“Change is inevitable. Adapting to change is unavoidable.”
It’s how you do it that sets you together or apart.”

WILLIAM NGWAKO MAPHOTO
NATIONAL HEALTHCARE SPENDING TREND

We are the stewards of the healthcare system and are called upon to reduce the unsustainable growth trend in healthcare costs. **Mission 2013** points us to the target and the path to success. We will take a close look at where our efforts are making a difference, where we are falling short and where greater collaboration—with our patients and with each other—can produce greater results.
Avoidable admissions and readmissions are seen as the greatest opportunity to reduce the cost trend while enhancing quality. This is community data for Erie and Niagara County, as provided by Treo Solutions. (Numbers based on SPARCS 2010 discharge data)

15,896 POTENTIALLY AVOIDABLE ADMISSIONS
6,982 POTENTIALLY AVOIDABLE READMISSIONS

$170,000,000 POTENTIALLY AVOIDABLE SPENDING
EMERGENCY ROOM VISITS IN UPSTATE NEW YORK

There are opportunities for significant savings if a percentage of patients who make potentially avoidable ER visits instead go to a physician’s office. The potential annual savings for those with commercial insurance in Upstate New York range from $8.1 million to $10.7 million with a 5% change, and from $40.5 million to $54.5 million with a 25% change. (Based on SPARCS 2009 data)

$8.1–10.7M saved with a 5% change
$16.2–21.4M saved with a 10% change
$40.5–54.5M saved with a 25% change

702,598 POTENTIALLY AVOIDABLE ER VISITS ACROSS UPSTATE NEW YORK.

PREVENTABLE READMISSIONS BREAKOUT BY APDRG (MEDICARE POPULATION) (Based on SPARCS 2010 data)

- CHRONIC OBSTRUCTIVE PULMONARY DISEASE 15%
- OTHER PNEUMONIA 14%
- ANGINA PECTORIS & CORONARY Atherosclerosis 7%
- KIDNEY & URINARY TRACT INFECTIONS 9%
- CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS 7%
- DIVERTICULITIS & DIVERTICULOSIS 4%
- SEIZURE 4%
- SEPTICEMIA & DISSEMINATED INFECTIONS 5%
- MAJOR RESPIRATORY INFECTIONS AND INFLAMMATIONS 4%
- HEART FAILURE 31%

WESTERN NEW YORK REGION
208,141 | 44% of visits

FINGER LAKES REGION
172,870 | 43% of visits

SOUTHERN TIER REGION
38,148 | 44% of visits

CENTRAL NEW YORK REGION
127,404 | 44% of visits

UTICA/ROME/NORTH COUNTRY REGION
156,035 | 46% of visits
POTENTIALLY AVOIDABLE ER VISITS IN WNY

1. NON EMERGENT
25%
Immediate medical care was not needed within 12 hours (e.g., sore throat)

2. EMERGENT/PRIMARY CARE-TREATABLE
19%
Treatment was needed within 12 hours, but care could have been provided effectively and safely in a primary care setting (e.g., ear infection)

3. EMERGENT/ER CARE NEEDED/PREVENTABLE/AVOIDABLE
4%
ER care was needed, but patients may have been able to avoid the emergency medical issue if they had received timely and effective outpatient care while they were sick (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.)

4. EMERGENT/ER CARE NEEDED/ NON PREVENTABLE/ AVOIDABLE
7%
ER care was needed and outpatient care treatment could not have prevented the condition (e.g., trauma)

5. UNCLASSIFIABLE
45%
Emergency room visits related to injuries or mental health, alcohol and drug-related issues, among others.

$14 BILLION
COST FOR NON-EMERGENT ISSUES
THE PHYSICIAN’S OFFICE IS ESTIMATED TO BE $650-750 LESS EXPENSIVE THAN GOING TO THE ER. (COMMERCIAL POPULATION)

46% of potentially avoidable ER cases are seen during typical working hours: 9AM TO 5PM

WASTED NATIONALLY IN ONE YEAR DUE TO MISUTILIZATION

WASTED NATIONALLY IN ONE YEAR DUE TO MISUTILIZATION

Source: PricewaterhouseCoopers Health Research Institute

Sources: NYU Center for Health and Public Service Research; SPARCS 2009 data
CHAIRMAN’S MESSAGE

As we start a new year, we are being challenged to adapt to a new way of doing business, one driven by value and not solely by volume. This new population health business model enables us to share in the savings that result from reducing unnecessary medical services. To be successful in the new model, we will have to learn to work together to deliver greater value to our patients. Catholic Medical Partners is prepared for the challenge.

Mission 2013 requires us to fully embrace clinical integration, namely to work together using best practices, team-based care, technology, care coordination and other strategies to reduce the cost trend. We have set an aggressive goal of reducing the cost trend for medical expenses related to overall patient care by 2.5 percent while enhancing quality. I would like to ask each of you to think about what you and your team can do to achieve this goal. Improving access, reducing unnecessary ER visits and duplication in testing, and reducing unnecessary admissions and readmissions are all central to this effort and critical to our success.

As chairman of the Catholic Medical Partners board of directors, I want to assure you that our strategic clinical integration initiatives are working. In my office, we have hired a head Care Coordinator to lead all of our efforts in this area and have taken measures to aid in the continuity of care. Our clinical team has also embraced pre-visit planning, standard orders to address health maintenance issues and medication reconciliation, all to ensure the quality of the care we provide. Referral agreements with other providers within the Catholic Medical Partners network have helped us establish stronger relationships and improve access and data sharing. We have also taken a close look at how we can improve operationally and have targeted areas for improvements, such as seeing patients more quickly post-discharge and improving patient flow within the office.

The foundation of our high performing health system is in place, and now we must execute by understanding our clinical goals and monitoring our results. Our mission is clear and I believe success is within our reach.

THOMAS DEGRAVE, DO
BOARD CHAIRMAN
PRESIDENT’S MESSAGE

I have always relied on a simple adage in my professional life: “put yourself and your organization in the position of greatest potential to achieve your goals.” As a long-time soccer coach, I have been relentless on emphasizing to our attackers to get to the goal and to defenders to prevent the opposition from getting behind our defense. This same approach has guided me in working with our physician leadership group over the past seven years.

Our clinical integration work was designed to put Catholic Medical Partners and all of our physicians in the position of greatest potential success. It may sound trite and commonplace, but success in the future will require good old collaboration and teamwork. Integrated delivery systems have led the way in designing clinical integration programs and Catholic Medical Partners has used this knowledge in our strategic initiatives.

One of the recurring comments I hear from physicians is that they feel isolated from their colleagues, and many tell me they don’t know many of the physicians who treat their patients. “I don’t go to the hospital anymore,” and “I miss the medical staff room and the interaction with colleagues” are two of the many sentiments that have been commonly expressed to me over the years. This reality came through loud and clear in our 2012 physician survey. The three most important areas of concern for physicians in the Catholic Medical Partners network are improving the quality of care in your offices, enhancing clinical communication between physicians and advocacy with the health plans. We will continue to follow through and address the issues and concerns of our members.

Improved quality outcomes and stronger business performance do not have to be at odds with one another. In fact, I think they can go hand-in-hand. You are the leaders in this important initiative. Our policies, health plan agreements and programs are designed to provide you a framework for success. We are counting on your leadership and engagement, and we trust that our annual report will strengthen your understanding and commitment to our goals.

DENNIS R. HORRIGAN
PRESIDENT AND CEO
Our challenge is not only to improve our clinical diagnosis and treatment, but to also gain a better understanding of how to deliver care to unique individuals with different medical conditions and social, economic and educational factors that impact their health.

CHIEF MEDICAL OFFICER’S MESSAGE

Physicians are the cornerstone of the healthcare system and we have been continually learning to adapt to changes in the way that care is being delivered. Ours has become a highly specialized profession. Nurse Practitioners and Physician Assistants are now part of our clinical practices. Clinical guidelines assist us in directing our care. We are working with new populations of patients, delivering more care in ambulatory settings, and we are learning how to use health information technology to be more efficient and effective.

While we have learned new ways of delivering healthcare, and while many aspects of care have changed, the critical dimensions of medical care are unchanged: the importance of a strong physician-patient relationship, the importance of access and effective communication with patients, and the need for coordination of care. These tenets of our profession also require us to be life-long learners and to continually gain knowledge, experience and know-how. Our challenge is not only to improve our clinical diagnosis and treatment, but to also gain a better understanding of how to deliver care to unique individuals with different medical conditions and social, economic and educational factors that impact their health. Each day, we treat patients who need preventive, acute, chronic and palliative care, and most patients need care in multiple areas. In order to address the realities that face the practice of medicine in today’s environment, we, as independent physicians, all must learn how to work with other providers and our Catholic Medical Partners colleagues to deliver better and more efficient care.

I recently read a wonderful quote from a physician who stated, “In medicine, thinking is our most important procedure.” I would like to elaborate on this statement and invite you to think about how we can gain knowledge and learn to deliver care more effectively and efficiently. We recently asked more than 200 office managers and physician leaders what we need to do in order to achieve our goal of bending the cost curve in healthcare. Their suggestions are discussed throughout this report.

While focusing on themes including improved access, stronger coordination of care and avoiding duplication may seem routine, it is no less important. Being a leader in the coordination of care requires us to understand and prevent potential breakdowns in clinical care. These are critical areas that we will need to address in our clinical offices and in other healthcare settings in the coming years.
In its recently released scorecard on local health system performance, the Commonwealth Fund looked at how our region compared to the rest of the country for multiple performance indicators. While we fared well in access to care, the report did reveal areas in which our local delivery system can improve and the opportunities that exist if we are able to make those improvements. For example, we are in the third quartile for hospital readmissions and ambulatory sensitive condition admissions in New York State.

We will continue to emphasize our clinical integration programs and the necessary commitment that our members must make to move our improvement agenda forward. It is this commitment, above all else, that will define our membership as we continue on our path toward improving the healthcare delivery system.

MICHAEL EDBAUER, DO
CHIEF MEDICAL OFFICER

“Being a leader in the coordination of care requires us to understand and prevent potential breakdowns in clinical care.”

1. The Commonwealth Fund Scorecard on Local Health System Performance, 2012
NATIONAL HEALTHCARE SPENDING TRENDS

On an individual basis, per enrollee spending for commercial insurance is projected to reach nearly $8,000 by 2020, while Medicare spending per enrollee is scheduled to reach approximately $15,000 in that same timeframe. Bending those trends by 2.5 percent starting in 2013 would result in cumulative savings of $9,988 per Medicare enrollee and $5,057 per commercial enrollee.

Sources: Centers for Medicare and Medicaid Services; Office of the Actuary, August 2011 and January 2012
HEALTHCARE SPENDING TREND

To put the opportunity that bending the cost trend represents into perspective, consider what realizing this goal would mean to our organization. Catholic Medical Partners now manages more than $1.3 billion in our risk contracts. It is incumbent on us to identify and act upon ways to reduce unnecessary spending while improving quality. Our charge, as articulated throughout this report, is to reduce the cost trend within our network by 2.5 percent. This is not an easy task, but the benefit for doing so can be great. Successfully bending the cost curve by 2.5 percent starting in 2013 could translate to approximately $22 million in shared savings under our risk contracts.

STRIVE FOR 2.5

As we enter 2013, the healthcare landscape is wrought with challenges. Physicians and facilities must make the shift to a business model based on value rather than volume. Health exchanges will create a new marketplace for individual consumers who will now make health plan choices based upon cost, quality and provider networks. The work Catholic Medical Partners has done has positioned us to succeed in this new marketplace.
“The need to reduce ER visits is critical. Patients need to be better informed about when and when not to use the ER. Protocols need to be more clearly established and communicated to patients. Too many visits are related to minor infectious disease that can be treated by the primary care physician.”

THOMAS A. CUMBO, MD,
CATHOLIC MEDICAL PARTNERS
BOARD OF DIRECTORS

ER UTILIZATION

In order to be successful in Mission 2013, the Catholic Medical Partners network must zero in on the unnecessary costs across the delivery system. This unsustainable growth in healthcare costs is exacerbated by improper utilization of the system—overuse, underuse and misuse. The emergency room is a key area of attention.

In 2010, there were 208,141 potentially avoidable ER visits in Western New York, which represents 43 percent of the total ER visits across the eight-county region. That rate mirrors what was taking place across all of Upstate New York, where 702,598 ER visits, or 44 percent, were potentially avoidable.

The reasons for potentially avoidable visits included back disorder, acute upper respiratory infection, ear infection and sore throat, among others. Nationwide, this improper utilization accounts for approximately $14 billion in wasted spending each year.1

While the 24/7 nature of the emergency room setting may sometimes lead patients to visit the ER instead of their physician’s office, not all potentially avoidable ER visits were a matter of time or access. In fact, 46 percent of all potentially avoidable ER cases were seen during the typical business hours of 9am–5pm.3

1. NYU Center for Health and Public Service Research, SPARCS 2009 data 2. PricewaterhouseCoopers Health Research Institute 3. SPARCS 2009 data
A CLOSER LOOK

Looking more closely at our patient populations, the Catholic Medical Partners network experiences nearly 160 ER visits per 1,000 members with commercial insurance and slightly less than 280 ER visits per 1,000 members in our Medicare populations. If the rate of potentially avoidable ER visits holds true at 44 percent, the potential cost savings that could be realized through proper understanding and utilization of the ER are substantial, as shown in the following chart.
ADMISSIONS AND READMISSIONS

In much the same way as utilization of the ER, potentially avoidable admissions and readmissions continue to saddle the healthcare delivery system with unnecessary costs. Through our Care Transitions program, we have been able to show some success in lowering the readmission rates for patients discharged from Catholic Health hospitals. The 30-day readmission rate (all cause) for the first ten months of 2012 was 36 percent better for patients who were part of the Care Transitions program than for those who did not receive Care Transitions guidance (5.82 admissions vs. 9.13 admissions).

Overall, the acute all cause 30-day readmission rate within Catholic Health hospitals is approximately 9 percent.

The all cause readmission rate for Medicare patients within Catholic Health is 15.7 percent, according to 2010 data released by the Centers for Medicare and Medicaid Services. This is better than the New York State average of 18.7 percent and the national rate of 16.8 percent. However, there is still more work to be done.

In 2010, local hospitals experienced nearly 16,000 potentially avoidable admissions and approximately 7,000 potentially avoidable readmissions. These cases represented more than $170 million in healthcare–related spending.²

This point is emphasized when you see that the nature of many of the admissions and readmissions in question include: heart failure, chronic obstructive pulmonary disease, pneumonia and infection.

The Commonwealth Fund, in its recent scorecard on local health system performance, cited that, if our region were able to improve to the level of the top one percent of health systems, there would be 3,679 fewer preventable hospital admissions. The savings associated with achieving that benchmark is more than $30 million across the area.³

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1. The Commonwealth Fund Scorecard on Local Health System Performance, 2012
2. Treo Solutions, Inc.; SPARCS 2010 data
3. The Commonwealth Fund Scorecard on Local Health System Performance, 2012
CARE TRANSITIONS VS. NON-CARE TRANSITIONS

30 Day Readmission Rate (All Cause)

Rate Differential
- Care Transitions Program
  - 2010: 6.89
  - 2011: 7.40
  - YTD October 2012: 5.82
- Non Care Transitions Program
  - 2010: 9.04
  - 2011: 9.57
  - YTD October 2012: 9.13

Rate Differential:
- 2010: 24%
- 2011: 23%
- YTD October 2012: 36%

ACUTE ALL CAUSE 30-DAY READMISSION RATE WITHIN CATHOLIC HEALTH HOSPITALS

- Target 9%
- Mean 9.25%

Does not include readmissions to Non-Catholic Health hospitals.
# PRACTICE IMPROVEMENT

It is abundantly clear that we have come to an important crossroads in the delivery of care and that we must make the transition from innovation to execution.

Catholic Medical Partners has spent several years building an infrastructure that we believe positions our network and our members for success in the new healthcare frontier. We have made significant investments in technology and clinical integration that are designed to help our physicians practice more effectively and more efficiently. In order to curb the unsustainable cost trends in healthcare, we must now put our infrastructure and our investments to their highest and best use.

## HOW DO WE GET THERE?

Team-based care is central to our success in the population health business model. As an organization comprised of independent physicians, it is crucial that we continue to develop a mindset that acknowledges the importance of interdependency. Now is truly the time for all partners to work together to address this growing concern. At the primary care level, the strategies for preventing avoidable admissions are outlined in the following chart:¹

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>RATIONALE</th>
<th>TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDENTIFY PATIENTS AT GREATEST RISK FOR PREVENTABLE ADMISSIONS</td>
<td>Critical to maximize limited resources by targeting a select group of patients.</td>
<td>Evaluate who your high risk patients are: age, multiple Dx, multiple Rx, admissions, re-admissions, etc.</td>
</tr>
<tr>
<td>EXPAND THE SCOPE OF THE PATIENT VISITS TO ENSURE COMPREHENSIVE TREATMENT</td>
<td>Providers should leverage patient visits to address all healthcare needs, not just chief complaint.</td>
<td>Use alerts/reminders, CC Visits, previsit planning</td>
</tr>
<tr>
<td>EXPAND ACCESS TO PRACTICE</td>
<td>This gives patients more opportunity to get the answers to their healthcare questions when they want and need them.</td>
<td>Create an Open Access schedule or implement a Patient Portal.</td>
</tr>
<tr>
<td>ACHIEVE PATIENT BUY-IN TO SELF MANAGEMENT GOALS</td>
<td>Patients are more likely to achieve health targets if they play an active role in creating their own goals.</td>
<td>Care coordination, EMMI, motivational interviewing, making formal commitment to change, follow up contacts.</td>
</tr>
<tr>
<td>EMBED SELF-MANAGEMENT REMINDERS INTO PATIENTS DAILY ROUTINES</td>
<td>Patients need reminders to consistently follow maintenance regimes and to understand when further action is warranted.</td>
<td>Patient Education</td>
</tr>
<tr>
<td>RE-ENGAGE PATIENTS MISSING CARE</td>
<td>Patients missing care are at much higher risk of avoidable acute care episodes.</td>
<td>Create reports of patients not seen in one year, or missing preventive screenings and conduct outreach, previsit planning.</td>
</tr>
</tbody>
</table>

¹ As modified from “Five Primary Care Strategies for Preventing Avoidable Hospital Admissions,” The Advisory Board, 2011
## WHAT OUR OFFICE MANAGERS ARE SAYING

### Target Areas for Practice Improvement

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce ER/urgent care needs</td>
<td>25</td>
</tr>
<tr>
<td>Access to care (Communication, PCP hours, etc.)</td>
<td>18</td>
</tr>
<tr>
<td>Reduce repeated/unnecessary test</td>
<td>17</td>
</tr>
<tr>
<td>Better EHR communication/referral</td>
<td>15</td>
</tr>
<tr>
<td>Patient education</td>
<td>11</td>
</tr>
<tr>
<td>Care coordination</td>
<td>10</td>
</tr>
<tr>
<td>Patient compliance</td>
<td>10</td>
</tr>
<tr>
<td>Patient tracking/follow-up</td>
<td>10</td>
</tr>
<tr>
<td>Reduce office supplies cost</td>
<td>7</td>
</tr>
<tr>
<td>Preventive care/screening</td>
<td>6</td>
</tr>
<tr>
<td>More efficient office care</td>
<td>4</td>
</tr>
<tr>
<td>Staff training</td>
<td>3</td>
</tr>
<tr>
<td>Data analysis for managing cost</td>
<td>2</td>
</tr>
<tr>
<td>Meaningful use</td>
<td>2</td>
</tr>
<tr>
<td>Reduce repeat admissions</td>
<td>2</td>
</tr>
<tr>
<td>Rx: reduce cost</td>
<td>2</td>
</tr>
<tr>
<td>Better overall care</td>
<td>1</td>
</tr>
<tr>
<td>Reduce unnecessary specialty care</td>
<td>1</td>
</tr>
</tbody>
</table>
“Our team will be focusing on using our EHR to coordinate care with other physicians and to find ways to better engage patients in their treatment, in order to reduce the debilitating complications of Diabetes.”

TONI MURPHY, DO, CATHOLIC MEDICAL PARTNERS BOARD OF DIRECTORS

UTILIZATION

Throughout the past year, Catholic Medical Partners worked with a number of physician practices to help identify improvement areas and articulate ways in which the practices could operate more effectively and efficiently by targeting utilization issues. A total of 16 sessions were held with practices in the fields of Internal Medicine, Family Practice, Endocrinology, Cardiology and Pulmonary. The groups explored the important role an active, well-coordinated care team, including physicians, clinicians, care coordinators, facilities and patients themselves, must play in achieving our goals. Pre-visit planning, active follow-up, identifying patients with high-risk conditions, better coordination of care for patients seeing multiple physicians and improved care transitions were just some of the interventions discussed which could positively impact our network’s ability to succeed.

The participants in our practice transformation sessions outlined specific goals for reducing hospitalizations and readmissions, namely:

- Monitoring admission/readmission rates for chronic conditions, such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease and Diabetes
- Increasing hospital tracking and following up with patients, including phone calls, and scheduling appointments with primary care office within two to seven days of discharge
- Better medication reconciliation at hospital follow-up visit appointment
As a result of our practice transformation series, several practices have actively engaged their clinical teams to work on the following strategies and interventions:

### Preventive Screening
- Flu and Pneumovax vaccination
- AAA screening
- Colonoscopy
- Mammograms
- PAP Smears
- Healthcare Proxy/Advanced Directives
- Diabetic Retinal/Foot Exams
- PHQ-9 for Depression

### Access to Care/Communication
- Implementation of Care Coordination
- Offering more same-day appointments
- Building a referral relationship among primary care and specialty providers
- More pre-visit planning
- Reducing patient wait times in waiting rooms
- Reducing wait times for appointments
- Distributing more patient education materials
- Reducing outstanding labs

### High Risk Patients
- Running up-to-date registries of certain patient populations, i.e. severe COPD, high-risk CHF
- Increasing measurement guidelines such as A1c levels, BP<130/80 and LDL<100
- Increasing other testing including PFT in COPD patients and LVDD levels
- Increasing palliative care in high-risk populations

### Other Recommendations
- Increasing the use/knowledge of care coordination
- Better use of EHR technology

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**Practice Distribution of Process Improvement Area**

Our practice transformation series focused on improvement objectives in the following categories: **preventive screening, access to care/communication, readmissions** and **high-risk patients**. The following chart shows the number of participating practices that are actively working on improvement initiatives in these areas.
“Open slots for patient appointments are limited. Due to that limitation, there has been an increase in patients visiting urgent care centers, which is leading to unnecessary testing and longer time before the patients get an appointment with a specialist.”

DAVID MARTINKE, DO,
CATHOLIC MEDICAL PARTNERS BOARD OF DIRECTORS

TEAM-BASED CARE

Patient access will continue to be an area in which we will need to be diligent in utilizing the resources available to our network. As the various aspects of the Affordable Care Act take shape over the next few years, increased numbers of insured patients can put even greater pressure on the delivery system, particularly at the primary care level. Without the ability to see a primary care physician, patients will be prone to develop costly habits, such as improperly utilizing the ER or urgent care settings, or not receiving the care they need, all of which will fuel a continued increase in costs.

Efforts like Catholic Medical Partners’ office-based care coordination program, nutrition and pharmacy program have helped create a pathway for improved access. These and other programs ensure that the office visit and communication do not end when the patient leaves the office. Today, we have a total of 300 nurses working as care coordinators with our affiliated practices, and the program has recently expanded into the areas of orthopedics, pulmonary, infectious disease, neurology and behavioral health in addition to the already established programs for IM/FP, cardiology, endocrinology, OB/GYN and pediatrics. Our support of the clinical office has also grown to include social work as a resource to assist with patient psychosocial and socioeconomic issues. Our nutrition team currently works with 41 practices, representing a mix of pediatric, adult and OB/GYN practices. Catholic Medical Partners has also led the way in the Patient Centered Medical Home effort, with 35 of our practices having achieved the highest level of NCQA recognition.

Our work is showing that the effective collaboration of clinicians can be of tremendous benefit to the patient. Combining team-based care with technological developments, such as increased use of patient portals, enhances the ability to reach patients and manage their care. Such enhancements can also improve the ability for patients to see the physician more quickly when a consultation and treatment are needed, thereby preserving the high-touch nature of the primary care setting.
ACCOUNTABILITY

The work and the commitment of many physicians, clinical teams and staff members throughout many years made it possible for Catholic Medical Partners to achieve an important organizational goal in a year which we dubbed the Era of Accountability. In April 2012, Catholic Medical Partners was one of 27 organizations from across the country chosen to participate in the Medicare Shared Savings Accountable Care Organization (ACO) program. This accomplishment provides our network with an opportunity to move our community closer to realizing the goals of true healthcare reform—improved quality, improved patient experience and lower costs.

Inasmuch as our recognition as an ACO was a transcendent moment in our organization’s history and the culmination of years of hard work, it marked an important beginning and a call to action. To realize our vision, we must continue to foster a culture of accountability—accountability to the principles of our organization, accountability to and for our patient populations and accountability to one another.
"When referring to a Cardiologist, we make sure that the patient has a copy of their lab work, an EKG if it was done recently, the most recent progress note, and any other pertinent information in an envelope as they leave their appointment with us to bring with them to their new appointment with the Cardiologist. Communicating with our patients in this way has helped maximize efficiency and minimize confusion.”

DAVID CLIFFORD, MD, CLIFFORD FAMILY PRACTICE

COMMUNICATION

The key to making important enhancements is communication—within the office, between providers and with patients. To help our physicians demonstrate success in the accountable care framework, we have taken important steps to build upon Catholic Medical Partners’ greatest strength and to create greater connectivity between our physicians. Our referral agreement initiative was introduced to not only generate a better understanding among our membership of who your partners are within the Catholic Medical Partners network, but to also engage physicians in meaningful dialogue on how primary care physicians and specialists can work together within our network to coordinate and deliver quality care and needed services to your patient populations. Such interactions can not only benefit your patients, but your practice and our entire network. Simply put, referral agreements are where the rubber meets the road in terms of communication and coordination between physicians.

We have also made significant investments in technology to help foster the effective and efficient exchange of clinical information between physicians. Catholic Medical Partners continues to lead the way in adoption and use of Electronic Health Record (EHR) technology, with more than 90 percent of our members using EHR systems in their practice. Furthermore, more than 300 practices have successfully met the Meaningful Use standards set forth by the Centers for Medicare and Medicaid Services (CMS). Incorporating the use of EHR technology into your clinical approach has fostered increased communication between physicians. This widespread adoption of technology has been further enhanced by the development of a process which allows physicians to make referrals between EHR systems that can include electronic documents such as the C62 (e.g., progress notes, consult reports or images) and the Continuity of Care Document (CCD).

KEY COMPONENTS OF A CCD

- Summary
- Functional Status
- Family/Social History
- Problems
- Allergies, Adverse Reactions, Alerts
- Medications
- Immunizations
- Vital signs
- Test Results
- Procedures
- Advance Directives
- Plan
ELECTRONIC REFERRALS

The CCD can include up to 18 components of a patient’s medical summary. The use of the CCD saves time for the receiving physician, allowing them to receive pertinent data instantaneously. Updated information is then sent back to the primary care physician, thereby closing the referral loop. This ensures that all of the patient’s physicians can be on the same page regarding patient history and treatment, helping to improve the efficiency and quality of the care provided. The exchange of CCDs and C62s among area providers has continued to increase.

ELECTRONIC REFERRAL RECORDS EXCHANGED IN 2012

Among 600 Medent users and physicians involved in interoperability test phase for e-ClinicalWorks/Allscripts
"The referral agreement process has most importantly improved our communication between specialists and primary care physicians, with the patients being the beneficiaries. Our relationship with Dr. Aravind Herle’s practice is such an example.

They have provided our group with a call in number that links us into their physician provider responsible for urgent primary care concerns in patient management for that particular day. Just recently, we had a patient who, in our clinical judgment, needed an urgent angiogram to assess him for coronary artery disease. In one phone call, we had him seen, with the angiogram being scheduled. End result: left main coronary artery disease, ‘the widow’s artery,’ with successful bypass surgery and a life saved.

Certainly not all patients need to be seen urgently. However, having access to an expert opinion to either change therapy or expedite a workup has improved patient quality, satisfaction, and has ultimately led to better outcomes.”

THOMAS DEGRAVE, DO, ORCHARD PARK FAMILY PRACTICE
“The Care Coordination program in our office has allowed us to provide even higher quality care, connecting more frequently with our patients, home nursing, and primary care physician offices. It has definitely kept a few of our high risk heart failure patients out of the hospital over the last several months and has even spurred on the development of an internal quality assurance committee. My referral agreement with Dr. Thomas DeGrave and direct conversation about our complementary roles, has led to efficient and enlightened care of some complex patients who required coronary angiography and cardiac surgery.”

ARAVIND HERLE, MD, CARDIOLOGY GROUP OF WNY, CHIEF OF CARDIOLOGY, MERCY HOSPITAL OF BUFFALO
“We cannot let patients with chronic conditions slip through the cracks. One of the key strategies we will be working on in my practice is the aggressive management of heart failure patients in order to help reduce readmission rates.”

JAMES RYCYNA, MD, CATHOLIC MEDICAL PARTNERS BOARD OF DIRECTORS

CHRONIC CONDITIONS

As important as our efforts are to work collaboratively and communicate with physicians and clinical team members, it is equally important to work and communicate with patients, particularly the high-risk population.

Chronic health conditions continue to be a major driver of healthcare costs nationwide. Statistics show that all cardiovascular disease in the United States costs $273 billion each year, and those expenditures are expected to triple to $818 billion by 2030. Consider also that Congestive Heart Failure results in 12–45 million office visits and 6.5 million hospital days each year. For Diabetes, the direct medical costs total $116 billion each year. More than $100 billion is spent on obesity medical and related costs.

To strengthen our approach to helping our practices and their patients manage chronic conditions, our NCQA-accredited Disease Management program has now been delegated to ten practices, with additional practices preparing for delegation. The cornerstone to the program is individualized goal setting and patient education. As a result of this patient-centered approach, our Disease Management program is showing significant improvement in helping patients manage chronic conditions such as Diabetes, Congestive Heart Failure and Coronary Artery Disease.

The charts on the following page reflect the work of the following Disease Management practices since 2009: Erickson and Erickson, DO, Family Care Physicians, PC, Lakeshore Primary Care Associates, Orchard Park Family Practice, Sheridan Drive Medical Group, LLP, and Southgate Medical Group, LLP.

QUALITY MEASURES FOR DIABETES
- Percentage of Patients with BP <130/80
- Percentage of Patients with A1c <7
- HbA1c Not tested/No discrete data

Approximate No. Diabetes = 5,000, CHF=700, CAD=3,000
PATIENT ENGAGEMENT

Our patient populations must not only see themselves as active partners in the care our physicians provide, but they must also, with the support of the clinical team, adopt healthy behavior patterns.

The costs of non-adherence among patients are equally as staggering as the costs associated with chronic conditions. A report published by the Patient Centered Primary Care Collaborative (PCPCC) in June 2012 stated that more than 3.5 million prescriptions are written in the United States each year and that four out of five patients leave their physician’s office with at least one prescription. In fact, medication is involved in 80 percent of all treatments, according to the PCPCC report. Yet, studies have consistently shown that 20-30 percent of medication prescriptions are never filled and that approximately 50 percent of medications for chronic disease are not taken as prescribed. The consequences for poor adherence to medication management are poor health outcomes and increased healthcare costs. Non-adherence has been estimated to cost the U.S. healthcare system between $100 billion and $289 billion annually.

According to the Commonwealth Fund’s local scorecard, 28.3 percent of adults age 18–64 in our region are obese, as defined by having a Body Mass Index greater than or equal to 30, placing them at risk for additional complications and chronic conditions. Estimates show that, in New York State, if residents who are classified as obese lowered their BMI by five percent by 2030, the cost savings from lower rates of obesity-related diseases would be approximately $40 billion.

Catholic Medical Partners understands that an educated and involved patient population is essential to achieving our clinical goals. By providing practices and patients important resources, we have been able to more fully engage patients in their care. The charts to the left highlight the impact our Nutrition/Pharmacy clinics have been able to demonstrate in helping patients with Diabetes improve several key quality measures.

OUR MISSION STARTS HERE

Catholic Medical Partners remains committed to improving healthcare in our community. Our path is designed to assist physicians in adapting to new ways of practicing and to adopt new technologies and care models, as well as to challenge patients to become educated, active and responsive partners in their own health. After all, our ultimate purpose is to help people in Western New York live healthier lives, and, in doing so, to build a more effective and efficient delivery system in our community.

We will succeed in accomplishing our mission through the leadership of our physicians, whether a primary care physician, pediatrician or specialist, office-based or hospital-based, solo practitioner or part of a group practice. We will accomplish our mission in collaboration with each other and with our partners at Catholic Health and Mount St. Mary’s Hospital. We will accomplish our mission through the implementation of technology and the use of evidence-based medicine. We will accomplish our mission because, together, we understand that bridging the gap in healthcare will lead us all to higher ground.

We will accomplish our mission.
We are Catholic Medical Partners.
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