

**CLINICAL INTGEGRATION
FOR INDEPENDENT PRACTICE ASSOCIATIONS**

Practical Solutions for IPAs and Member Physicians

White Paper

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Abstract: Clinical Integration In An IPA And How ICLOPS Does It

Until recently, physicians found financial safety in numbers. They could negotiate managed care contracts with health insurance companies through networks of doctors in Independent Practice Associations (IPAs), and get higher reimbursement than available individually. Now this benefit is at risk. The FTC is requiring that IPAs demonstrate that they are “clinically integrated” in order to negotiate fee-for-service contracts, and is challenging IPAs under anti-trust laws for noncompetitive behavior.

The FTC provides little guidance as to all the requirements of “clinical integration,” but there are concepts coming out of court decisions and arguments to use as a starting point. One reality is clear: most IPAs do not have the infrastructure or tools to meet even modest definitions of clinical integration. This paper presents options for IPAs to consider in order to continue serving physicians. These are all activities that can be acted upon now, without any changes to systems in use or imposition of new work for member physicians. ICLOPS provides a practical approach to doing this. ICLOPS enables IPAs to face the ultimate challenge: clinically integrating multiple independent practices with different practice environments, clinical styles, and information systems.

As IPAs begin to address the basic elements of clinical integration, they will see new possibilities for helping practices flourish in the evolving economic environment, deliver better patient care, and grow. These opportunities are a natural outgrowth of the data analysis and interventions needed to become cohesive and patient-centered.

ICLOPS is a company that analyzes physician practice data to drive targeted and organized communications to patients. The communications increase revenue, quality, and patient retention for physician practices by ensuring better follow-up care, especially for chronic disease patients; improve patient management of their health; and increase patient satisfaction with physician services.

The Basic Rules of Clinical Integration

An IPA that is clinically integrated means that the organization produces improved quality of care and efficiencies beyond what the individual physician practice could achieve. This assumes that the IPA can assure a certain standard of care that is distinct from its contracting functions. Some basic principles and functions are inherent in delivering care to patients within a defined set of standards:

- A clinical rather than financial focus. The role of the IPA until now has been predominantly to negotiate rates, credential physician membership, and assist in the resolution of payer issues. Under a clinically integrated IPA, the focus will shift to ensuring better services for patients. Negotiations with payers on quality and operational issues will become increasingly important in the future as insurance plans adopt quality-based reimbursement schedules.
- The IPA must have an influence on all of the patients cared for by its physicians. This assumes that the IPA has broader oversight than for patients included in negotiated contracts. The IPA must make sure there are not two standards of care, one for the patients involved in contracts they negotiate, and another for the patients of its member physicians who are not covered by an IPA contract.
- Aggregation of data for analysis and oversight of quality functions is essential to clinical integration. Without aggregated data, it is impossible to define and demonstrate results of interventions for individual physicians. Aggregated data does not necessarily mean the existence of a common electronic medical record in use by member physicians; there are other means of creating a common database and measurement tools for different practices.
- The measurement of outcomes within its physician practices, and determining causes for poor outcomes, is a key aspect of clinical integration.
- A strong peer-review process to affect outcomes for patients will be essential after the analysis and measurement of data.

These five components appear deceptively simple. The fact is they require a thorough retooling of IPAs to incorporate three new functions:

- **Development of the capacity to review data under fee-for-service contracts.** This will be new to IPAs and difficult to achieve; under fee-for-service contracts the physician is paid directly by the insurance company, and the IPA has no access to this data for reviewing clinical services. Therefore, the first task in clinical integration requires the development of a means to access data and aggregate it for analysis.
- **Analytical expertise and tools that go well beyond the traditional scope.** As an example, a physician new in practice has only seen many of her diabetic patients for one visit. If these patients have poor diabetes control, is this a measure of her performance? Not necessarily. If the physician has a high-risk population, there may be no evidence that her care or outcomes need improvement. Other analytical expertise that will be needed include stratification of risk within patient populations, visit tracking, and monitoring of results over time and among physicians will be important.
- **Interventions to achieve results within practices.** This means that the IPA will have to take specific actions to improve the results for individual member physicians, rather than provide general advice. As part of this effort, the IPA will also identify patient-driven outcome issues, such as patients with poor adherence to medication use and therapy prescribed by the physician because they can't afford medications, are fearful of side effects, harbor concerns about their treatment, or are too anxious or depressed to effectively manage their own health. Addressing these issues, which are often overlooked in busy practices, will improve clinical outcomes.

ICLOPS: A Practical Model of Clinical Integration for IPAs

ICLOPS' model of clinical integration contains two essential components: analysis of practice data to measure performance and identify patients who need services, and communication with those patients to arrange for evaluation and care. The analysis and patient communications are combined in a package of services called the ICLOPS Clinical Toolset.

ICLOPS identifies patients by conditions, procedures, age, and gender, assisting physicians in managing existing patients with chronic diseases and ensuring frequent follow-up. The ICLOPS services are completely integrated into physician practices, building on existing systems and processes, and they cause no additional work for the practice.

IPAs, needing a common database as the underpinning of clinical integration efforts, sometimes attempt to push for an "ideal" scenario by adopting a common practice management system or electronic medical record. There are several problems with this approach. First, it takes an extremely long time for physician practices to migrate to a common system – even if there is a legal way for the central organization to pay for it. Second, it confuses system tools with clinical integration. Housing the data centrally is the easy part; much harder is the consistent effort to undertake identification of patients requiring services and subsequent interventions that produce results in quality improvement.

It makes more sense to start with existing systems in use by physician practices in IPAs and aggregate their data for analysis, then seek an electronic medical record as a long-term strategy. Using existing systems means that the barrier to implementation of clinical integration is less. There is no extra large cost for the IPA or practices for a system purchase, nor time spent convincing the practice of the value and implementing the tools. The real focus can then be on using the data and analyses to identify patients by condition and other factors to evaluate care against standards. This is the philosophy behind the ICLOPS approach.

The ICLOPS Clinical Toolset for IPAs has several key components:

- ICLOPS uses billing data for analyses as a core dataset. This can be supplemented by EMR and external data, such as data from an outside lab, if available. ICLOPS can work with any practice management system.
- ICLOPS prepares the data extract and creates the analysis database. The individual practice data is kept separately in the ICLOPS data architecture and can be aggregated across all clients to assist IPA oversight.
- ICLOPS services are delivered to both the individual physician practice and the IPA. The services to physicians deliver benefits for the practice in improved revenues with better clinical follow-up, reduced risk of malpractice claims, and growth of new patients. ICLOPS equips IPAs with clinical management tools to review quality performance and implements the communications that generate improvements in quality. These have particular applicability to chronic disease patients and preventive services required by payers.

The ICLOPS Clinical Toolset focuses on four targeted patient groups in the first phase of Communications, to address specific patient compliance issues. These are patients who are: behind schedule in office visits, require diagnostic tests, need comprehensive visits, or should be called back to discuss new treatments or risk factors for their conditions.

By using the ICLOPS approach, an IPA can speedily meet requirements for basic clinical integration and show real benefits to member physicians through revenue increases. When EMR technology is adopted by physician practices, ICLOPS services to practices in an IPA would then be enhanced with a more comprehensive database. This makes it possible to structure a solution that is both operationally and politically feasible for independently practicing physicians in an IPA.

New Opportunities for IPAs in Clinical Integration

IPAs have the opportunity to expand their services and influence in the health care market, and improve the bottom lines for member physicians. They successfully brought physicians together to level the playing field with payers and to allow access to patients in capitation contracts. As capitation has receded in the market, IPAs must prepare to assist their physicians in new ways. The power of aggregating data from its physicians and providing new mechanisms for patient communication will transform IPAs.

As IPAs reorient their direction, there are many essential functions that they can fill to support member physicians. A partial list of these, provided below, gives a glimpse into the transformation of the IPA into a cohesive clinical and financial network for physicians. ICLOPS has the tools IPAs can utilize to make this transition.

1. IPAs can provide quality and outcomes comparisons across physician practices in order to motivate physicians. The ability to aggregate and compare data across practices will be an increasingly important role for IPAs in the future. Physicians need to be able to see how they “stack up” in these measurements by a friendly and supportive organization, so that they may react and improve. The IPA should also provide a detailed analysis of the composition of the patients involved in the quality analysis.
2. IPAs can influence physicians at the point of care. Prompts and reminders are important tools to assist physicians in addressing care that may be overlooked or missed. This is a natural outgrowth of patient communications, where the filing of letters in patient charts can be an opportunity to structure the anticipated visit.
3. Influencing physician-patient communication and tracking outside of the office visit will be an important IPA activity. An excellent opportunity for the IPA is to provide the physicians in the IPA with the tools to track selected populations of patients and write them letters urging return visits and/or comprehensive visits. This is a mechanism to provide direct, organized communication to patients. In addition to improving quality, this increases

volume and intensity of services for the practice. Tracking the response to these letters through follow-up visits and sending additional mailings are beyond the capabilities of most practices; the IPA can introduce this technology and approach broadly throughout the physicians in the IPA. Documenting the mailing of these letters is an important quality process and also important in lowering liability risk. By combining physician resources, detailed quality projects may be initiated that can provide benefit across specialties. For example, identifying patients at risk for abdominal aortic aneurysms and directing them to obtain abdominal ultrasounds will identify patients for surgery who in the past would have experienced sudden death.

4. IPAs can determine potential problems for patients who have had procedures or courses of treatment. Developing a process of capturing and organizing feedback from patients after surgery or intense courses of treatment is the first step in a quality process that IPAs must offer to different specialists within the IPA. This is a process that is unobtrusive and offers proceduralists and other specialists a mechanism to evaluate themselves and seek opportunities for quality improvement.
5. IPAs should assist physicians in lowering risk and preventing injury in the physicians' patient population. The IPA data can identify patients at risk of injury (e.g. elderly patients with diagnoses of fainting or dizziness) for intense evaluation and intervention. The IPA may further assist its physicians in identifying at-risk individuals as part of the patient communications efforts.
6. IPA activities should increase the income of its physicians in a fee-for-service environment. Physicians are under great financial pressure from liability insurance costs and increased costs for rent, staff, benefits, etc. This is particularly true for primary care physicians. IPAs must address this issue in order to get the attention of the physicians. Actions that increase volume and intensity of services must be done in a manner that also increases quality of care for patients. Clinical trials may afford IPAs a means to increase revenue for some physicians. Additionally, capturing additional revenue in pay-for-performance will benefit physicians financially. The actions of IPAs should buffer physicians from further revenue

loss, which might happen under pay-for-performance and when patients pay higher deductibles and co-payments.

7. IPAs should use a population-based perspective to assist its physician members, particularly for reacting quickly to new guidelines or treatment recommendations. The CDC has recently published new guidelines for a new meningococcal vaccine. The IPA may assist its physician members by organizing mailings to parents of children who should receive the vaccine. This avoids waiting for patients to come to the office to receive advice on the immunization, and it assures that the patients eligible for the vaccine are given instructions to receive it. This is also a means to lower liability risk for the physicians in the IPA.

Using ICLOPS Support for Clinically Integrating the IPA

ICLOPS has the expertise and tools to help IPAs expand their services to member physicians and sustain their contracting capabilities. Implementing these tools is a simple process. ICLOPS recommends a phased approach to clinical integration, beginning with a focus on primary care and one or two specialty practices in the IPA. The implementation involves these steps:

- Survey of practice management systems in use by member physician practices, and other systems to be tapped for analysis
- Development of a phased-in approach for development of the database, beginning with primary care practices on similar systems, or high priority groups of primary care physicians and specialists
- Identification of clinical diagnoses, conditions, and procedures to be measured and tracked
- Extraction of the data by ICLOPS and the development of an analytical database with tools for the IPA and the practice
- ICLOPS initial analysis of practice performance, and generation of first patient contact lists and physician-to-patient communications
- Monthly extracts of practice data and subsequent generation of patient communications
- Tracking and follow-up communications to patients who have or have not responded to letters
- Quarterly analyses to IPA that report results by practice and by care standards

Summary of Clinical Integration Issues for IPAs

ICLOPS provides IPAs an immediate solution to the need to clinically integrate its member physicians. Because of forces in the market, this is a necessity for IPAs that wish to continue offering physicians the ability to contract as a group for fee-for-service contracts. IPAs offer the best realistic alternative for physicians to continue to practice independently and yet receive critical support functions. Clinical integration is an opportunity for IPAs to help these physicians in new ways.

The practical tools ICLOPS uses are built on existing practice realities – the need for a low cost, low technology, and low workload solution. ICLOPS offers an immediate solution to IPAs seeking to clinically integrate. Physician practices that are busy and financially distressed – the majority of current groups – will benefit from the ICLOPS services in new revenues and better patient adherence to clinical guidelines. IPAs will achieve the ongoing ability to provide service to physicians and help these physicians thrive under new pay-for-performance plans.

Comments Welcome

ICLOPS encourages discussion and comments of the statements in this White Paper. Please contact Thomas Dent, MD, (312) 255-8421. Visit our website at www.ICLOPS.com.