



hvpa  
Huron Valley  
Physicians Association P.C.



2009

**Year In Review**

On the Path to Organized Systems of Care

# Greetings From Oz



Paul Harkaway, M.D. - President



Well, it must be that time of year because I am already seeing the ads, though I wonder why they just don't start them in July given how early they seem to want you to start buying stuff nobody needs or wants.

So there goes another year. And what have we done? The health care machine continues to grind on. Once again, like it or not, we have promise of change, like we have had many times before. But the health care powers (defined as anyone with any interest in health care who does not touch patients) continue to define the agenda. Even the Feds in defining the need to change the paradigm started by saying that changing the private insurance industry and malpractice reform were not on the table. And they have been arguing incessantly about the "public option." Really? So what are we changing here?

And so, instead we see changes like the proprietary health care informatics revolution driven by an industry with its eye on the prize – federal "stimulus" dollars- and the promise of, and necessity for, costly upgrades (that providers will need like an addict needs a fix) for all of eternity. And for those of you actually providing the care and trying to use these "tools", thank you for recognizing and acknowledging the grandeur and splendor of the Information Emperor's new set of clothes. Not to worry, they will look even more splendid when we add the 3.0.5 upgrade cummerbund next year. What's that you say? The Emperor is not wearing any clothes? More Koolaid-laced eggnog for you, you "nattering naybob." Where is your holiday spirit?

Well, in one sense it doesn't really matter what we or they say or don't say, does it? There will have to be change. The economics of it will not allow for escape. The math is actually pretty simple. Absent change, in about, oh 20 years, the average family's entire income will be devoted to health care premiums alone. No food. No gas. No house payment or rent. No shoes for the kids. No Grey Goose or Coors lite, or cable TV, or furniture, or laundry soap. No cell phone or vacuum cleaner. Just health insurance.

If you accept that 20 years is the blink of an eye (the universe by comparison is about 14 billion years old and they just found some city underwater that is about 5000 years old), the math can't be ignored by anybody other than a congressman and/or congresswoman. And I don't even think they will be able to ignore it much longer, try as they might

Which leads me to the age old question- where are the docs? The good news is they are busy seeing patients and doing their best to make a difference. The bad news is there is a "twister" coming their way, and if they don't move, they will wake up in Oz with flying monkeys picking their stuffing out. My last weekend on call in the ICU with our new information system pretty much felt like that- and I never even got in to see the Wizard

So with all that as a prelude, where is the silver lining? Where it always has been- with the physicians. We know health care. We know what needs to be changed. We know where the waste is. Give us a pick and a shovel and get out of our way and we can show you where the gold is in them thar hills. Per usual, we are not organized to do the work, but it would not be that hard for us to become so. All that matters is whether or not we want to.

If you want to, then let's build an Accountable Care Organization (ACO). It's not much harder than the crane my brother built with his Christmas erector set when we were growing up. And like him, we have all the parts, minus a few screws that he dropped and my mother vacuumed up while wondering why the vacuum was rattling so much. This ACO stuff is really not a new concept, just a new name. We actually have done it before, but not with the sick patients that we know how to care for. The main ingredients are will, cooperation, collaboration, data, passion for quality and effective patient care, courage and ability to change.

Or , alternatively- They'll get you my pretty -----  
--- and your little dog too.

# Primary Care Message



Deborah Peery, M.D. - Primary Care Representative



As the first decade of the 21st century draws to a close it is time to look back at our successes, failures and our hopes for the future. We have in the recent past, had to deal with patients who have been laid off, lost health insurance or seen their benefits significantly reduced. We have also seen reimbursements decline and our fees shrink while insurance companies force us to earn them back through pay-for-performance (P4P) measures, some of which have dubious health improvement benefits. We have seen capitation disappear although it will likely return in a different form and with a new name- Accountable Care Organization (ACO).

In all this upheaval, we primary care doctors continue to struggle to survive and provide quality care in partnership with our patients. Many HVPA primary care practices have gone through the application process and been accepted under Blue Cross Blue Shield's Patient Centered Medical Home (PCMH) project. In exchange for implementing the tenets of a PCMH (personal physician, physician-directed medical practice, whole person orientation, coordinated care, quality and safety, enhanced access) BCBS gives those designated offices slightly increased reimbursements. While much of the work of transformation must be done by the care teams at the individual office level, HVPA staff and IT initiatives have offered invaluable assistance.

The e-prescribing initiative (DrFirst) has been successful through a hardware stipend, license subsidy, and training which allowed many primary care doctors to implement e-prescribing. DrFirst provides improvements in safety and formulary compliance, as well as the ability to give specialist and other treating health care providers an accurate, updated medication and allergy list.

For practices that took advantage of it, the Medfusion provider-patient portal benefits primary care practices in two ways. Having a patient web portal gives us the

ability to offer online features to patients, making our practices more attractive. These include online registration, ability for patients to make and update changes in real time, request appointments and prescription refills, and send and receive secure emails. Another feature is virtual office visits, which can provide cost effective health care for patients and another source of revenue for providers. Practices also have the ability to email patients, making it a quick and effective way to communicate timely health announcements, changes in office policy or practice, and advertise new services.

A second benefit for both PCPs and SCPs is the referral piece of Medfusion which allows referrals and the necessary data to be sent to specialists in an efficient and effective way. This benefit can be used by all physicians with access to the internet, even those not utilizing the other Medfusion capabilities.

As we enter into the next decade, I look back with regret that several primary care groups chose to leave HVPA. However, I look forward to the work we have started and are continuing. I also see that HVPA is in a unique position going forward as we have the skeleton of an organization to form a functioning ACO with our membership of primary and specialty care physicians and our experience over the years of working with our hospital partner. As always, I believe the primary care physicians need to be at the front of any health care transformation as we have a unique perspective that gives us the ability to help improve the health of our patients.

**In 2009, HVPA had 37 physicians selected for PCMH-designation by the BCBSM PGIP Program**

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**HVPA currently has over 250 physicians electronically prescribing.**

# Quality & Efficiency of Care



Ray Rion, M.D. - Associate Medical Director

HVPA began more intense work on commercial quality and pay-for-performance plans in mid- 2008 and has continued this work through 2009. The focus and assistance HVPA has offered led to significant success in 2008 with a 350% increase in primary care quality incentive revenue captured by the network under BCN compared to 2007.

During 2009, HVPA underwent a significant reorganization. The Performance Improvement Committee was replaced by the Quality Committee which had its first meeting in the summer. The first year of the new committee was dedicated to the choosing of short term goals and targets. The committee decided to focus on primary care variables of care that were common, important, and part of commercial payors pay-for-performance programs.

The factors that were chosen for initial emphasis were three cancer screening services (mammography, pap screening, and colorectal) and several diabetes measures, (A1C testing and control, LDL testing and control, urine nephropathy screening, and retinal screening.)

HVPA began work on these variables in 2008 and much of the activity in 2009 was a continuation of this work. At year end, 2008 performance of the network was near statewide averages. For those who have become fully engaged in the process there has been some significant improvement in quality scores. There are many physicians who have dramatically improved their scores through a combination of closing data gaps and outreach to patients to provide care. There are also many physicians who were already performing at a very high level and have continued to do so. This best illustrates that success on the quality measures is a process not an event; it requires focus, organization, and sustained attention.

Our quality work has presented several challenges to a

loosely affiliated network like HVPA. Some of this work involves outreach to patients who may not be active in a practice. We have some physicians who do not feel this type of population management is part of their job. We have an independent network where private business owners can participate in this work or not. HVPA has assumed some of the “grunt work” of closing data gaps (data entry) between plan data and actual care provided that occurs due to patients changing insurers, insurers being purchased, and reliance on plan supplied data. Many of our primary care practices are small and can be prone to significant disruption from staff turnover or poor staff performance. Quality work and population management also runs headlong into fee for service payment for primary care and the primary care physician as “hamster in the wheel”.

Staff models have the ability to direct work in a more intentional and often more effective fashion. Having spent over a decade at the University I can attest to the difference between what we at HVPA currently do-suggest, ask, cajole, etc - and what occurs in a staff model, which is, if necessary, manage physicians and overtly direct behavior. Staff models also have a regulated group of physicians, with problematic performers coached to improve or moved out.

Staff model primary care groups have a distinct organizational competitive advantage over HVPA when it comes to deciding and acting upon business priorities or new directions. They are focused and improving their clinical performance.

HVPA has expended significant energy and effort in the information technology area to develop tools to support clinical practices. HVPA has developed a data warehouse, has joined with myIHIE, and evaluated the commercial disease registry, Wellcentive. We are optimistic that the data warehouse and interfaces will allow us to gather and develop our own data across many or all payors.

We will become responsible for tracking our own clinical performance and not be reliant on the health plans for this. After much effort and thought, we have decided to build on the work of the Quality Institute and build our own registry. The advantage of this to users of the registry is better electronic interfaces to automatically populate clinical data and better interfaces to health plans. Wellcentive requires extensive manual data entry. Turning medical practices into data entry clerks is not the way to the future.



A disease registry should allow you to search and list your patients by disease and insurance, provide a useful point of care form with prompts for needed care (e.g. Mrs. Smith needs pap screening and mammography), provide a list of patients with services due (e.g. diabetics who need services), and help you capture pay-for-performance revenue. We are optimistic that our disease registry once fully implemented, will help physicians in our network provide high quality care.



HVPA's quality management performance continues to track in the top quartile for Southeast Michigan-based physician organizations<sup>1</sup>

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HVPA's utilization management performance is average to below average compared to other Southeast Michigan-based physician organizations

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Focused areas for Improvement include pharmacy, radiology, and emergency department use.



<sup>1</sup> As reported on Southeast Michigan Health Care Performance Reports, [www.mycompare.org](http://www.mycompare.org)

# Specialty Care Message



Larry Adler, M.D.  
Specialty Care Representative

If you don't believe that we as physicians are in the service business, then you can probably skip the rest of this article. We at HVPA have continued to expand participation in the Medfusion initiative in order to improve communication between Primary Care physicians and Specialists related to the referral process as well as between patients and their physicians. A recent survey revealed that 57% of patients desired a secure internet site to communicate with their physicians. It is apparent, that in order to maintain a competitive advantage over our competitors, and to provide unparalleled customer service, we will need to develop a robust system of interactive electronic communication.

To date, between HVPA and stand alone licenses, there are 216 physicians in our network on Medfusion, along with 35 using the referral portal only and 19 non-HVPA providers using the technology to refer to our specialists. There are 29 specialty practices and 10 primary care offices involved. A list of the practices is available on the HVPA website, but suffice it to say, we have certainly achieved more than a critical mass of specialty practices to make this an efficient and cost saving method for offices to refer their patients. I would like to acknowledge the outstanding effort by Deb Roberts in driving the success of this initiative and if you are interested in joining our effort please contact HVPA for more information.

27,000+ registered patients in our network.

200+ fully licensed primary care physician users

50 non-licensed physicians are participating in the referral portal, including some non-HVPA physicians



# Behavioral Health



Tom Zelnik, M.D.

HVPA members providing psychiatric and addiction medicine services continue to address challenges as well as potential opportunities within the organization. Although recent federal parity legislation seeks to eliminate arbitrary coverage limitations for patients with psychiatric disorders, subjective interpretation of medical necessity criteria by external reviewers may still undermine legislative intent. Further, mental health insurance "carve outs" continue to work against better coordinated care for the numerous patients we serve with co-morbid psychiatric and medical/surgical conditions.

Many psychiatric members of HVPA have actively participated in and promoted a funded study of implementation of evidence-based practices in the pharmacological treatment of mood disorders. In addition to private (Psychiatric Associates of Michigan) and SJMH-based psychiatric settings, pilot primary care settings (Washtenaw Medicine, Dr. Deb Peery) and one specialty setting (Michigan Heart) were studied as part of this project. Quantitative as well as qualitative study methods were used, and progress to date has qualified us for continuation in future phases of this state-wide effort to develop an internet-based registry and interactive decision support tool for physicians caring for patients with depression and other psychiatric disorders.

Potential future involvement of HVPA in the development of an Accountable Care Organization is of great interest to psychiatric members. Universal coverage and gradual reimbursement reform will hopefully help to break down barriers to better coordinated care for patients so commonly affected by co-morbid medical/surgical and psychiatric conditions. Effective management of many chronic conditions within the constraints of finite medical resources will require nothing less.

# HVPA

# Committees



## Board of Directors

The ultimate and exclusive authority over all affairs of the Corporation is vested in the Board of Directors. The Board sets and/or approves the mission, goals, and strategic plans for the Corporation and all of the policies, procedures, financial, and other managerial directives to achieve those ends. Examples include approval of annual budgets, capital expenditures, membership applications, medical services agreements, and compensation. The Board of Directors has no authority to take any actions inconsistent with the terms of the Bylaws.

- Larry Adler, MD
- Rod Beer, MD
- Tom Dell, MD
- Paul Harkaway, MD
- Deborah Peery, MD
- Ray Rion, MD
- Michael Sanson, MD
- Rod Smith, MD
- Tom Zelnik, MD

## Performance Improvement Team

The purpose of The Performance Improvement Team (PIT) is to review, recommend, adopt and monitor IPA policy decisions and programs that enhance the operations and delivery of patient-centered, high quality, appropriate and efficient health care services by HVPA practices/members. PIT identifies, discusses and provides recommendations on matters consistent within its purview and in accordance with the overall strategic objectives of the HVPA Board

- Larry Adler, MD
- Jack Carman, MD
- Bruce Genovese, MD
- Paul Harkaway, MD- Chair
- Mike Mikhail, MD
- Kristyn Murry, MD
- Deborah Peery, MD
- Ray Rion, MD
- Michael Sanson, MD
- Rod Smith, MD
- Tendai Thomas, MD
- Kevin Taylor, MD
- David Vandenberg, MD
- Tom Zelnik, MD

## Quality & Utilization Committee

The purpose of the Quality Committee is to review, recommend, adopt, monitor, and improve IPA ambulatory quality measures and programs. These actions enhance the operations and delivery of patient-centered, high quality, appropriate and efficient health care services by HVPA practices/members. The Quality Committee identifies, discusses and provides recommendations on matters consistent within its purview and in accordance with the overall strategic objectives of the HVPA Board.

- Jack Carman, MD
- Michael DeBacker, MD
- Paul Harkaway, MD- Co-chair
- Zehra Noorani, MD
- Deborah Peery, MD
- Ray Rion, MD- Chair
- Pam Shore, MD
- Kevin Taylor, MD
- Tendai Thomas, MD

## Business & Finance Committee

The purpose of the Business & Finance Committee (BFC) is to review, recommend and obtain consensus for HVPA business/financial policy decisions and programs that support strategic goals adopted by the Board of Directors and the Performance Improvement Team (PIT). The BFC identifies, discusses and provides recommendations on matters consistent within its purview and in alignment with overall strategic objectives.

- Larry Adler, MD- Co-chair
- Bruce Cicone, MD
- Thomas Gravelyn, MD
- Sherry Jones
- Pat Neinas
- Joe O'Connor
- Deborah Peery, MD- Co-chair
- Rita Rodriguez
- Michael Sanson, MD
- Rod Smith, MD
- Robert Vartebedian, MD

### **Membership Committee**

The Membership Credentialing Committee reports directly to the HVPA Board of Directors and is charged with the responsibility of recommending the approval or denial of membership to physician applicants. The committee's peer review process examines each practitioner's primary source credentials to ensure that all organizational criteria are met before making its recommendations. An applicant's training and ability to deliver quality medical care are at the forefront of HVPA's organizational criteria in the peer review process.

- Frank Judge, MD
- Ray Rion, MD
- Bruce Stubbs, MD
- Kevin Taylor, MD

### **Office Operations Committee**

The purpose of the Office Operations Committee (OOC) is to review, recommend, develop and implement network operational policies and/or programs that support daily practice operations which promote the delivery of efficient, patient-centered health care services. The OOC identifies, discusses and provides recommendations on matters consistent within its purview (practice management) alignment with the overall strategic objectives of the Performance Improvement Team (PIT) and the HVPA Board of Directors.

- Brenda Bacon
- Amy Landingham
- Judy Lewis
- Denise Kozlowski
- Tracy O'Brien
- Deb Roberts
- Rebecca Swegles
- Kelly Tefend
- Sharon Watson

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