The 2015 Value Report

Reporting on 2014 Results

Advocate Physician Partners

Letter from the CEO

Advocate Physician Partners (APP) is pleased to present the 2015 Value Report. Our accomplishments in 2014, as well as our blueprint for success in the years ahead, demonstrate how we are even more committed to creating value by delivering quality outcomes in a cost effective manner for patients.

More than 4,800 employed and aligned physicians throughout the Chicago area and Central Illinois partner with APP to improve health care quality, build lifelong relationships with patients, and reduce the overall cost of care. APP's efforts are linked with those initiatives identified by government and private payers that can successfully transform the health care system in the U.S.

In 2014, the state of Illinois implemented mandatory managed care enrollment for the Medicaid population. Advocate Accountable Care, APP's accountable care entity (APP ACE), was launched as a strategy to ensure Medicaid patients could continue to see our physicians and visit our hospitals. One in five patients served by Advocate, over 150,000 patients annually, is covered by Medicaid. Half of all newborn deliveries and over half of the payer mix of Advocate Children's Hospital are patients on Medicaid. As enrollment continues to grow, APP has the potential to impact the health of over 100,000 Medicaid beneficiaries in the Chicagoland and Central Illinois regions.

APP's ACE brings us closer to a single model of care for patients that positions us to better manage cost and quality, while aligning with Advocate's faith-based mission of serving the health needs of all individuals, families, and communities.

I am pleased to report that APP continues to demonstrate high levels of performance in quality and efficiency metrics through the nationally-recognized Clinical Integration (CI) Program. As the market focuses on creating value, payers will desire to align products and plans with physicians and health systems that have a proven track record of delivering value to patients and employers. These high-performing networks, such as APP, are critical for the future of value-based care models.

APP has also been an active participant in Advocate Health Care's Culture of Safety, a system-wide effort that fully realizes our commitment to being a high-reliability organization in every setting. By developing a culture where patient safety is a top priority, APP has created transparency, accountability, and measurable value. We continue to improve safety and outcomes through working with our member physicians to implement innovative approaches to managing the entire patient population we serve.

We hope you find this year's Value Report informative and thought-provoking, and we welcome the opportunity to share our programs with you.

Sincerely,

Lee B. Sacks, MD
CEO, Advocate Physician Partners
Executive Vice President, Chief Medical Officer
Advocate Health Care

Letter from the President

Advocate Physician Partners (APP) continues to be recognized as a market leader while navigating the challenges of the ever-changing health care landscape. We work with our member physicians and hospitals to develop innovative programs that improve outcomes, safety, and the patient experience.

APP again achieved outstanding results in all areas of our Clinical Integration (CI) Program in 2014, while the number of patients in our chronic disease registries increased by 38 percent. The implementation of our fourth generation registry resulted in better identification of patients from multiple data sources, and proved to be a tool that was easier for our physicians and office staff to use to drive performance.

Also in 2014, APP expanded support for our physician members by launching a field operations team to engage with practices in-person. Through monthly meetings, a dedicated team of field advisors review complex topics with APP practices and provide additional assistance as required. Most importantly, the team of nearly 30 field advisors helps APP physicians apply key learnings to everyday operations in their practices. Physicians have appreciated this more personalized approach.

We specifically want to acknowledge the significant impact of the Advocate Sherman Hospital physician-hospital organization (PHO) in 2014, as it achieved a score comparable to the established network, and attained the highest first-year CI score of any new APP site. These results were enabled and achieved more quickly than anticipated by use of the new registry tool and support from the field operations team. Last year, we announced a new clinical affiliation with Silver Cross Hospital in New Lenox, Illinois. Silver Cross Hospital and physicians are participating in the CI program beginning this year and will benefit from these same investments.

We continue to invest in population health strategies to further identify gaps in quality and efficiency and link more tailored interventions to individuals in our population. As we move deeper into risk-based contracts and the Medicare Advantage market segment in particular, we will be required to offer more innovative solutions for data sharing, care management models, and access to care.

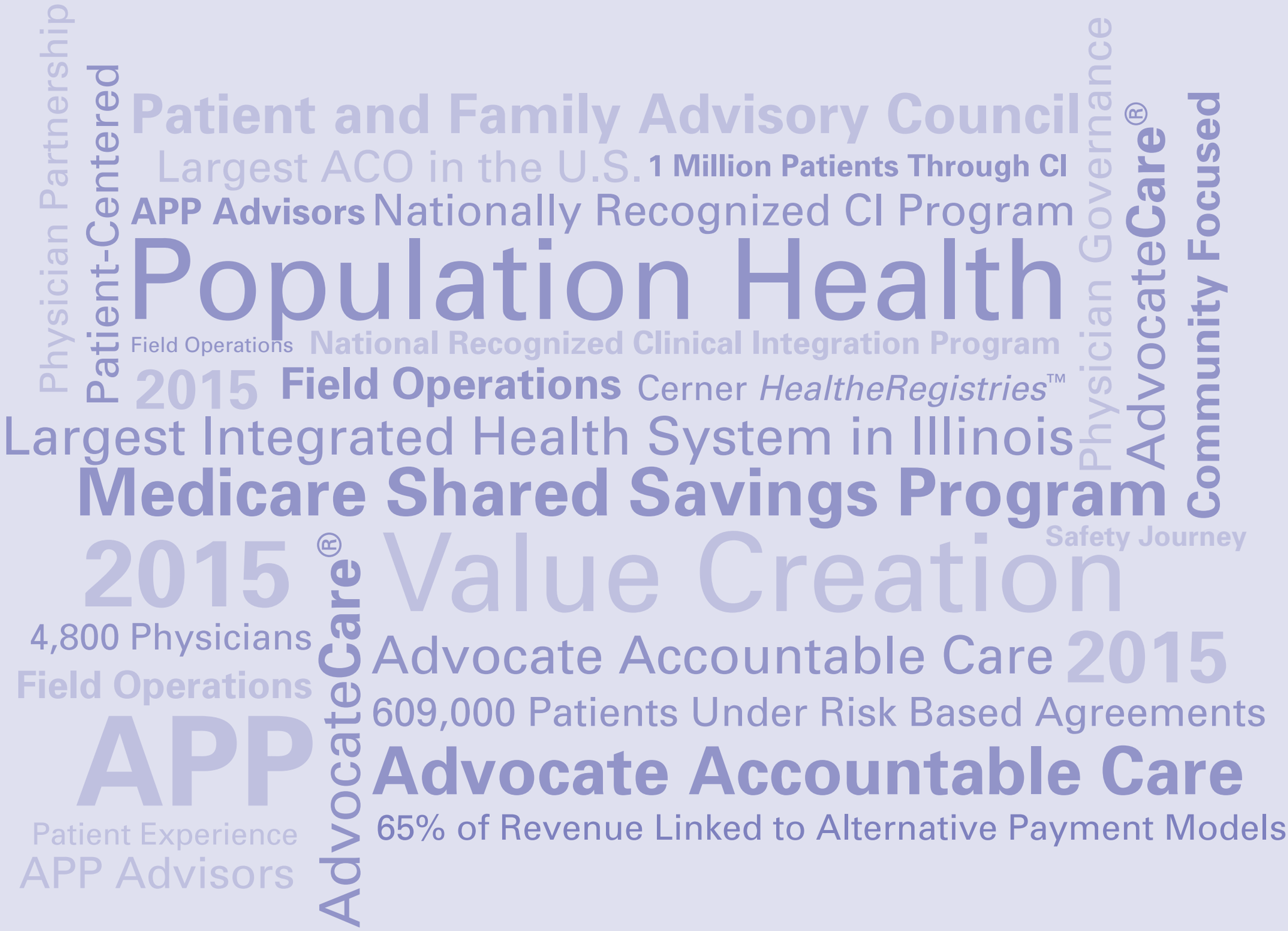
In the pages that follow, we share our 2014 results and highlight some of the ways we have made noticeable progress in transitioning from a culture of pay-for-performance to pay-for-value.

We value the partnerships we have developed throughout our journey and look forward to the challenges ahead.

Mike Englehart
President, Advocate Physician Partners

APP's vision—to be the leading care management and managed care contracting organization.

visited on 8/14/2015



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The Evolution of Clinical Integration

Pankaj Patel, MD
Senior Medical Director
Advocate Physician Partners

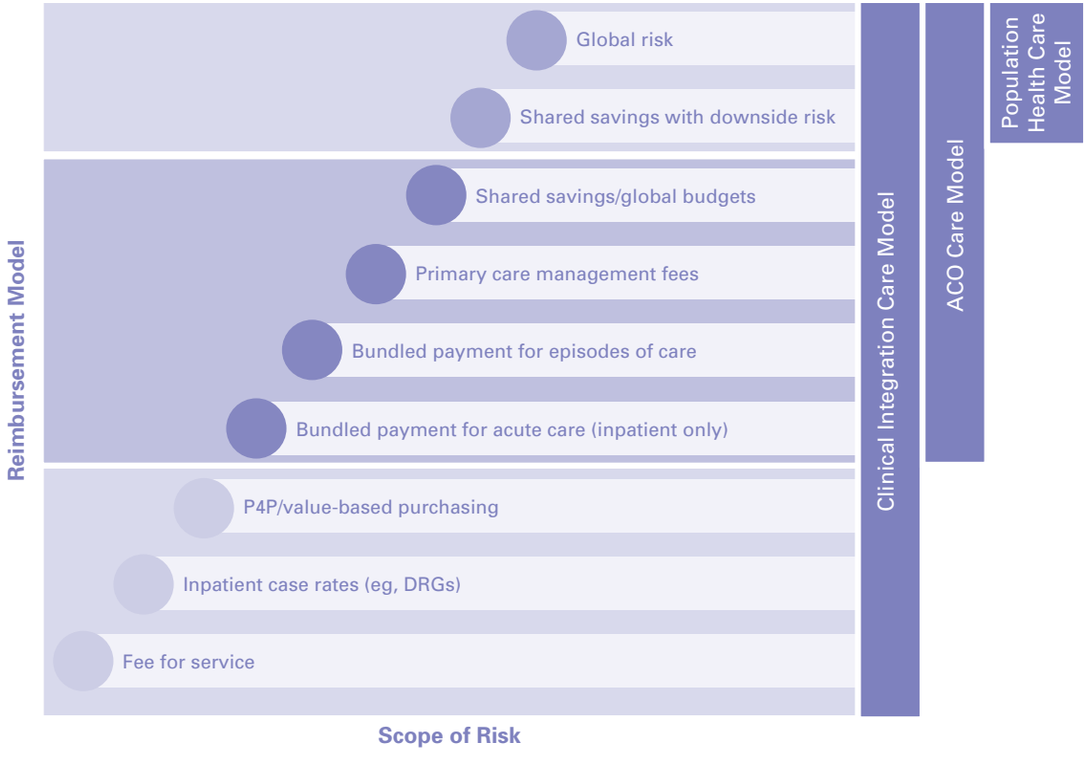
From its inception in 2004 to today, Advocate Physician Partners (APP) has continued to evolve as a national leader in clinical delivery system redesign and innovation.

The Clinical Integration (CI) Program remains core to APP operations as the vehicle for physicians and hospitals to collaborate and improve quality and efficiency for all patients, regardless of their benefit plan.

With over 1 million patients currently benefiting from the program, APP has demonstrated that a physician-hospital organization (PHO) with over 4,800 employed and aligned physicians and 12 hospitals can together reduce costs while improving health outcomes.

This nationally-recognized program is the foundation of the progression to value-based contracts with Medicare, Medicaid, and commercial payers.

Evolving APP Value-Based Contract Structures



Over 1 million patients currently benefit from APP's CI Program.

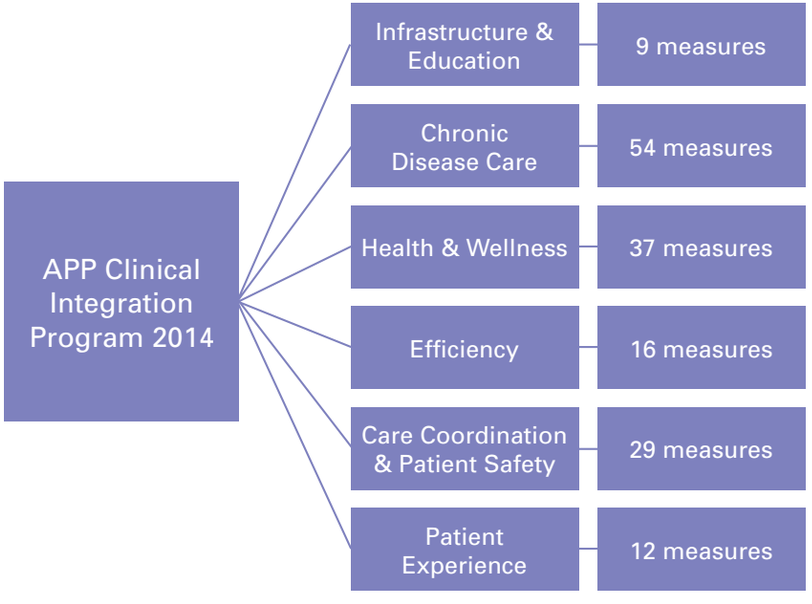
Clinical focus has expanded beyond management of subpopulations of patients with specific diseases and conditions towards optimal management of entire populations. This has placed added focus on health and wellness, patient safety, and coordination of care along the continuum of clinical need. APP's overarching priority is to support physicians in providing:

- Safe care, free of avoidable harm;
- Primary and secondary prevention to avoid disease where possible;
- Early detection and management of patients who develop unavoidable chronic diseases.

The CI performance metrics are built on the standards set by industry leadership groups including the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), the Agency for Health Care Research and Quality (AHRQ) and the American Medical Association (AMA), among others. The program is also market-sensitive and includes measures recommended by health plans and employer groups in Chicago. These measures represent local health priorities that have significant impact on absenteeism and lost days from school. Most health plans use APP's common set of performance metrics. This allows for more reliable feedback to physicians and the health plans as it includes performance related to the majority of their patients rather than a subset of patients based on their specific health plan. This has created a clear focus for physicians and helped to prevent duplication of efforts.

APP continues to broaden its scope and depth by adding new performance metrics relevant to advancing primary and specialty care as well as hospital and organizational goals. There are currently over 100 clinical performance metrics that fall in one of six domains: Infrastructure & Education; Chronic Disease Care; Health & Wellness; Efficiency; Care Coordination & Patient Safety; and Patient Experience.

Clinical Integration Program Structure



New metrics are added every year after a thorough vetting process that includes an assessment of their impact on morbidity, mortality, costs, and patient experience. Metrics are tested to assess data integrity and validity, detailed operational definitions are developed, and strategies to provide clinical support to clinicians are created before a communication plan is shared with all physicians prior to the measurement year.

More recently, APP has included performance metrics that relate to the health experience of defined commercial and Medicare populations. This requires a higher degree of collaboration and teamwork.

The focus on continuous quality improvement leads APP to raise performance standards annually. APP continues to achieve top decile and top quartile performance in many areas when compared to available national benchmarks.

NCQA Benchmarks
90th Percentile

Diabetes Performance Measures	2014 APP Performance*	2014 NCQA The State of Health Care Quality Published Results		
		NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
Age < 65 years Hypertension Control < 140/80 mmHg	70.60%	56.80%	47.10%	——
Age < 65 years Hypertension Control < 140/90 mmHg	87.80%	78.10%	71.30%	——
Age < 65 years HbA1c < 8%	65.60%	69.30%	63.70%	——
Age < 65 years HbA1c > 9%	23.60%	19.00%	25.50%	——
Age < 65 years LDL < 100 mg/dL	57.40%	57.10%	50.90%	——
Age < 65 years Nephropathy Monitoring	92.00%	91.20%	85.40%	——
Age ≥ 65 years Hypertension Control < 140/90 mmHg	90.20%			72.70%
Age ≥ 65 years HbA1c < 8%	77.50%	——	——	75.90%
Age ≥ 65 years HbA1c > 9%	14.00%	——	——	15.20%
Age ≥ 65 years LDL < 100 mg/dL	69.30%	——	——	63.50%
Age ≥ 65 years Nephropathy Monitoring	95.40%	——	——	92.40%

Cardiac Performance Measures	2014 APP Performance*	NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
IVD/CAD Age < 65 years LDL < 100 mg/dL	63.70%	71.00%	61.60%	——
IVD/CAD Age ≥ 65 years LDL < 100 mg/dL	68.60%	——	——	66.40%
HBP Age < 65 years BP Measurement	96.50%	76.90%	67.30%	——
HBP Age ≥ 65 and ≤ 85 years BP Measurement	97.00%	——	——	74.40%

COPD Performance Measures	2014 APP Performance*	NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
COPD Age ≥ 40 and < 65 years Spirometry Testing	74.50%	56.90%	48.50%	——
COPD Age ≥ 65 years Spirometry Testing	73.20%	——	——	46.40%

Adult/Senior Wellness Performance Measures	2014 APP Performance*	NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
Age < 65 years Body Mass Index	94.60%	92.20%	78.60%	——
Age ≥ 65 years Body Mass Index	96.50%	——	——	94.40%
Age ≥ 65 years Screening for Future Falls Risk	75.10%	——	——	66.30%

NCQA Performance Measures

APP Performance for all patients exceeds NCQA population specific benchmarks

*2014 APP Performance
Age < 65 years includes commercial HMO and PPO
Age ≥ 65 Includes MSSP, MA, HMO and PPO

Cancer Screening Performance Measures	2014 APP Performance*	NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
Age 50 – 65 years Mammogram Screening	82.10%	82.00%	75.70%	——
Age ≥ 65 years Mammogram Screening	82.50%	——	——	80.10%

Pediatric Wellness Performance Measures	2014 APP Performance*	NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
Age 3 – 17 years Body Mass Index	95.60%	86.90%	63.40%	——
Age 3 – 17 years Nutrition Assessment and Counseling	89.20%	83.90%	68.80%	——
Age 3 – 17 years Physical Activity Assessment and Counseling	89.90%	81.00%	63.20%	——

Childhood Immunizations Performance Measures	2014 APP Performance*	NCQA 90th Percentile Commercial HMO*	NCQA 90th Percentile Commercial PPO*	NCQA 90th Percentile Medicare PPO*
Rotavirus Vaccination – by Age 2	91.60%	88.10%	84.20%	——
Hepatitis A Shot – 1 vaccination by Age 2	89.30%	91.70%	88.90%	——

NCQA Benchmarks
75th Percentile

Performance Measures	2014 APP Performance*	2014 NCQA The State of Health Care Quality Published Results		
		NCQA 75th Percentile Commercial HMO*	NCQA 75th Percentile Commercial PPO*	NCQA 75th Percentile Medicare PPO*
Diabetes Age < 65 years Annual Eye Exam	57.80%	66.70%	52.20%	——
Diabetes Age < 65 years LDL Screening	85.00%	87.80%	84.70%	——
Diabetes Age ≥ 65 years Annual Eye Exam	71.00%	——	——	72.20%
Diabetes Age ≥ 65 years LDL Screening	89.40%	——	——	90.60%
Diabetes < 65 years HbA1c Test	91.10%	92.70%	90.00%	——
Diabetes ≥ 65 years HbA1c Test	94.70%	——	——	93.60%
IVD/CAD Age < 65 years LDL Screening	83.00%	89.60%	86.00%	——
IVD/CAD Age ≥ 65 years LDL Screening	82.60%	——	——	91.00%
Age 50 – 65 years Colorectal Cancer Screening	62.40%	69.70%	60.70%	——
Age ≥ 65 years Colorectal Cancer Screening	70.50%	——	——	67.70%
Combo Rate 3 Series of Immunization by Age 2	81.40%	82.80%	76.60%	——
Hepatitis A Shot – 1 vaccination by Age 2	89.30%	88.50%	84.50%	——

NCQA Performance Measures

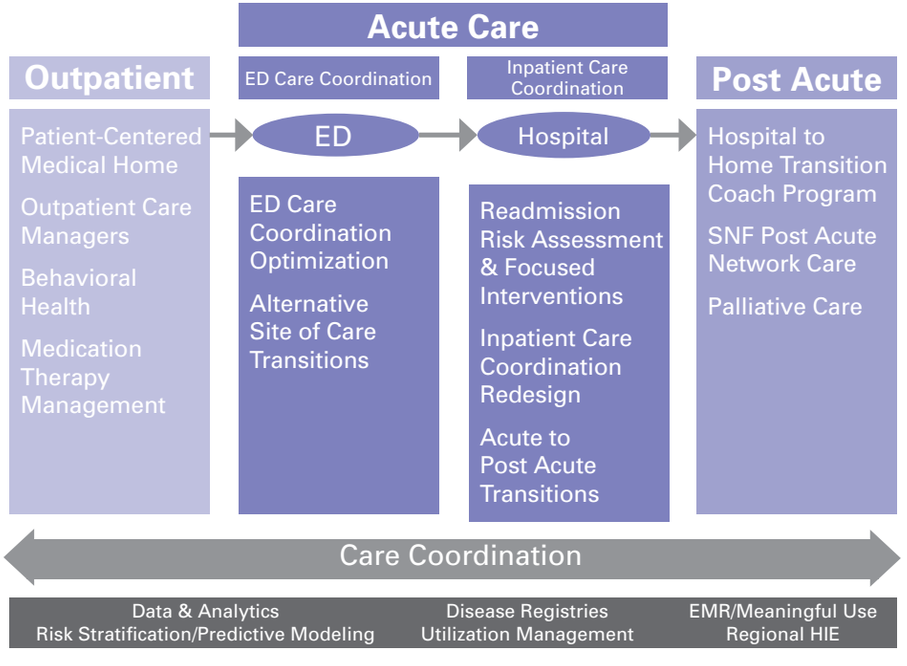
APP Performance for all patients exceeds NCQA population specific benchmarks

*2014 APP Performance
Age < 65 years includes commercial HMO and PPO
Age ≥ 65 Includes MSSP, MA, HMO and PPO

Over the last year, an APP interdisciplinary committee and work groups with clinical content experts developed several streamlined clinical practice guidelines (CPGs) and point-of-care protocols for common conditions. Patient self-management tools consistent with these CPGs were established to increase a patients' level of engagement from monitoring to self-management. Several online continuing medical education accredited programs were developed that highlight the use of CPGs, point-of-care protocols, and patient self-management tools.

Advocate Health Care's coordination model, Advocate**Care**®, establishes critical links between inpatient, skilled nursing, ambulatory, and home care. Transitions represent one of the most common causes of avoidable errors in health care. Details of this model are described later in this report.

Advocate**Care**® Programs Across the Continuum



An essential component of population health management is to address unmet clinical needs. These unmet needs may be a function of patients who are not seeking care, delaying care, or have not attained agreed upon clinical goals. APP's patient outreach program encourages patients to access needed services. This program includes both mail and telephonic reminders. In 2014, over 500,000 such reminder efforts were made to both commercial and Medicare insured patients. Outreach materials are reviewed and approved by physician members of APP's Quality Improvement and CI Committee.

There is recognition that traditional physician offices are not conducive to the optimization of population health management. APP has committed significant time and resources to help practices re-engineer functions to improve access, better coordinate care across sites and clinicians, and standardize approaches to clinical care while fully considering patient preferences and values. These enhanced functions represent standards recommended by NCQA towards patient-centered medical home certification. An extension of this process has been to better integrate behavioral health care in primary care physician (PCP) offices. This system-wide initiative has led to the development of a primary care and behavioral health specialist co-located pilot hub in Chicago's south region. Local PCP practices may access needed services and consultations from this hub and will soon have telemedicine capabilities. A similar hub is planned for Chicago's north region in 2015.

The CI incentive system is an important catalyst for improvement that has been structured to relate to contemporary understandings of behavioral economics, loss aversion, and peer pressure. Pay-for-performance has moved to pay-for-value contribution for PCPs and specialists.

APP's focus on evidence-supported care, coordination of care along the continuum of clinical need, prevention and management of chronic disease, and pursuit of benchmark performance levels results in fewer medical errors, improved patient outcomes, reductions in employee absenteeism, and reduced health care costs.

Patient Registry: Enhancing Care at the Point of Delivery

Population health management requires new health information systems and analytic capabilities. In 2014, APP transitioned to a new, robust integrated patient registry system that supports full population health management. APP has set a roadmap to integrate multiple data sources, improve tools to measure outcomes, and impact care at the point of delivery.

In 2013, Advocate Health Care became a developmental partner with Cerner Corporation to create Cerner *HealtheRegistries*™. The registry system is built on the Cerner *HealtheIntent*™ platform, which will also serve as the foundation for new solutions. The platform collects and normalizes clinical and administrative (eligibility, claims, etc.) data to enable a view of patient activity across the care continuum. *HealtheIntent*™ integrates over 60 clinical and transactional sources of information, aggregating patient data across all sites of care. The platform also offers better mining of these data sources to identify patients with chronic illness. Once identified, these patients are included in the appropriate registries and programs.

The registry system incorporates tools to track key measures of health and wellbeing of large populations, which has become essential as the number of patients included in APP's registries has grown. The total number of unique patients in the chronic disease registries increased by 38 percent from 2013 to 2014.

In collaboration with Cerner Corporation, Advocate developed several new analytic capabilities. To drive improvements in specific preventive clinical interventions, tools were created to help segment populations based on clinical needs, and predict the risk of hospital readmissions and falls in hospitalized patients.

Chronic Disease Registry	Total Unique Patients 2013	Total Unique Patients 2014	% Change
Asthma	223,973	309,035	38.0%
COPD			
CHF			
Hypertension			
Diabetes			
IVD/CAD			

Diabetes Registry

2010
HMO & PPO
20,007

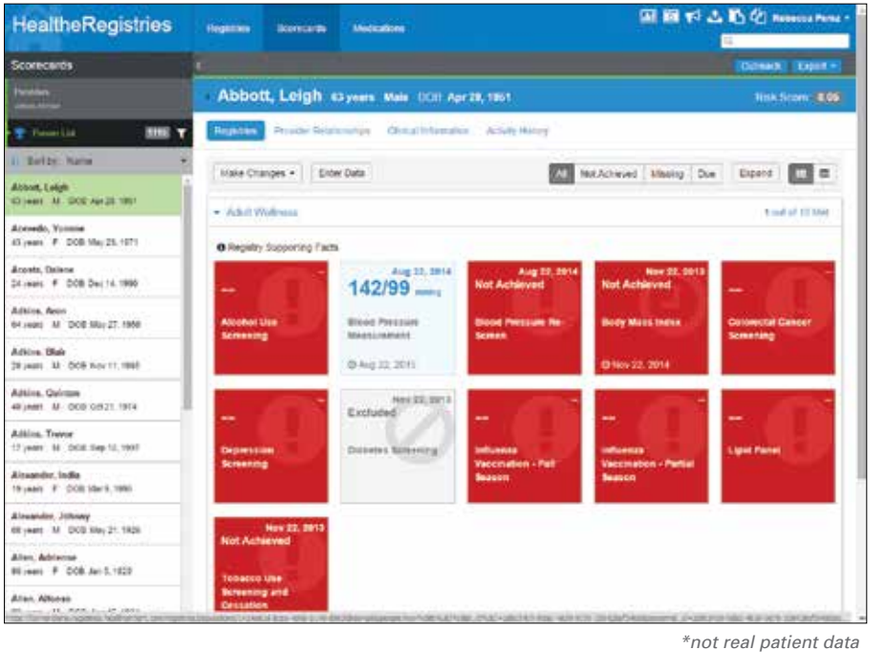
2014
HMO, PPO, MSSP, MA,
MMAI, EPO
43,746

one person = 1,000 people

As population size in the registry increases, physicians are provided with a comprehensive view. This enables physicians to manage these larger populations with better analytic capabilities. Registries include patients seen in physician practices as well as those assigned or attributed to physicians through value-based contracts. APP physicians see their population as not only those patients they treat for illness but also those patients who do not seek care.

Through the *HealtheIntent*™ platform, the registry system pulls data on a daily basis from multiple inpatient and ambulatory electronic medical records. In 2014, real time performance feedback resulted in more proactive care and performance targets being achieved six to 10 weeks earlier in the year. Patients received needed interventions sooner and physicians were able to reach out to patients to develop plans of care or link them to care management programs.

By providing performance feedback and a view of the unmet care needs of all patients, APP encourages patient engagement and proactive management.



*not real patient data

Next generation IT tools support patient engagement and proactive health and wellness management.

Enterprise Master Person Index: Ensuring Data Integrity

APP is leading the Advocate Health Care system initiative to create a trusted source for a reliable enterprise master person index (EMPI). EMPI is the connection between various data sources that contain patient information and clinical records. The EMPI system identifies unique patients and links their records from all sources together. This enables Advocate to collaborate with the Metropolitan Chicago Healthcare Council Exchange. An accurate EMPI may be considered the most important resource in a health care setting as it links an individual's activity within an organization and across the continuum of care.

visited on 8/14/2015

Advocate Safety Journey

In 2011, leaders across Advocate Health Care came together to develop a strategic plan for patient safety. Advocate has set an impactful goal to eliminate all patient safety events resulting in serious harm by the year 2020. Advocate remains firm in its commitment to create the safest and best place for patients to heal, physicians to practice, and associates to work. Since beginning the safety journey, Advocate has made significant progress toward this goal. The first step was to develop a culture where associates and physicians felt comfortable reporting safety issues and near misses without reprimand. In 2014, Advocate saw:

- Completion of a 12-part leadership training series on high-reliability health care
- Increase of 66 percent in the reporting and identification of serious safety events
- Increase of 320 percent in identification of serious safety events through peer review

Advocate established a serious safety event baseline in 2014 to measure progress towards zero serious safety events. The goal in 2015 is to reduce serious safety events by 20 percent while also ensuring that reporting continues.

APP plays an essential role in supporting safety by creating high reliable data, tools, and processes for physicians to coordinate patient care. Two areas of focus in 2014 included identifying medications with high rates of adverse reactions and ensuring safe transitions through care management.

High-Risk Medications

Medications play an essential function in improving health and treating disease. Some are known to have side effects, including drug-to-drug or drug-to-disease interactions, and may even cause potentially serious safety concerns in certain populations. APP has previously highlighted programs such as medication reconciliation and medication therapy management as ways to prevent complications.

Authorities, including academic institutions, have identified medications with high rates of adverse reactions, especially in older patients when measured at the population level. These are referred to as "High-Risk Medications" or HRMs.

Over the last two years, APP has actively engaged prescribers in an effort to bring awareness to HRM prescribing and to encourage the utilization of equally effective, yet safer therapeutic alternatives. Tactics include quarterly outreach to prescribers identifying patients who have been prescribed HRMs, and regularly scheduled discussions at group and one-on-one physician meetings.

These efforts have resulted in changes to prescribing patterns of HRMs in the Medicare Shared Savings Program (MSSP) and Medicare Advantage populations. For example, nearly 30 percent of oral sulfonylurea prescription claims were for a glyburide-containing product (considered an HRM in the elderly) in the 4th quarter of 2012. In the 3rd quarter of 2014, glyburide claims decreased by nearly 14 percent. Similar results have been demonstrated for several other targeted HRMs.

APP has taken these efforts to the next level by introducing a new HRM prescribing measure to the CI Program in 2015. This measure will highlight HRM prescribing for physicians and will result in reduced adverse events.

Care Management Across the Advocate Health Care Continuum

The traditional model of health care delivery is fragmented. Historically hospitals, physicians, and post-acute providers have focused predominantly on the care needs of the patient in that setting. Advocate's 2020 vision for coordinated care is meant to ensure safe transitions across all settings of care.

To accomplish this objective, Advocate has designed an enterprise care management approach which includes: Outpatient Care Management, Emergency Department (ED) Care Management, Inpatient Care Management, and Post-Acute Care.

- **Outpatient Care Management:** A traditional PCP practice team does not have a dedicated role to coordinate care for high-risk patients. Through APP, every PCP has an assigned outpatient care management resource. APP has close to 100 care managers, social workers, and other staff in the field to support patient care.

  These individuals work with patients to identify and address social, financial, educational, and other barriers to care. The outpatient care management staff provides inter-visit management, serving as a trusted bridge between the patient and care team. Custom care plans are developed based on patient preferences, values, and capabilities. The care managers focus on enhancing patient knowledge, behavior change, adoption of self-care techniques and care navigation. They work with over 18,000 patients annually have an average daily census of close to 10,000 high-risk patients.

- **ED Care Management:** Patients today may seek care at the ED because they do not have a PCP, lack health insurance, or because it is perceived to be more convenient. Some patients can become frequent utilizers of the ED, leading to higher and unnecessary costs. Often times, these patients can be treated in more appropriate care settings like a physician office or an immediate care center. Educating patients on the appropriate use of the ED benefits the patient through reduced out-of-pocket costs (ED copays are typically higher than office visits), but more importantly, improved follow-up care and long-term condition management by their PCP.

  ED care managers work with the ED physicians and hospitalists to consider the appropriateness for admission and alternate sites of care. Care managers may work with patients and families to better understand community resources available to them (home care, nursing home) at the time of the ED visit to avoid being admitted to the hospital.

- **Inpatient Care Coordination Redesign:** The first few days after a patient is discharged from an inpatient setting are the most critical in preventing a readmission. It is during this time that patients and their family/caregivers assume greater responsibility in the healing and recovery process. Critical questions for the inpatient care management team prior to discharge are (1) What is the most appropriate care setting? and (2) Does the patient and family understand the care plan as communicated to them? Advocate has designed tools to aid inpatient care managers in identifying the setting of care most appropriate for each patient and those at the greatest risk for readmission. When a patient is determined to be at high risk for readmission, they are provided with disease-specific education and detailed discharge instructions related to follow-up care and medications. As a result, Advocate has experienced a 20 percent reduction in readmissions.

- **Post-Acute Care:** Advocate's Post-Acute model includes home care, hospice, home medical equipment, home infusion, a skilled nursing facility ("SNF") network, a long-term acute care hospital ("LTACH") network, transition coach, and palliative care. Advocate directly provides each of these services with the exception of only limited SNF care sites. APP physicians refer patients to over 100 independent SNFs throughout the Chicago and Central Illinois regions. The health outcomes within these settings is highly variable. To ensure patients advance toward their individualized goals in the discharge care plan, Advocate has placed advanced practice nurses and physicians at 38 sites to manage their care. As a result, the average length of stay in the SNF network has decreased by five days and hospital readmissions have been reduced by 8.6 percent.



By developing a culture where patient safety is a top priority, APP has created transparency, accountability, and measurable value.

Access and Patient-Centered Medical Home

Current literature reinforces the need to re-engineer physician office workflows to better manage the health and wellness of entire populations.

Patient-Centered Medical Home (PCMH) optimizes the link between electronic medical records and patient registries to help close quality gaps, encourage patient self-care, and coordinate care across sites and providers. Improving access is also a critical component of this patient-centric model of care delivery.

APP helps practices improve traditional patient visit access as well as other convenient models of access based on patient preference and needs.

An open-access model with available same-day appointments has been developed in many practices. A snapshot of 14 practices in January 2015 demonstrated over 800 same-day appointments with an average of six per day.

Advanced use of the patient portal is a key component of communication for care planning, test tracking, and referral follow-up. Practices have dramatically increased their use of the portal by instituting these advanced features.

To date, APP has supported over 60 practices and 350 physicians in the journey to achieve level 3 National Committee for Quality Assurance (NCQA) recognition. NCQA evaluates practices using 28 elements and classifies them according to three levels of recognition, with level 3 being the highest.

While APP continues to use NCQA as the framework, an important additional goal is to promote and create an environment for continuous self-monitoring and improvement at the practice level.

Advocate Medical Group – Hazel Crest's journey to become a PCMH began in August 2013. Dr. Kathleen O'Shea-Wilk, internal medicine physician, was the PCMH physician champion for the practice. NCQA level 3 PCMH recognition was achieved in October 2014.

When Katherine Carter-Williams, a 54-year old single mother, began seeing Dr. Kathleen O'Shea-Wilk in July 2013, she suffered from poorly-controlled diabetes, high blood pressure, and asthma. As part of the PCMH journey, Katherine was one of Dr. O'Shea-Wilk's first patients to receive a care plan.

During care plan visits, Dr. O'Shea Wilks and Katherine have one-on-one conversations to review barriers to health, discuss diet and exercise, and set goals on blood pressure and blood sugar levels to get them under control.

"Katherine shares obstacles such as her current living arrangements, family concerns, and financial constraints that may affect her progress," said Dr. O'Shea Wilk. "Together, we discuss how to motivate her to make the changes she needs for her health."

As a result of these visits, Katherine now exercises, has a healthier diet, and is losing weight.

"For me, the care plans are a different way of listening to our patients and hearing things we may have missed before," added Dr. O'Shea Wilk. "We ask questions differently, simple things like—do you have a working glucose monitor? We now get helpful responses such as—it broke and it is in the drawer. Those types of answers are key to planning and managing care."

Alison Shank, care manager for the practice, is also a key member on Katherine's team. Shank works with Katherine on a monthly basis to reinforce Dr. O'Shea Wilks orders, make sure she keeps her appointments, review her blood pressure and blood sugars, and give her a pep talk. Initially, the two spoke each month for about 30 months. Now that Katherine is doing so well and taking responsibility for her own health, the calls are much shorter.

"The close team relationship between the care manager, patient, and physician really helps make a difference, especially with patients like Katherine who feel very overwhelmed," said Dr. O'Shea Wilk.

Today, Katherine's blood pressure and blood sugar levels are in normal ranges. She has lost more than 70 pounds and is on target to continue her weight loss.

"Dr. Kathleen O'Shea-Wilk is like no other doctor I have seen before. When we meet, she is not in a hurry. She takes the time to sit next to me and talk about everything in my life—my health, my stressors, my economic conditions, and my family.

She explains things to me in a way I understand and we create goals together.

In addition to our time together, she has sent me to a nutritionist to learn healthier eating habits, and a physical therapist to learn how to exercise. She follows my progress, checking in with me to see how I am doing. As a result, I have lost over 70 pounds, take less medication, and overall, feel so much better.

Dr. O'Shea-Wilk has helped change my life for the better. I would not be here without her."

– Katherine Carter-Williams, Patient of Dr. Kathleen O'Shea-Wilk, Internal Medicine

*Above testimonials shared with permission of the patient, physician, and care manager

"Dr. O'Shea-Wilk has helped change my life for the better. I would not be here without her."

– Katherine Carter-Williams

visited on 8/14/2015

2014 Performance

Clinical Integration Program

The following tables and featured CI initiatives provide insight into APP's 2014 CI performance. Actual performance was compared to the targets for each metric. There are currently over 100 clinical performance metrics that fall in one of six domains: Infrastructure & Education; Chronic Disease Care; Health & Wellness; Efficiency; Care Coordination & Patient Safety; and Patient Experience.

APP continues to demonstrate high levels of performance in quality and efficiency metrics through the nationally-recognized CI Program.

Clinical Integration Performance Measures Demonstration	2014 Performance Indicator	
	<65 Years Old	65+ Years Old
Chronic Disease Care		
Asthma Care		
Asthma Action Plan	●	
Asthma Control Assessed	●	
Asthma Medication Management	●	
Chronic Obstructive Pulmonary Disease: Spirometry Evaluation	●	●
Congestive Heart Failure		
Appropriate Medication – ACEi or ARBs	●	●
Appropriate Medication – Beta Blockers	●	●
Controlling High Blood Pressure		
Blood Pressure Control < 140/90 mm/Hg	●	●
Blood Pressure Measurement	●	●
Diabetes Care		
% Annual Eye Examinations	●	●
% Foot Exam Performed	●	●
% HbA1c Performed	●	●
% HbA1c Performed < 8	●	●
% HbA1c Performed > 9 or untested	●	●
% LDL performed	●	●
% of LDLs < 100 mg/dL	●	●
% of LDLs > 130 mg/dL or untested	●	●
Body Mass Index	●	●
Comprehensive Care	●	●
Hypertension Control <140/80 mm/Hg	●	
Hypertension Control <140/90 mm/Hg	●	●
Nephropathy Testing	●	●

Performance Measures Key

- ● Performance Exceeded 2014 Target
- ● Actual Performance Below Target by < 5 Percentage Points
- ● Actual Performance Below Target by > 5 Percentage Points

Clinical Integration Performance Measures Demonstration	2014 Performance Indicator	
	<65 Years Old	65+ Years Old
Ischemic Vascular Disease/Coronary Artery Disease		
% of Blood Pressure Control < 140/90 mg/Hg	●	●
% of Blood Pressure Measurement	●	●
% of LDLs < 100 mg/dL	●	●
% of LDLs > 130 mg/dL or untested	●	●
% of LDLs Performed	●	●
Body Mass Index	●	●
Comprehensive Care	●	●
Use of Anti-Platelet Medication	●	●
Health and Wellness	**<65 Years Old**	**65+ Years Old**
Childhood Immunization Combo 3 by age 2	●	
Childhood Immunization – Hep A	●	
Childhood Immunization – Rotovirus	●	
Depression Screening and Follow-Up Plan	●	●
Influenza Vaccination	●	●
Cancer Screening: Cervical	●	
Cancer Screening: Colorectal	●	●
Cancer Screening: Mammography	●	
Maternal Depression Screening	●	
Population Health Wellness Initiative – Adult		
Alcohol Assessment	●	●
Blood Pressure	●	●
Body Mass Index	●	●
Body Mass Index Follow-Up Plan	●	●
Exercise Assessment & Counseling	●	●

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Clinical Integration Performance Measures Demonstration	2014 Performance Indicator	
	<65 Years Old	65+ Years Old
Population Health Wellness Initiative – Senior		
Pneumococcal Vaccination		●
Screening for Future Falls Risk		●
Population Health Wellness Initiative – Pediatrics		
Blood Pressure	●	
Body Mass Index	●	
Nutrition and Counseling	●	
Physical Activity Assessment and Counseling	●	
Screen Time Assessment and Counseling	●	
Smoking Assessment and Cessation Counseling	●	●
Efficiency	**<65 Years Old**	**65+ Years Old**
Readmissions/10,000	●	●
Appropriate Imaging Utilization		
Abdomen CT	●	●
Thorax CT	●	●
Average Length of Stay Milliman Well Managed	●	●
Admits/1000	●	●
Emergency Department Core Measures		
Admit Decision Time to ED Departure for Admitted Patients	●	●
Median Time from ED Arrival to ED Departure	●	●
Emergency Department Visits/1000	●	●
Left the ED without Being Seen	●	●
Pharmaceutical Initiative		
Generic Statin Use	●	●
Generic Medication Usage	●	●
Care Coordination & Patient Safety	**<65 Years Old**	**65+ Years Old**
Communication between SCP (proceduralist), PCP and Patient	●	●
In-Network Acute Care	●	●

Clinical Integration Performance Measures Demonstration	2014 Performance Indicator	
	<65 Years Old	65+ Years Old
Oncology Care		
ASCO Quality Oncology Program Completion or MD Anderson Accreditation	●	●
Radiology Turnaround Times		
General Radiology Reports < 12 hrs	●	●
General Radiology Reports < 8 hrs	●	●
Interventional Radiology Reports (< 12 hrs)	●	●
Diagnostic Mammography Reports – Test to Committed < 8 hrs	●	●
Diagnostic Mammography Reports – Test to Report < 8 hrs	●	●
Screening Mammography Reports – Test to Committed < 24 hrs	●	●
Screening Mammography Reports – Test to Report Completion < 24 hrs	●	●
Surgical Care Improvement Project		
Appropriate DVT Prophylaxis Received Timely	●	●
Beta-Blocker Peri-Operative Period – Surgery Patients	●	●
Controlled Post Operative Serum Glucose – Cardiac Surgery	●	●
Perioperative Temperature Management	●	●
Post Operative Urinary Catheter Removal	●	●
Prophylactic Antibiotic Administration – Pre Surgery	●	●
Prophylactic Antibiotic Discontinued – Post Surgery	●	●
Prophylactic Antibiotic Selection for Surgical Patients	●	●
Patient Experience	**<65 Years Old**	**65+ Years Old**
ED Patient Satisfaction	●	●
In-Patient Satisfaction with Physician	●	●
Outpatient Satisfaction – Primary Care	●	●
Outpatient Satisfaction – Specialty Care	●	●

Featured Clinical Integration Initiatives

Generic Prescribing Initiative

Core to population health strategies is patient and physician access to the appropriate medication at the right time. The adage "a medication a patient can't afford is a medication that a patient won't take" is at the heart of the access to medication issue. A 2004 RAND[1] study found that doubling copays for medications reduced medication adherence by up to 45 percent. As adherence declined due to increased copays, emergency room visits increased by 17 percent and hospital stays rose 10 percent. One tactic to improve adherence is to use equally-effective, lower cost generic medications.[1] APP's Clinical Pharmacists actively engage physicians to highlight opportunities to use equally-effective, lower cost medications.

In 2014, the Advocate Generic Dispensing Rate was nearly 2 percent higher than the Chicagoland market. This difference resulted in an estimated $5.7 million in reduced patient out-of-pocket expense. In addition, more than $17 million of overall health care drug expenditures were avoided by utilizing lower cost, equally-effective generics.[2,3,4]

Asthma Outcomes

As the prevalence of asthma has increased over the past decade, APP realized a need for better access to care and medications for asthma patients.

In response, APP developed Clinical Pathways to provide standardized guidelines to physicians when treating asthma patients, along with point-of-care tools. APP is piloting a targeted asthma community outreach program to help develop more specific tactics towards patient activation and engagement. An interactive mobile app is also being developed to support asthma patients.

Metrics/Results

APP achieved a control rate of 74 percent for patients with asthma, exceeding the national control rate of 50 percent.[1]

Asthma Control Rate	
APP	National
74%	50%

Impact on Quality and Cost

APP's comprehensive Asthma Outcomes initiative resulted in a control rate 24 percentage points above national averages and saved $17 million annually in direct and indirect medical costs above the national average. This amount includes an additional 71,436 days saved from absenteeism and lost productivity annually.

APP is committed to creating value by delivering quality outcomes in a cost effective manner for patients.

Diabetes Care Outcomes

APP has developed Clinical Pathways, point-of-care tools, patient-self management tools, and several continuing medical education courses to support physicians in their treatment of diabetic patients. The following data includes only commercial HMO and PPO, which represents less than half of the total diabetic registry population.

Metrics/Results

In 2014, APP physicians exceeded targets and performed at or well above national averages on all control measures.[1] Despite serving more patients in its programs, APP physicians and patients were able to improve performance on a number of related measures.

Impact on Quality and Cost

APP's Diabetes Care initiative resulted in an additional 7,232 years of life, 11,572 years of sight and 8,679 years free from kidney disease.

Calculating savings from just one of the control outcomes—poor HbA1c—for commercial patients only, APP saved more than $1.4 million annually above national performance levels. Factoring in savings from the cholesterol and blood pressure control outcomes would significantly increase these annual savings.

Childhood Immunization Initiative

Metrics/Results

In 2014, APP achieved an administration rate of 80.4 percent for Combination 3 immunizations for all HMO and PPO patients 2 years of age. This rate exceeds the 75th percentile for combined HMO and PPO according to the most recent NCQA State of Health Care Quality Report.[1]

Additionally, APP's rates of immunization for rotavirus-related diseases exceeded national rates by 9.2 percentage points for HMO and 19 percentage points for PPO patients.

Rotavirus Cluster Immunization Rates			
National HMO	APP HMO	National PPO	APP PPO
80%	89%	72%	91%

Impact on Quality and Cost

Studies have shown that complications of the rotavirus cluster, such as diarrhea, are responsible for increased hospitalizations. APP's rate of immunization for rotavirus-related diseases above the national average resulted in savings of over $4 million in avoided hospitalization costs. It is important to note these savings are for just one complication. Savings would increase significantly if all complications related to the 12 recommended vaccinations were considered.

Generic Prescribing Outcomes

1. Goldman DP, Joyce GF, et al: Pharmacy Benefits and the Use of Drugs by the Chronically Ill. *JAMA*. 2004 May 19;291(10)2344-50. Accessed March 27, 2015. http://jama.jamanetwork.com/Issue.aspx?journalid=67&issueID=4928&direction=P
2. Lieberman, JN, Roebuck, C: Prescription Drug Costs and the Generic Dispensing Ration. *Journal of Managed Care Pharmacy*. 2004 September 16;7. Accessed March 27, 2015. http://www.amcp.org/data/jmcp/502-506.pdf
3. Prime Therapeutics 2012 Drug Trend Insights. Accessed March 27, 2015. http://www.primetherapeutics.com/pdf/2012PrimeDrugTrendInsights.pdf
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Asthma Outcomes

1. Mintz M, Gilsenan A, et al: Assessment of Asthma Control in Primary Care. *CMRO* October 2009, 25(10):2523-2531

Diabetes Outcomes

1. National Committee for Quality Assurance: The State of Health Care Quality 2014: HEDIS Effectiveness of Care

Child Immunization Outcomes

1. National Committee for Quality Assurance: The State of Health Care Quality 2014: HEDIS Effectiveness of Care

ACO Performance

The ACO movement is a multi-year journey with a commitment to changing organizational culture and implementing programs that coordinate patient care and lower cost. In 2014, APP invested over $20 million in programs, technology, and new processes to more effectively manage care.

Early results for each of the populations APP manages show steady and consistent improvement in bending the cost of care. APP has lowered or maintained cost flat on each of our value-based contracts.

Preliminary Cost Savings Results	
1.4 percent below target	Blue Cross PPO Shared Savings Cost Trend
2.7 percent below target	Combined full-risk HMO
0.2 percent below target	Medicare Shared Savings

Medicare Shared Savings Program

APP joined the Medicare Shared Savings Program (MSSP) in July 2012. For an ACO's first performance year, quality performance is assessed on a pay-for-reporting basis only. APP's first performance year was from July 2012 through December 2013. APP was required to submit data for calendar year 2012 and 2013. APP scored 100 percent on complete and accurate reporting of all 33 quality measures each time.

Pay-for-performance on quality measures is being phased in beginning in 2015 and is based on 2014 data. Data for 2014 is not currently available. Applying 2014 CMS Benchmarks to APP's most current MSSP quality data collected in 2013 demonstrates high performance across all measurement domains:

2013 Performance Year One Results	
Domain	**2013 Domain Scored Using 2014 CMS Benchmark Rules**
Patient/Caregiver Experience	97%
Care Coordination/Patient Safety	81%
Preventive Health	89%
At Risk Population	95%
ACO Estimated Quality Score: 90%	

Performance exceeded CMS benchmarks in 25 of 33 measures:

- 6 of 33 measures ≥90 percent/percentile (18% of measures)
- 18 of 33 measures ≥70 percent/percentile (55% of measures)
- 25 of 33 measures ≥50 percent/percentile (76% of measures)

Opportunities for improvement exist and APP has implemented strategies to improve including:

- Implementing and reinforcing Clinical Pathways
- Continued alignment of MSSP measures into our CI Program
- Physician education (e-learning)
- Practice education via Quality Improvement Nurse/Field Operation Advisers
- Patient reminders and outreach

Medicare Advantage Stars

CMS uses a star rating system to evaluate the quality of Medicare Advantage plans. Exemplary performance is only possible when plans and providers work together—with quality being the common goal. Plans receive a rating between 1 and 5 stars. Plans rated higher than 3 stars receive bonus payments. Bonus payments are passed on to participating providers through negotiated agreements. Plans rated below 2 stars are not eligible for bonus payments. Beginning in 2015, CMS may terminate low performing plans. APP's CI Program helped support the BCBS Medicare Advantage product achieve a 4 star rating in 2014.

Acknowledgments

APP would also like to extend sincere thanks and recognition to our more than 4,800 physician members for their leadership and commitment to quality.

Special thanks to our associates who dedicate their time, talents and energy to the advancement of APP's vision—to be the leading care management and managed care contracting organization.

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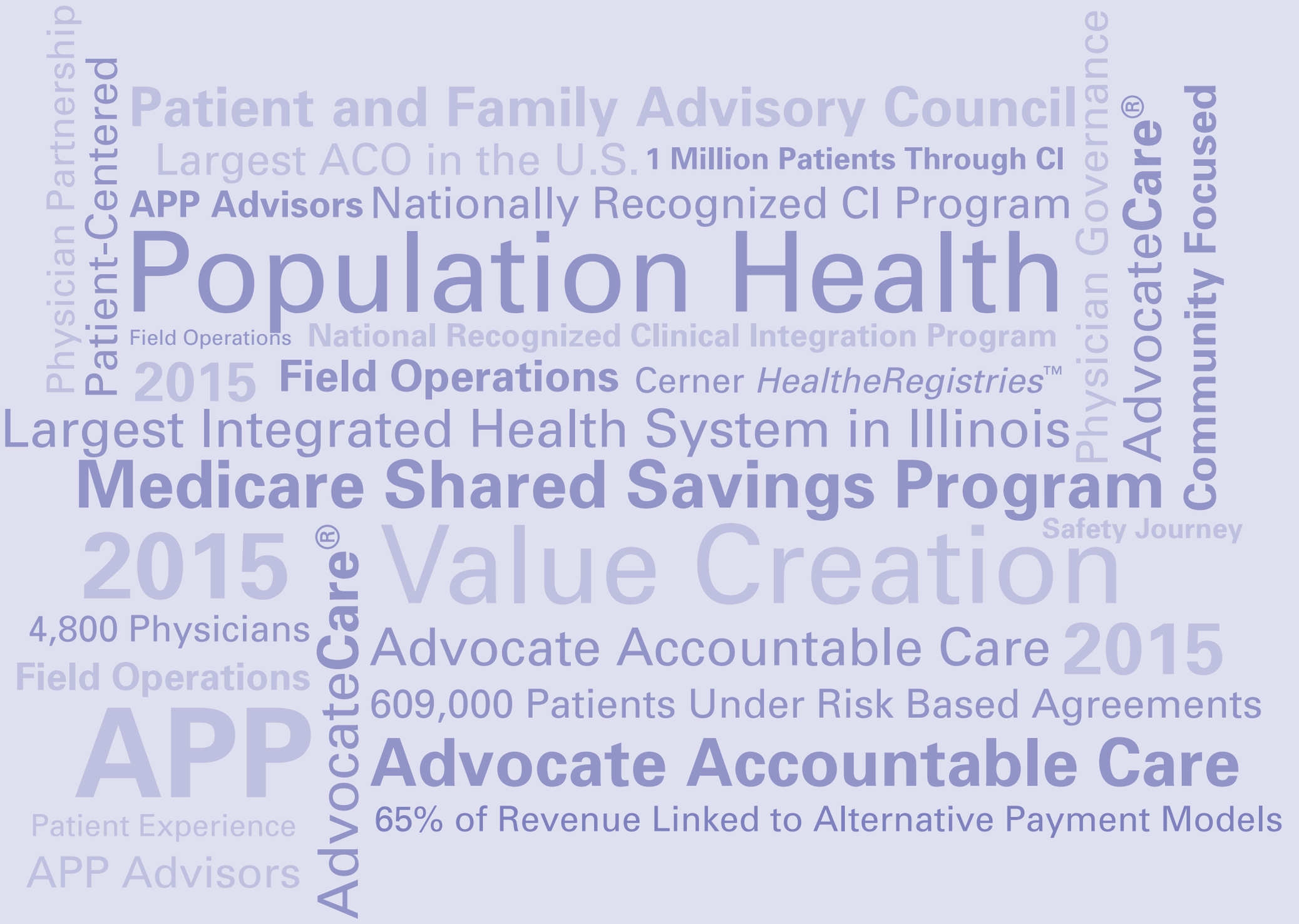

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1701 West Golf Road, Suite 2-1100 || Rolling Meadows, IL 60008 || 847.699.4300

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