our Alliance and how they can become involved in the Alliance on a daily basis. In addition, Scott Fenn and Joseph Oaks of Baptist Health System are also available to discuss our goals and mission of the Baptist Physician Alliance in the hope that physicians will wish to be a part of this as we go forward.
News in Health, Quality and Reimbursement

Payers Focus on Quality Initiatives

Under the leadership of the physician-led Quality Committee, Baptist Physician Alliance is in the process of developing the necessary policies and programs that position our physician practices for improved quality/operating performance and to ensure ongoing success. Payers, Medicare and Medicaid are increasingly measuring quality of care and determining new reimbursement methodologies based on clinical quality indicators and operating performance. BPA must be prepared to accurately demonstrate and report results in those areas.

Blue Cross Blue Shield of Alabama’s (BCBS) Value Based Payment Program (VBP), which launched in January 2011, is one example of a quality and performance based reimbursement methodology. The VBP provides supplemental reimbursement to higher performing network physicians. Eligible physicians receive a 5% supplemental payment on defined Evaluation & Management and Preventive codes. The criteria used to determine a physician’s eligibility are:

• Process of Care Outcome Performance (BCBS Quality & Transparency Data)
• Patient Satisfaction Performance
• Utilization/Efficiency Performance

The most recently published BCBS Physician Quality and Transparency Data is based on claims filed from July 2009 through June 2010. The self-reporting period for this data closed on March 25, 2011. The new quality scores (including any corrections resulting from self-reporting) are now available on the BCBS web site for the public to view.

Patient-Centered Medical Home

A Patient-Centered Medical Home (PCMH) is designed to strengthen the physician-patient relationship through coordinated care and a team approach to delivering care. The result of this partnership among patients, primary care physicians and staff is improved quality and efficiency. The team approach, which goes beyond a typical office visit, can include further education as well as help patients take a more active role in their treatment through self-management tools, which ultimately leads to better compliance and outcomes. These enhanced services in a PCMH are generally coordinated through the efforts of a health coach who in most cases is a new member of a physician’s care team. Work flow in the practice is redesigned to emphasize the team-based approach to care led by the primary care physician and the health coach (who is usually a highly experienced nurse practitioner with experience in working with patients with multiple chronic medical conditions).

Hoover Internal Medicine was recently recognized as a Level 3 Patient-Centered Medical Home from the National Committee for Quality Assurance (NCQA) Physician Practice Connections. Level 3 designation is the highest achievable recognition. Hoover Internal Medicine is the first Level 3 PCMH in Birmingham.

NextGen EHR

As our health care delivery model changes, it becomes increasingly important for physicians to have the necessary tools available to serve their patients, document clinical and financial information, and coordinate this information with other providers and payers. Physicians that participate in the Baptist Physician Alliance (BPA) have the opportunity to adopt the NextGen electronic health record (EHR) solution, one of the leading EHRs in the market, at a reduced rate structure.

Baptist Health Centers physicians have adopted the NextGen product and have begun implementing the system within the network of practice locations. Additionally, NextGen is currently being implemented for approximately 50 independent physicians that are affiliated with BPA. Baptist Health System has a team of implementation specialists dedicated to the NextGen product and can provide technical expertise during the install process.

To learn more about the NextGen solution, visit the PhysiciansFirst web site at www.gophysiciansfirst.com and click on the NextGen icon. You may also contact Phillip Langston in the PhysiciansFirst office at 205-715-5922.
### Meet Our Board of Directors

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### Next Issue
- Recruitment/Membership Update
- Quality Initiative Development
- Payer Engagement Update