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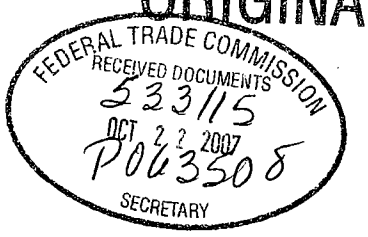


October 22, 2007

**VIA COURIER**

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Room 172
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

Dear Mr. Clark:

Pursuant to the request of your staff, we are re-submitting the public document submission for the Greater Rochester Independent Practice Association, Inc. All mentions of confidentiality have been removed from the enclosed documents. For your records, the original submission was filed on October 15, 2007.

If you have any questions, please call me – (202) 326-5046 – or Jeff Miles – (202) 326-5008.

Sincerely,

Christi J. Braun

Christi J. Braun

Enclosure

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June 28, 2006

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Room 172
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

Dear Mr. Clark:

Pursuant to Federal Trade Commission Procedure Rules 1.1 through 1.4, 16 C.F.R. §§ 1.1-1.4 (2006), the Greater Rochester Independent Practice Association, Inc. ("GRIPA") requests an advisory opinion regarding the Commission's enforcement intentions, including the appropriate standard of analysis, if GRIPA negotiates contract terms, including price terms, and signs contracts on behalf of its physician members with payers as part of the sale of the integrated services described in this letter.

GRIPA is an independent practice association ("IPA") located in Rochester, New York. Its provider network includes primary-care physicians ("PCPs") and specialty-care physicians ("SCPs") who practice primarily in Monroe County (in which Rochester is located) and Wayne County (immediately east of Monroe County), New York, as well as two hospitals and many ancillary-service providers operating in the same geographic area. To meet the demand of payers in the area for a network that will hold its members accountable for the provision of high-quality services delivered in an efficient manner, GRIPA proposes to develop a non-risk-sharing physician network joint venture or multi-provider network as described in Statements 8 and 9 of the U.S. Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care (1996) ("Statements").

GRIPA will sell Rochester-area health plans, employers, and other payers, on a fee-for-service basis, a new product consisting of its interdependent members' medical services intertwined with a number of collaborative activities designed to improve clinical outcomes and efficiencies (the "clinical-improvement services"). The clinical-improvement services will be developed and implemented by and among GRIPA's physician members and between those members and GRIPA's staff. The clinical-improvement services will result in higher quality medical services delivered more efficiently than GRIPA physicians could render individually.

For the clinical-improvement services to achieve the intended quality improvements and efficiencies, GRIPA needs to contract on behalf of its physician members, as we explain later.

## I. Background Facts

### A. The Greater Rochester Independent Practice Association

#### 1. GRIPA's History & Structure

GRIPA was incorporated as a New York business corporation in 1996 to contract, on a risk basis, with HMOs for the provision of physician and other health-care services.[1] ViaHealth, a Rochester health-care system led by Rochester General Hospital ("RGH"), owns 50 percent of the shares in GRIPA, and two physician organizations ("POs"), Rochester General Physicians Organization, Inc. ("RGPO") and Wayne County Physicians Organization ("WCPO"), own the remaining 50 percent of GRIPA shares. ViaHealth's system is comprised of RGH and Newark-Wayne Community Hospital ("NWCH") located in Newark, New York, about 34 miles east of RGH, as well as ancillary service providers and approximately 130 employed physicians.

ViaHealth has six seats on GRIPA's Board of Directors. RGPO has four seats, and WCPO has two seats.[2] The boards of directors of RGPO and WCPO each nominate physicians from their membership for their respective seats on the GRIPA Board. ViaHealth's seats on the GRIPA Board are held by ViaHealth's chief executive officer, chief financial officer, and vice president of medical affairs; the chair of the ViaHealth Health Care Services Board of Directors (the board overseeing RGH and NWCH); and two citizens from the Rochester community.

Subsequent to its founding in 1996, GRIPA entered into a number of risk contracts with payers operating in the Rochester area. At present, it continues to contract with one payer on a risk basis. The prevalence of risk contracting, however, has declined precipitously in the Rochester area, just as it has across the country. Accordingly, in 2005, GRIPA undertook a strategic study to plan its future. It considered several options, including simply dissolving, implementing a messenger arrangement, instituting some type of unilateral risk-sharing arrangement, merging some of its members' practice groups, and developing and implementing a program integrating its physicians' services and clinical-management activities. It chose the last option for two primary reasons. First, Rochester-area payers and providers, over the last seven years, have begun to require and emphasize quality- and efficiency-based initiatives. The integration of GRIPA's physicians' services and the clinical-improvement services, as proposed

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[1] Exhibit 1, Certificate of Incorporation of Greater Rochester Independent Practice Association, Inc. In 1997, the GRIPA shareholders created a second corporation, ViaHealth PPO, Inc., to contract with payers for non-HMO products because New York law prohibits IPAs from contracting with entities other than HMOs. To simplify this request, we refer only to GRIPA in this letter. Supporting documents may, however, mention ViaHealth PPO, Inc.

[2] Exhibit 2, By-Laws of the Corporation for Greater Rochester Independent Practice Association, Inc. This a draft version of the by-laws that is subject to further revision. It has board approval, but not shareholder approval.

here, fit directly into payer plans and should be well-received by payers. Second, GRIPA intends to offer a valuable new product that none of its members could offer individually and that, to the best of its knowledge, no other Rochester-area group intends to offer. GRIPA, thus, intends to differentiate itself from its competitors by offering a different, higher quality, and more valuable product for which it hopes that payers will be willing to pay a premium.

The GRIPA Board decided to develop this integrated product only after a long and careful study. Over the past several months, GRIPA has hosted a number of meetings for its physician members to discuss this integrated product concept in detail and, in particular, to assess its members' support for the clinical-improvement services initiative. Almost all the physicians voiced strong support for the program, and many have volunteered to serve on GRIPA organizational and operational committees to develop and implement the clinical-improvement services. Through its web-site surveys and written surveys passed out at informational meetings, GRIPA's physicians have indicated that they anticipate substantial benefits for their patients and themselves from the collaborative activities and clinical-improvement services, including increased practice and patient support from GRIPA, improved patient outcomes, improved interaction with their colleagues, faster service to patients, and financial benefits from GRIPA's sale of a more attractive product to payers and their own ability to see more patients.

### 2. GRIPA's Physician Network

Each GRIPA physician member must be a shareholder in either RGPO or WCPO.[3] The PO members initially paid for their stock in the POs, and much of that money was used to capitalize GRIPA. The POs currently have 636 shareholders who are members of GRIPA, including the 130 ViaHealth-employed physicians. In addition to these PO physician members, GRIPA contracts with 119 other physicians in order to provide adequate specialty and geographic network coverage under its risk contract. Currently, there are 717 physicians participating in GRIPA's risk contract who will be eligible to participate in its proposed integrated product, 81 of who are contract physicians. Of the 717 physicians, 257 are PCPs, practicing in the specialties of family practice, general practice, internal medicine, and pediatrics, and the remainder are SCPs. GRIPA anticipates that, of these physicians, approximately 90 percent of the PCPs and more than 75 percent of the SCPs will participate in its new program. Although the SCPs may have some financial incentive to contract directly with the payers because they may be able to obtain higher reimbursement individually than through GRIPA, the SCPs also understand that they need to align themselves with their referral sources, many of whom will participate in GRIPA's integrated product.

[3] Exhibit 3, GRIPA's physician provider participation contract.

The 717 GRIPA physicians practice in 41 medical specialties and subspecialties, including adolescent medicine (1, 1)[4]; allergy and immunology (10, 6); anesthesiology (36, 3); cardiology (40, 16); colon & rectal surgery (7, 2); child psych (2, 2); critical care medicine (1, 1); dermatology (21, 13); endocrinology (6, 5); family medicine (20, 11); gastroenterology (15, 8); general surgery (22, 11); geriatric medicine (16, 14); gynecologic oncology (3, 1); gynecology (4, 3); hematology/oncology (14, 8); infectious disease (5, 3); internal medicine (134, 68); maternal/fetal (5, 1); medical genetics (1, 1) nephrology (7, 1); neurological surgery (6, 5); neurology (14, 7); obstetrics & gynecology (46, 20); ophthalmology (25, 14); oral surgery (4, 4); orthopedics (20, 13); otolaryngology (14, 8); pain management (4, 2); pediatrics (100, 30); physical medicine & rehabilitation (2, 1); plastic surgery (9, 5); psychiatry (22, 16); pulmonology (10, 5); radiology (50, 7); radiation oncology (6, 3); reproductive endocrinology (2, 1); rheumatology (5,2); thoracic surgery (5, 3); urology (16, 9); and vascular surgery (6, 5).[5]

### B. Rochester-Area Health Systems

Rochester-area health-care providers serve a community of more than 800,000 residents and provide some of the most sophisticated care in the region. The University of Rochester Medical Center includes the University of Rochester School of Medicine and Dentistry, the University of Rochester Medical Faculty Group, Strong Memorial Hospital, and the Golisano Children's Hospital at Strong. In addition to Strong Memorial and Golisano Children's Hospital, Strong Health, ViaHealth's major competitor, owns and operates Highland Hospital and employs nearly 1,000 physicians.[6] The Strong-employed physician network is a major competitor of GRIPA. Strong Memorial and ViaHealth's RGH are both tertiary-care centers and draw patients from the entire northwest New York region.[7] Three additional general acute-care hospitals—Highland Hospital (affiliated with Strong), NWCH (affiliated with ViaHealth), and Unity Health System's Park Ridge Hospital—serve Monroe and Wayne Counties. Approximately 53 percent of all inpatient admissions in the Rochester area are to Strong Health's hospitals. In comparison, RGH receives approximately 29 percent of all Rochester-area admissions and Park Ridge receives approximately 16 percent.[8]

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[4] The numbers in the parentheses are: (1) the total number of GRIPA physicians in each specialty, and (2) the number of medical groups within which those physicians practice. Some physicians practice in more than one specialty and are therefore listed more than once.

[5] Exhibit 4, directory charts listing GRIPA owner physicians, contracted providers, and secondary specialties.

[6] For more information about Strong Health, see http://www.stronghealth.com/about.

[7] More than a third of Strong's inpatients reside outside Monroe County. See http://www.urmc.rochester.edu/vp_search/aboutus.cfm.

[8] Exhibit 5, hospital utilization graphs. The remaining two percent of admissions occur at Lakeside Hospital, which is a 61-bed acute-care hospital near the western border of Monroe County.

GRIPA physicians actively practice at all of the hospitals in the Rochester area, and a large percentage have privileges at more than one hospital. Geographically, GRIPA's physicians are not concentrated in one area but rather are dispersed relatively equally throughout the Rochester area.[9]

### C. The Rochester Payer Market

Two payers dominate the commercial health-insurance business in the Rochester area: Excellus Health Plan, Inc. (the local Blue Cross/Blue Shield plan), and Preferred Care, which recently merged with MVP Health Care. Excellus covers approximately 70 percent of the privately insured lives in the Rochester area, and Preferred Care's share of the market is approximately 25 percent. These companies are the only ones that offer HMO products in the Rochester area and are the largest commercial payers with respect to PPO products. Other payers offering PPO products and networks in the Rochester area include Aetna U.S. Healthcare, CIGNA, Health Now (the parent company of BlueCross BlueShield of Western New York), and POMCO (a benefits administrator for self-insured employers).

### D. Other Rochester-Area Physician Networks and Payer Alternatives

GRIPA competes, or potentially competes, with individually contracting physicians (including its own members), other IPAs, and POs. GRIPA has never been an exclusive network, and so its members can and do contract with payers through other channels.

Currently, there are two IPAs and two POs in the area that contract with payers. The Rochester Community Individual Practice Association, Inc. ("RCIPA") has the largest physician enrollment of all Rochester-area IPAs, with approximately 3,200 physicians and allied health professionals who practice in the counties of Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, and Yates.[10] The Rochester Individual Practice Association, Inc. ("RIPA"), the second largest IPA in the area, has approximately 2,700 physician members in Monroe, Wayne, and Livingston Counties.[11] Because of New York state law prohibiting IPAs from contracting with customers other than HMOs, the RIPA physicians created Crossbridge Physicians, P.C. to contract for other types of products, such as PPOs. As of 2005, more than 3,700 physicians and ancillary providers contracted through Crossbridge. Finally, Preferred Health Network ("PHN") is a PO with approximately 700 PCPs and 1,000 SCPs in its network.[12] Almost every GRIPA physician is a member of RCIPA, RIPA, and Crossbridge and thus contracts through them as well as through GRIPA.

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[9] Exhibit 6, map showing area covered by GRIPA and Exhibit 7, chart reflecting specialty numbers by zip code.

[10] For more information about RCIPA, see http://www.rcipa.com.

[11] See http://www.ripa.org for additional information about RIPA.

[12] For more information on PHN, see http://www.preferredcare.org/onlineservices/provider/ipa.html.

Historically, the Rochester-area IPAs (including GRIPA) and POs have been non-exclusive in the sense that their members are free to contract with payers individually or through other organizations, but some (not GRIPA) have been exclusive in that they contract only with a single payer. RCIPA contracted with Excellus until 1998, when a dispute over contract payments arose. RIPA, which contracted exclusively with Preferred Care through 1998, filled the gap left by RCIPA and entered into an exclusive contract with Excellus. GRIPA's risk contract with Excellus, which expired in December 2005, operated as an overlay to the RIPA contract, such that all participating GRIPA physicians also had to be RIPA members, and the claims of patients choosing GRIPA PCPs were paid by GRIPA using the RIPA fee schedule. RIPA's risk contract with Excellus will expire at the end of 2006, at which point RIPA will no longer act as a physician contracting organization. RIPA intends to become a management services organization for Excellus. Crossbridge's contracts with Excellus for its POS, PPO, and EPO plans will also terminate at the end of 2006, and it is likely Crossbridge will go out of business entirely. Excellus has signed direct contracts, covering all of its products, with a majority of the Rochester-area physicians.[13]

When RIPA terminated its contract with Preferred Care in 1998, Preferred Care established its own PO, PHN, for the purpose of contracting with Rochester-area physicians. Preferred Care's medical director runs PHN, and operational costs are paid by Preferred Care. As a payer-controlled PO, PHN is not free to contract on the physicians' behalves with any other payer. GRIPA is currently the only independent IPA contracting with Preferred Care, although it has no exclusive contract. The majority of GRIPA's physicians are not members of PHN because GRIPA began contracting with Preferred Care prior to PHN's formation.

After terminating its contract with Excellus in 1998, RCIPA began contracting with Aetna on a non-risk basis as a "messenger model" PO. Although RCIPA contracts with POMCO and at least one other third-party benefits administrator, RCIPA is constrained by its agreement with Aetna from contracting with any other area health plans.

A new Rochester-area PO, Community Private Practice Physicians Organization ("C3PO"), is currently in the formation stages. Organized in part as a response to the Excellus direct-contract efforts and RIPA's decline, C3PO proposes to operate as a "messenger" for private practice physicians, provide group purchasing benefits, and facilitate the exchange of information between private practitioners. We anticipate that GRIPA physicians will join C3PO.

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[13] See http://www.democratandchronicle.com/apps/pbcs.dll/article?AID=/20060615/BUSINESS/606150345/1001.

## E. GRIPA's Current Operations

GRIPA's chief executive officer, Gregg Coughlin, and its chief medical officer ("CMO"), Eric Nielsen, M.D., are responsible for directing the daily operations of the corporation. GRIPA currently has a staff of 35 full-time-equivalent employees.[14]

To support its risk-contracting program, GRIPA already has a robust information system in place and a sizeable staff to manage its information technology ("IT") system. As it implements its new clinical-improvement services program, GRIPA intends to substantially expand that system, as explained later. Its current system includes a data warehouse used to store claims information and software to analyze the claims data and prepare reports for GRIPA's physicians and leadership.

As part of its current risk-contracting program, GRIPA operates a credentialing program and several medical-management programs. GRIPA's Credentialing Committee, composed of five GRIPA physicians and the CMO, makes recommendations to the GRIPA Board based on its review and assessment of licensing and malpractice information, as well as office site-visit scores for medical record-keeping practices, patient safety, privacy, and comfort. To become a member of the GRIPA network, physicians must meet the GRIPA credentialing criteria, which are compliant with all requirements of the National Committee for Quality Assurance.[15]

GRIPA's Care Management Services ("CMS") Department has operational responsibility for GRIPA's current clinical programs, providing case-, disease-, and pharmacy-management services. GRIPA identifies patients needing CMS assistance through physician referrals and predictive modeling, a process that involves mining claims and utilization data to group patients by disease states and then by cost and high-use risk. After patient lists are generated, they are stratified at the physician level, allowing the CMS department to target physician practices with high volumes of risk-contract patients who would benefit from CMS assistance. CMS then conducts initial patient assessments, evaluating the patients and determining the needs as psycho-social (case management), chronic disease state (disease management), or pharmaceutical (pharmaceutical management).

Through its case-management program, GRIPA nurse and social-work case managers work on both a one-on-one basis and in group settings with patients who are high-cost, high-use, or suffer from co-morbidities. GRIPA educates the patients, monitors their progress through visits and telephone calls, and ensures that these patients receive the care they need. Depending on the patients' needs and the results of screening assessments, the patients may be enrolled in one of GRIPA's disease-management programs.

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[14] Exhibit 8, GRIPA organizational chart.

[15] Exhibit 9, GRIPA Credentialing & Re-Credentialing Process Policy.

GRIPA's three clinical pharmacists staff its Clinical Consulting Pharmacy Program, working with both patients and physicians to reduce medication costs and errors, and optimize patient therapy and outcomes. Prior to visiting a physician's office, the GRIPA clinical pharmacist runs a data report for the physician to determine the pharmaceutical usage level of the physician's patients, the types of drugs the physician typically prescribes, and the physician's percentage of high-risk patients. After identifying the high-risk patients, the pharmacist reviews their charts to determine whether (1) the patients are receiving the appropriate medicines in the proper dosages; (2) any drugs are contraindicated; (3) the patients are meeting care goals in a timely fashion; and (4) the physician is avoiding unnecessary costs by prescribing generic drugs, less costly formulary alternatives, and drugs that can be split into half tablets. Upon completion of each chart review, the pharmacist places a written consultation report in the front of the chart for the physician.

Through collaborations between the case managers, clinical pharmacists, and GRIPA member physicians, GRIPA's current disease-management programs focus on diabetes, asthma, and heart failure. The three disease-specific programs allow GRIPA to focus on the specific populations responsible for the largest percentage of GRIPA-patient medical costs. GRIPA also has a similar specialized program for geriatric patients, which focuses on medical, safety, and quality-of-life issues. As GRIPA establishes its new clinical-improvement services, it will expand its focus to include a number of additional diseases, such as coronary artery disease ("CAD") and chronic obstructive pulmonary disease ("COPD").

GRIPA's current disease-management programs consist of (1) developing and reinforcing treatment and prescription plans, (2) patient education about the disease and treatment, (3) pharmaceutical compliance monitoring, and (4) monitoring patient compliance with treatment plans. GRIPA also monitors claims, laboratory, and pharmacy data to determine whether disease-management patients' treatments comply with guidelines.[16] If the data reflect a need for changes in care, then the CMS staff will review the patient's chart to determine whether recommendations should to be made to the physician, and whether the patient would benefit from additional personalized attention.

## II. GRIPA's Proposed Program to Integrate through Clinical-Improvement Services

GRIPA's new program will partially integrate its physician practices in ways that will generate efficiencies for health-care consumers, payers, and physicians by improving medical-care quality, generating more cost-effective service delivery, and reducing population costs. An ancillary goal is to produce and market a higher quality, higher value product for which payers are willing to pay a premium price. To these ends, GRIPA will do the following: (1) develop a collaborative, interdependent network of PCPs and SCPs to provide their medical care in a seamless, coordinated manner; (2) promote the collaboration of its physicians in (a) designing, implementing, and applying evidence-based practice guidelines or protocols and quality

[16] Exhibit 10, Diabetes Patient Profile.

benchmarks, (b) monitoring each other's individual and GRIPA's aggregate performance in applying the guidelines and in achieving the network's performance benchmarks, to improve patient outcomes and to reduce costs and resource utilization; (3) integrate its physicians and providers of other medical services in the community through a web-based electronic clinical-information system in which GRIPA physicians share clinical information related to their common patients, order prescriptions and lab tests electronically, and access patient information from hospitals and ancillary providers throughout the community; and (4) decrease the overall administrative and regulatory burden of its participating physicians by reducing paperwork and the time needed to process treatment information.

### A. Clinical Guideline Development, Implementation, Monitoring, and Corrective Action

GRIPA's physicians, together, will develop and implement evidence-based clinical guidelines, or protocols, affecting all medical specialties represented within GRIPA and affecting those morbidities generating the largest portion of health-care costs of GRIPA's patient population. Clinical guidelines may represent the best practices in medicine, but physicians often ignore guideline sets because they receive different ones from each payer with which they contract, their specialty societies, and quality-improvement organizations. To overcome these problems, GRIPA will establish a single set of guidelines that apply to all its members for all GRIPA patients, regardless of payment source. By developing its own guidelines, GRIPA intends to tap into the broad base of its members' knowledge and experience and to facilitate the sharing of the individual physicians' best practices that otherwise would not be shared among competitors. By investing their time and expertise in establishing the group's quality standards, the GRIPA physicians will develop a greater sense of loyalty among themselves and to GRIPA and also develop a greater sense of ownership of GRIPA and its efficiency and quality goals. GRIPA also believes that if the physicians themselves (or their local peers) create the guidelines, the physicians will be more receptive to following them. By requiring all of its members to adhere to evidence-based guidelines, which GRIPA will do, it believes the overall quality of care its physicians provide will be measurably improved.

The guidelines will provide a high-level description of GRIPA-developed "best practices" for specific disease states. Each guideline will generally include several "rules," or recommendations regarding care that the physicians should provide (*e.g.*, one rule in a diabetes guideline is the performance of a yearly eye exam). However, not all rules within a guideline can be used as "measures" of physician performance because of limitations created by the availability of data to track compliance with the rules. For example, a physician may follow a guideline rule by prescribing aspirin to a heart patient, but the compliance can't be measured because no data (an electronic prescription or an insurance claim for a prescription) will be generated due to aspirin's classification as an over-the-counter medication. Therefore, as the GRIPA physicians develop their guidelines, they will also determine the measures GRIPA will use to assess the physicians' performance under those guidelines.

### 1. Guideline Development and Adoption

GRIPA will collect guidelines from sources across the country, such as the National Committee for Quality Assurance, the Agency for Healthcare Research and Quality, Milliman, and the Centers for Medicare and Medicaid Services. From these, and the knowledge and experience of its own physicians in different specialties, GRIPA will develop its own proprietary guidelines, and associated measures.[17] Starting with the disease states that affect the largest portion of GRIPA patient health-care costs, GRIPA physicians and staff will identify potential guidelines. The staff will then research and document national and local standards that support each guideline, potential measures that could be used to monitor compliance with the proposed guideline, and national and local benchmarks that could be potential targets for the selected measures. GRIPA's staff will then present the documentation to GRIPA's Clinical Integration Committee ("CIC"), which will be responsible for overseeing implementation of the integrative activities and clinical-improvement services, including creation of its clinical policies and quality standards and enforcement of those policies and standards, following GRIPA Board approval. Composed of 12 physicians, at least six of whom must be PCPs or Ob/Gyns, the CIC will review all of the guideline research and make changes to the proposed guidelines and their associated measures, incorporating Rochester-area best practices. The CIC will then seek review and recommendations from GRIPA's member physicians in order to capture the most appropriate course to high-quality outcomes that, absent their integrative efforts through GRIPA, the physicians would not otherwise share with their competitors.

To facilitate the collection and compilation of the physicians' knowledge and experience, the CIC will create 16 Specialty Advisory Groups ("SAGs") based on medical specialty. The following 11 SAGs will be single-specialty committees: Anesthesiology, Cardiology, Dermatology, Gastroenterology, General Surgery, Obstetrics & Gynecology, Neurology, Ophthalmology, Orthopedics, Psychiatry, and Radiology. Three additional SAGs will group specialties that share commonalities: Hematology-Oncology/Radiation Oncology, Adult Primary Care, and Pediatrics/Pediatric Specialties. There will also be two multi-specialty SAGs that group together specialties in which there are few physicians --Medical Specialties (Critical Care, Endocrinology, Infectious Disease, Nephrology, Rehabilitation, Pulmonary, Rheumatology, Pain Management) and Surgical Specialties (Colorectal, Neurological, Oral, Otolaryngology, Plastic, Thoracic, Vascular, Urology). Each single-specialty SAG will have three to five physician members, and the multi-specialty SAGs will include one to three physicians in each subspecialty represented.

After the CIC completes its initial review of a proposed guideline, meetings will be scheduled for the SAGs whose members will be affected by the proposed guideline. At these meetings, the physicians will discuss the practical implications and clinical effectiveness of the rules of each guideline and the utility of the possible measures that could be derived from the rules. Although initial meetings may include only the members of single SAGs, GRIPA

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[17] Exhibit 11, Clinical Guideline/Measure Selection Process.

anticipates holding meetings that bring together all of the members of all of the SAGs whose physicians would be required to comply with the guideline, if approved. The SAG members (and others in their specialties) should benefit greatly from these multi-specialty discussions because they will learn how different medical specialties approach treatment of specific diseases and the co-morbidities associated with those diseases. By integrating the shared knowledge and experiences of its physicians, GRIPA will develop more detailed, more useful, and more acceptable guidelines for its members than if the physicians were to attempt to develop guidelines individually, which, of course, they would not do.

After the SAGs complete their review of the proposed guidelines and associated measures, they will make recommendations to the CIC, which will make any modifications it deems appropriate and then approve each guideline and measure set. The CMO will then present the guidelines, and their associated measures, to the GRIPA Board for approval (or disapproval or return to the CIC for additional study and modification). Upon board approval, GRIPA physicians will be contractually obligated, through their GRIPA physician participation agreements, to provide care consistent with the guidelines, and their compliance will be monitored based on the associated measures.

All GRIPA physicians will be significantly affected by the new guidelines. Each will receive an information package, notifying them of the guidelines affecting them and providing them with educational materials about those guidelines and how to implement them. The new guidelines will also be made available on GRIPA's Internet portal (discussed later in Section II.C). The SAGs will convene educational meetings to introduce and explain the new guidelines to their colleagues and to provide a forum for them to discuss actual application of the guidelines, possible improvements to the guidelines, and how to meet the guidelines' compliance benchmarks. In addition to making guideline adoption more successful, GRIPA anticipates that these multi-specialty meetings will result in greater collaboration among its physicians in the care of individual patients by opening new lines of communication between different types of specialists who previously may not have had occasion to consult or refer patients among themselves (*e.g.*, cardiologists and endocrinologists in the treatment of diabetics).

To assess the need for guideline revisions, the CIC will solicit specific feedback from affected network physicians at six-month intervals after guideline implementation. Even if GRIPA receives no feedback, the CIC and the SAGs will review the guidelines and measures on an annual basis to ensure that the guidelines contain up-to-date clinical procedures and the measures are indicative of performance improvement. GRIPA will also encourage its physicians to collaborate in submitting comments to the CIC about the guidelines and quality improvement measures affecting them.

### 2. Individual and Group Performance Benchmarks

The CIC, with substantial input from the SAGs, will establish recommended performance targets, or benchmarks, against which GRIPA will measure its physicians' individual and

network compliance with the guidelines. Some of the performance targets for GRIPA's new measures will be process-based (*e.g.*, measuring percentage of diabetic patients receiving an annual eye exam), and others will be outcome-based (*e.g.*, measuring percentage of diabetic patients with hemoglobin A1c <7%). The CIC and SAGs will review local, regional, and national standards in establishing GRIPA benchmarks. For measures that GRIPA has used for its risk contracts, GRIPA will initially set the benchmarks for its PPO patients at the same level as those for the HMO risk patients. Where a national or local benchmark is not available, or the current GRIPA performance is well-below or significantly above the national or local benchmark, GRIPA will set the benchmark at the 80$^{th}$ percentile of the current GRIPA network performance. GRIPA wants to challenge its members to improve the quality of care that they provide, but it also understands that it must set its benchmarks at levels that its members can reasonably achieve within a 12-month period so they will be motivated, not discouraged.

Network-level efficiency measures will be determined from evidence-based research studies where proven quality improvement and cost-savings have been achieved. This will be done for each guideline that GRIPA develops. Some examples of cost-savings models are a 1% reduction in A1C values per diabetic patient;[18] serum creatinine levels for hypertensive patients; reduction of MRIs for patients with low back pain; and reduction of admissions for patients with CHF. GRIPA will select cost-savings models and validate their reliability and data assumptions. All available data sources will be considered when creating network-efficiency models. Validation of the cost-saving models' assumptions will be necessary to predict potential opportunity accurately. Benchmarks for these measures will be based on evidence-based studies from which proven cost-savings have been achieved. The GRIPA Board will have final approval of the benchmarks.

### 3. Monitoring and Corrective Action

An integrated entity is no stronger than its weakest participant. Therefore, GRIPA will pay close attention to the individual performance of its members, as well as to the network's aggregate performance. To monitor GRIPA physician compliance with the guidelines and achievement of performance goals, GRIPA will obtain information from the physicians' medical-service claims about patient diagnoses and physician treatments provided. GRIPA will require all participating physicians to provide it with copies of all medical-service claim forms when they submit the claims to payers. To simplify this process, GRIPA is working with its members' practice-management vendors and electronic billing services to ensure system interoperability so that the physicians' offices and the billing services can submit the claims directly to GRIPA as the bills are generated. In addition, GRIPA will work with its members who use web-based billing systems to set up their online systems to allow those physicians to submit a copy to GRIPA electronically as the claims are sent to payers. Physicians who still use paper billing systems will be required to fax copies of claims to GRIPA when they submit those claims to the payers.

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[18] Exhibit 12, GRIPA Cost Savings Model for A1c Control.

When GRIPA receives these claim forms, its IT staff will electronically extract the pertinent information–patient identifiers, provider identifiers, payer name, patient diagnosis, CPT code identifying the service provided, ICD-9 codes identifying the diagnoses, and date of service.[19] This data will then be combined with electronic prescription and laboratory results data downloaded from the Healthvision central data store (discussed later at Section II.C.1) and then will be transferred to the internal GRIPA data warehouse for processing through its , a clinical support application that will allow GRIPA to apply the guideline measures to collected patient data and generate individual physician and network performance reports.

To improve individual performance and provide opportunities for the physicians to work collaboratively to improve the network's performance, GRIPA will provide feedback to its physicians quarterly using performance reports. GRIPA already has a report-card system for its risk contracts to report the performance of PCPs, OB/Gyns, orthopedists, and cardiologists against GRIPA-established benchmarks.[20] For its new clinical-improvement services, GRIPA will generate similar performance reports for all physicians reflecting their and GRIPA's performance against the GRIPA benchmarks for the newly developed guideline measures. Each report will define the measures and show the physician (1) his or her compliance rate for each measure, (2) a comparison of each compliance rate to the last quarter's results, (3) his or her cumulative compliance "score" for all measures, and (4) the average score for all physicians to whom each measure applies. As GRIPA has done with its risk-contract report cards, it will use a weighting system for the clinical-improvement services performance-report scores so that it can compare quality across all physicians and specialties. The individual and network quarterly performance-report results will be mailed to the physicians and the network results will be posted on GRIPA's Internet portal, with scores displayed by peer group.[21] The top 10 best-performing physicians on each measure will be disclosed to all GRIPA physicians.[22] Identifying the best performers has several goals and benefits: (1) the best performers will be recognized by their peers, placing pressure on poorer performers to improve; (2) poorer performers will seek guidance from their higher-performing peers; and (3) physicians will vie for a top 10 position, continually improving their quality, because they realize that poor performance may adversely affect referrals from other GRIPA physicians. GRIPA also will post a blinded report ranking all physicians by score, which will permit physicians to see where they rank among their peers and motivate improvement.

GRIPA's data analysis staff will identify, for evaluation by the CIC, physicians whose performance is deficient relative to the benchmarks and the network average. The CIC will also

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[19] Exhibit 13, Claims Data Extract Requirements.

[20] Exhibit 14, PCP Performance Profile Summary.

[21] Exhibit 15, Clinical Guidelines Summary.

[22] Exhibit 16, Top 10 Physicians Chart.

look at GRIPA's and individual physicians' actual medical expenses and utilization compared to what was expected based on past data (*e.g.*, total medical expense and use of emergency room services). Risk-adjusting each physicians' patient data, based on the severity of his or her patients' illnesses, will allow GRIPA to compare medical costs and utilization across patients with similar diseases and compare the performance of physicians who treat those conditions. In addition to these risk-adjusted measures, GRIPA will measure overall utilization within selected episodes of care, allowing the CIC to review all of the medical services a patient received (*e.g.*, office visits, hospitalizations, and prescriptions) for one episode of an illness. Where the CIC finds physician compliance with practice guidelines and performance measures deficient, it will refer the matter to GRIPA's Quality Assurance Council ("the Council") for further review.

The 16 members of the Council—four PCPs and 12 SCPs—will be chosen by lottery. All physicians who are not serving on a GRIPA committee will be eligible and are required, under the terms of the participation agreement, to serve if selected. Each Council member will serve a one-year term, and the terms will be staggered by quarters, allowing four physicians to cycle on and off every four months. By composing the committee in this manner, GRIPA will involve a larger number of its members in the peer-review function, making the performance of the network and its physician members a concern of the majority.

In addition to reviewing and investigating the performance of each physician referred by the CIC, the Council will review the bottom 10 percent of performers across all members. After collecting and analyzing performance data and other quality information relating to a non-compliant physician, the Council will determine the appropriate course of action to help the physician improve his or her performance. If any formal action is warranted, the Council will create a Quality Assurance Action Plan, which will describe the deficiencies (or areas of guideline non-compliance), the recommended discipline, and a time frame within which the physician must improve his or her performance to meet the GRIPA benchmark.[23] Potential disciplinary measures that the Council may recommend include education sessions with the CMO and the highest scoring physician for the identified measures, warnings, monetary sanctions,[24] or expulsion. The non-compliant physician may accept the Council's Quality Assurance Action Plan, or appeal to the CIC, which will appoint a three-member panel, including one clinical peer from the same specialty, to evaluate the Council's findings and recommendations.[25] If the panel's determination is adverse, the physician may also appeal to the GRIPA Board. Once a Quality Assurance Action Plan is final, the Council will assist the CIC in

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[23] Exhibit 17, Policy: Quality Assurance Action Plan.

[24] GRIPA hopes to include a gain-sharing or pay-for-performance component in its contracts with payers. If GRIPA is successful in saving payers money or meeting payers' quality targets, the payers will then make a "bonus" payment to GRIPA. The physicians will each be eligible to receive a share of the "bonus" if the network, as a whole, meets the requirements. As a disciplinary measure, the Council will be able to impose monetary sanctions that would require a non-compliant physician to forfeit all, or a portion, of his or her share of the bonus.

[25] In the event the Council recommends expulsion, an appeal to the full CIC is automatic. If the CIC affirms the expulsion recommendation, the Board must also affirm the decision, under New York Law, for the action to occur.

monitoring the performance of the subject physician and meeting with the physician to ensure compliance. If improvement does not result within the allotted period, the Council may recommend extension of the Quality Assurance Action Plan, or further disciplinary action. The GRIPA Board, on the recommendation of the CIC and after appropriate due-process procedures, may expel a physician refusing or failing to comply with a Quality Assurance Action Plan, or whose performance is habitually deficient.[26]

GRIPA's CIC and its Medical Management Committee ("MMC") will share responsibility for network quality improvement. In GRIPA's risk-sharing program, the MMC—comprised of six GRIPA physicians, the CMO, the Director of CMS, the Manager of Pharmacy Services, and four ViaHealth representatives—is responsible for overseeing GRIPA's utilization and quality management and the network's quality performance under its risk contracts. For clinical-improvement services, the CIC will focus on implementing quality changes at the individual physician level, while the MMC will work on improving performance of the entire network and the outcomes specific to GRIPA's disease-management programs.

To determine whether the GRIPA network is achieving the significant efficiencies its expects from its integrative activities, the CIC and MMC will monitor and review the physicians' aggregate performance under the network quality and cost benchmarks. The committees will receive reports at each meeting showing cost-savings achieved compared to predicted cost-savings. All network efficiency measures will be continuously updated and available via the GRIPA Dashboard, a central data-reporting portal that contains all GRIPA network and provider-specific monitoring reports and is readily accessible to all GRIPA staff and quality assurance committees.[27] The Dashboard includes a series of triggers that alert GRIPA when any monitoring measure reaches a pre-defined lower variance limit and requires additional attention to reverse the downward trend. If the CIC or MMC determine that the benchmark-level efficiencies are not being achieved or cost savings are less than projected, additional detailed analyses will be performed to determine network causes for these deficiencies. These causes may include utilization or quality variability between network providers, patient demographics, patient illness burden, or under-utilization of medical-management services. Depending upon the causes, the CIC or MMC will determine the best course of action to solve the problem, which may include general network education, meetings of the relevant SAGs to identify the best approach to changing physician practices and to determine whether patient education or intervention may be necessary, revision of the guidelines, re-evaluation of the benchmarks, creation of new medical-management programs to work with the physicians and their patients, quality assurance action plans for deficient or non-compliant providers, and/or work with payers to identify other possible means of achieving improvement.

As it does now under GRIPA's risk contracts, the MMC will also serve as a forum for meeting with the payers' medical directors to review GRIPA's performance and to identify

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[26] Exhibit 18, Policy: Clinical Integration Panel Expulsion.

[27] Exhibit 19, Clinical Guidelines Dashboard.

opportunities for improving quality and reducing costs with regard to the individual payers' patients. GRIPA anticipates that, under its new integrated-product contracts, its MMC will share GRIPA's data and reports with the payers' medical directors at these meetings.

### B. Medical-Management and Physician Support Programs

In implementing a program to clinically integrate its physicians, GRIPA through collaboration between its physicians and its CMS staff, will continue its utilization-, case-, disease-, and pharmacy-management programs, but its social workers, nurses, and pharmacists will broaden their patient population from high-cost/use patients covered by risk contracts to all high-cost/use patients of all participating GRIPA physicians under GRIPA contracts. Thus, GRIPA will be able to touch a much larger number of patients and physicians.

CMS will use a two-prong approach to quality improvement. First, CMS will work with the physicians and their staffs to better understand and apply the GRIPA guidelines to affected patients. To truly integrate, GRIPA's physicians will need to change their approach to practicing medicine from an individualized practice to collaborative treatment, providing care among the PCPs, SCPs, their nursing staffs, and GRIPA's staff. Being on site at physician offices will allow GRIPA staff to make recommendations to the physicians regarding adherence to guidelines, including optimizing medical treatment, initiating referrals, providing clinical education, developing collaborative care plans between practices, and assisting with patient compliance. The CMS staff will also help train member physicians' nurses and staff regarding the treatment needs of patients with asthma, diabetes, heart failure, CAD, and COPD (and, later, other maladies) so that the physicians are not the only ones in the offices working towards guideline compliance. The added support to the physicians and their staffs by CMS staff should result in improved quality of care for the patients by increasing collaboration between all providers and sites of service.

One tool that CMS staff will use to help the physicians is a Clinical Services Report ("CSR"), which identifies patients who have not received the care recommended by the guidelines and what care is still needed.[28] Like a disease registry, the CSR identifies patients who fall into the categories of high cost, high utilization, chronic disease, co-morbid diagnoses, and under-utilization (no preventive care). The CSR, however, provides more information and will be a continuously updated on-line resource customized for each GRIPA physician. GRIPA physicians will use the CSR to review the charts of the patients identified on the CSR to determine whether GRIPA is missing data or needs to correct its data, and take action on guidelines and measures that have not been met. In addition, the CSR will help the physicians and CMS identify patients who could benefit from enrollment in the CMS programs.

CMS's second approach to quality improvement will be to work with patients. By supporting physicians' offices and working directly with the physicians, CMS staff and

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[28] Exhibit 20, Clinical Services Report. GRIPA currently uses a paper version of the CSR for its risk contracts.

physicians, together, will identify potential patient-driven issues, such as poor adherence to medical-treatment plans. The case managers will work with these patients to identify barriers to adherence, which may include inability to afford medications, fear of side effects, lack of knowledge, depression, anxiety, etc. Addressing these issues, which physicians in busy practices are often unable to do, will improve patient outcomes and the network's quality. In collaboration with the patients' physicians, CMS staff will educate and encourage better follow-up care and improve the patients' self-management of their health in one-on-one and group settings.

### C. An Electronic Clinical-Information System Requiring and Generating Interdependent Action

GRIPA will help develop and establish, and its physicians will use, new information technology systems that will result in patient information flowing freely and securely among GRIPA's physicians so that they may coordinate their treatment. The benefits of using the technology include reduced medical errors, improved patient outcomes and satisfaction, and more efficient provision of care and use of resources.

GRIPA has contracted with Healthvision, Inc., to create jointly an online portal through which GRIPA physicians will receive electronic access to complete patient information about GRIPA patients and be electronically connected to one another.[29] Healthvision is the leading national provider of Internet-based infrastructures, or portals, for electronic patient-treatment information exchanges.[30] Healthvision's e-health*SOURCE*™ system provides an information infrastructure that permits health-care providers to share clinical, administrative, and financial data, regardless of the technology used to send or access the data—that is, it facilitates communication between interoperable systems. Through GRIPA's portal, GRIPA and its physicians will have immediate access to the patient information they need, when they need it, to make the most appropriate patient-care decisions possible either through collaboration among themselves or unilaterally.

To participate in GRIPA's new integrated-product network, physicians must agree to attend training in the technology, use the technology as it is implemented, and contribute to the store and flow of information. GRIPA will provide each physician with a tablet computer, access to the necessary Internet service at a discounted price, and technical support so each physician can comply with these requirements. GRIPA will monitor use of the portal by each physician and each office, and will contact physicians who do not use the portal in compliance with the requirements set by the GRIPA Board. The physicians' performance reports reflect use of the portal, and physicians' scores will be negatively affected by their failure to use the portal. The CIC and the Council will also take into account portal use when evaluating physician compliance and quality improvement and will discipline physicians for repeated failure to use the portal and the electronic applications.

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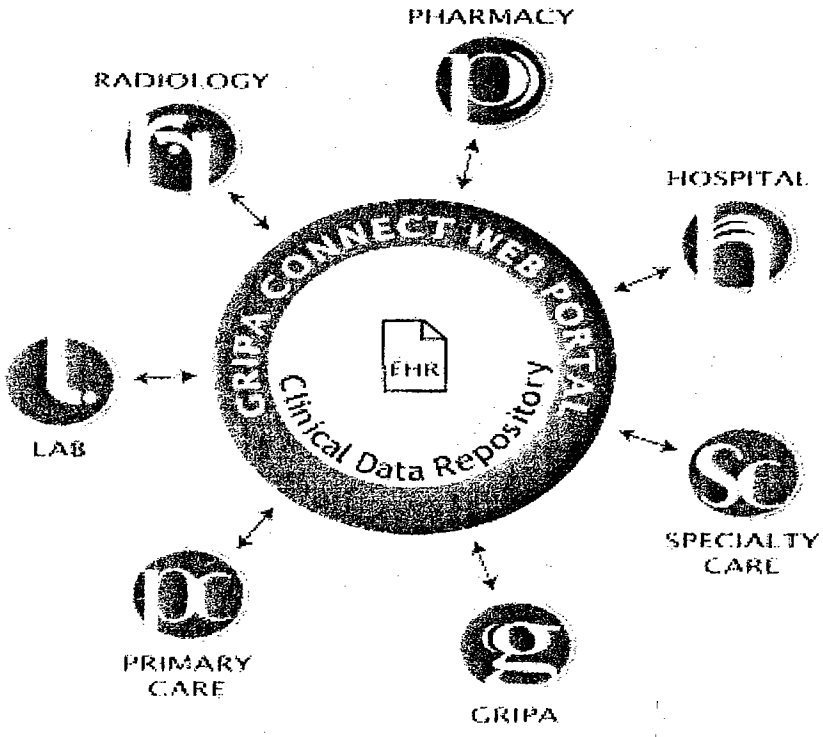
[29] Exhibit 21, Addendum 1, Contract Narrative.

[30] For information about Healthvision, see http://www.Healthvision.com.

### 1. GRIPA Clinical-Information System--Clinical Data Flowing Into the Information Systems and Available to GRIPA Physicians

The core of Healthvision's information infrastructure is a "central data store" within which all of the GRIPA patients' inpatient and outpatient information—collected from GRIPA and its physicians, as well as Rochester-area hospitals, labs, radiology providers, and pharmacies—will be matched by patient identifiers, such as demographic information, and aggregated into a single record for each patient. Healthvision, in real time, will receive (1) patient referral and consultation notes; (2) written drug prescriptions; (3) lab orders and corresponding lab test results; (4) diagnostic imaging reports and Internet links to the images; (5) hospital inpatient and outpatient information, such as patient registration and visit information, discharge summaries, discharge instructions, consulting physicians' notes, hospital radiology reports, and hospital laboratory results; and (6) information on filled prescriptions, as it becomes available, all represented graphically as follows:




ViaHealth's internal IT system, the Clinical Care System ("CCS"), which is already operative will connect with the new Healthvision portal and transfer hospital patient data to the central data store as it is generated in the hospitals' computer systems. As the central data store receives this information, the patients' hospital information will be added to their health records in the portal, so that when GRIPA physicians access the patients' records through the portal they

will see the new hospital-related information, including hospital-discharge summaries and instructions and transcribed physician consultation notes. This information will be most pertinent to PCPs who use hospitalists because they will have all of their GRIPA patients' hospital-treatment information available on the same system as all of their office-based treatment information. In addition, the information will provide GRIPA physicians with a better understanding of their patients' medical history and will also lead to greater collaboration among office and hospital-based physicians because they can more easily share information and work together to treat their common GRIPA patients.

### 2. GRIPA Clinical-Information System--Computer Applications Facilitating Improved Quality, Greater Efficiency, and Reduced Costs

GRIPA physicians will have access to patient records and results on the portal from any computer with a high-speed Internet connection. Each GRIPA physician will have a personalized "clinician desktop" that will organize all the different information available into easy-to-access and use categories, such as patient data, guidelines, messages, prescriptions, lab results, and referrals. From the clinician desktop, GRIPA physicians will also be able to access the electronic applications supplied by Healthvision, including: (1) secure electronic messaging, (2) referral management, (3) electronic prescribing, and (4) lab-order entry. We briefly describe each of these applications:

#### a. Patient health records

When a GRIPA physician reviews a patient record on the portal, he or she will be able to identify all the other physicians who have treated the patient, when those physicians saw the patient, the services those physicians provided, and the diseases or conditions treated. Using this information, the physician will be expected to collaborate with the patient's other treating physicians so that their efforts are not duplicated, orders are not contradictory, and the best course of care is determined and applied. This type of collaboration should result in reduced financial and time costs for the patient and payer and higher quality care for the patient. The patient treatment data will also permit the physicians individually to provide better care for their patients because they will better understand their patients' overall health, medical history, and current treatments.

#### b. Guidelines

All GRIPA physicians will be able to view the GRIPA practice guidelines on the portal, which will also include links to supporting documentation, clinical vignettes, and references. Patient records on the portal will include all data applicable to the guidelines (*e.g.*, lab results, office visits, and prescribed and filled prescriptions). Initially, the guidelines will be available as a reference so that physicians can see ways to improve the patients' care. In the second phase of GRIPA's IT rollout, the guidelines will provide patient-specific "prompts" as the physicians enter information at the point of care (*e.g.*, a request to enter the date of the last eye exam, which

may result in the physician conducting the exam to meet the data request). The online guidelines will facilitate greater guideline compliance by GRIPA physicians, which should result in improved patient health and reduced long-term health-care costs. By providing the guideline information on the portal, the GRIPA physicians will also be able to review the guidelines with their patients at the time of care, using them as patient-education tools and a means of explaining the patient's treatment regimen. This should result in higher patient satisfaction levels and improved compliance with treatment plans.

**c. Secure electronic messaging**

Healthvision's Secure Health Message Center is an electronic messaging system run through the portal that functions much like e-mail. All its transmissions will be secure and will comply with HIPAA and other privacy requirements. The Message Center will be the application through which GRIPA physicians receive communications from each other, GRIPA, clinical laboratories, diagnostic imaging facilities, and hospitals. GRIPA will use the Message Center to send information regarding specific patients receiving special assistance from GRIPA's CMS staff, which will permit the physicians to take an active role in the care of patients enrolled in the GRIPA case- and disease-management programs. Most important, the Message Center will facilitate collaborative care. No longer will the physicians have to sit on hold or "play phone-tag" in order to consult with each other. They will exchange patient test results and scanned treatment notes and charts and then confer regarding patient-specific information contained on the portal. This should result in greater cooperation and more seamless care among PCPs and SCPs.

**d. Electronic referral management**

To maximize the effect of its quality improvement efforts and the opportunities for collaboration among its physicians in patient care, GRIPA will require intra-network referrals of the GRIPA integrated-product patients, except in unusual circumstances. GRIPA does not anticipate that this will be difficult because its network of PCPs and SCPs has already developed strong intra-network referral patterns because of GRIPA risk arrangements. For example, in 2005, 77 percent of all physician referrals under one of GRIPA's risk contracts and 93 percent of referrals under another were within the GRIPA network. To ensure, though, that GRIPA physicians continue intra-network referrals, GRIPA will electronically monitor referrals via Referral Management, a Healthvision application connected to the portal. Physicians who fail to comply with the intra-network referral requirement will be subject to review and discipline by the CIC. The referral relationships developed through years of risk contracting, and those required under the new integrated-product program, will make collaboration on patient care easier and thus more likely and therefore should result in better treatment outcomes.

Referral Management will also facilitate communication between referring and consulting physicians and their office staffs. Once a referring physician completes the electronic referral request, Referral Management will send a message to the consulting physician seeking

acceptance or rejection of the consultation. If he or she accepts, the consulting physician will automatically obtain access to the referred patient's information on the portal, such as lab results, medication lists, radiology reports and diagnostic images. This should greatly reduce the time needed to transfer patient treatment information and provides the consultant a more complete patient history. After the initial appointment, the consultant will complete an electronic consultation report for the referring physician, which will initiate discussion between the physicians regarding the best course of treatment for the patient and allow them to determine whether the consultant will continue to treat the patient. If the consulting physician continues treatment, the referring physician will continue to monitor treatment and confer with the consultant electronically. This collaboration in patient care should result in more holistic patient care and medical-cost savings by reducing duplicate tests and diagnostic images. Referral Management will increase communication and collaboration among the GRIPA physicians, save physicians' and their staffs' time in collecting and transmitting patients' medical histories and treatment plans, and improve the referral process for patients.

**e. Electronic prescribing**

A third application that Healthvision will provide GRIPA physicians via the portal is electronic prescribing. Allscripts, the nation's leading provider of e-prescribing software, created Healthvision's electronic prescription application. The e-prescribing system will show all prescriptions written and renewed for the patient by GRIPA physicians and will allow a physician to order new, or renewal, prescriptions efficiently. If a GRIPA physician attempts to prescribe drugs for which a patient already has a prescription, the e-prescribing system will alert the physician, preventing duplication and saving money for the payer. The e-prescribing system will also create cost savings by suggesting generics or alternative drugs that comply with payers' formularies. The system also reduces the likelihood of an adverse drug event by providing patient safety alerts if it detects possible drug-to-drug interactions, patient allergies, or cross-sensitivities. The physician can choose whether to print the prescription for the patient, fax it to a pharmacy, or electronically submit it to the pharmacy,[32] preventing adverse drug events resulting from illegible prescriptions and saving patient and office staff time dealing with pharmacies.

**f. Electronic lab orders and results**

A final Healthvision application that GRIPA physicians will access through the clinician desktop is the Lab Order Management Module, through which GRIPA physicians will order laboratory procedures and tests for their patients. The Lab Module will eliminate problems relating to illegible handwriting and patient miscommunications, saving payers money and

patients time and hassle. It will also reduce duplication of tests by alerting the ordering physician that the same test was recently completed for another GRIPA physician, resulting in additional cost savings. In addition, the module will verify the medical necessity of the ordered tests against the payer's set criteria, alerting the physician to any preauthorization requirements or coverage issues. Once the order is entered, the physician's office staff can track it in the system to determine when the patient specimen is collected and when a lab report is generated, ensuring that the lab results are available before the patient arrives for his or her next appointment. When the lab report is completed, the physician will receive the report through the Message Center, and the test results will be added to the patient's information in the central data store, allowing the ordering physician to consult with his or her colleagues in the treatment of the patient.

### g. The cost of the technology

Given the breadth and depth of the services the Healthvision portal will provide, GRIPA's contract with Healthvision is expensive. GRIPA will pay Healthvision more than $2 million over the next three years for the implementation, operation, and support of the portal and for Healthvision's software applications for secure messaging, referral management, e-prescribing, and electronic lab orders. In addition, the cost of providing each GRIPA physician with a tablet computer will be approximately . The physicians will pay for their wireless Internet connections—about $70 per month. In addition to these direct monetary outlays, use of the technology will require physicians to invest their own time. They will be required to attend eight hours of training at a time cost of approximately per physician, which equates to for the network. Physicians will spend an additional two hours per month on clinical-improvement activities and compliance with the guidelines. The value of the physicians' time for these hours is approximately $100 per hour per physician—more than per year if all 717 eligible physicians participate.

To fund GRIPA initially, the POs made combined capital contributions of Over time, GRIPA has accumulated reserves of approximately . a portion of which it will use to fund its technology. This money is its physicians' money. Absent its investment in the program to integrate its members, GRIPA would likely have returned the money to its physicians through annual risk contract withhold returns. GRIPA also will use the $227,835 grant it received from New York as a part of the state's health information technology initiative.

## III. GRIPA Contracting with Payers

GRIPA's clinical-improvement services program will permit it to offer payers more than just the medical services of a network of physicians. Rather, GRIPA will integrate these services with collaborative patient-care activities among its physicians that will improve the efficacy and efficiency of those services above the level that would exist absent the program. GRIPA believes that the integration of these services and the physician services of its members will provide it with a competitive advantage over other physician groups and individual physicians

unable or unwilling to offer this type of integrated product. By contracting with GRIPA, both payers and GRIPA members will realize significant transactions-cost efficiencies resulting from greatly reduced and more efficient contract negotiations and single-signature contracting. More important, GRIPA physicians, through their interdependent action, will increase output by producing a higher quality product using proportionally fewer resources.

GRIPA has already met with local officials of both Excellus and Preferred Care to gauge their interest in GRIPA's proposed integrated product. GRIPA's CEO and CMO perceived that these payers are interested in the program's potential to increase quality and lower the quality-adjusted, if not the actual, cost of medical services in the Rochester area.

### A. GRIPA's Contracting Procedure

GRIPA intends to negotiate fee-for-service contacts with interested and willing self-insured employers, third-party administrators, managed-care organizations, and health insurers for its new integrated product. As noted below, GRIPA's participation agreements with its physicians will require that each GRIPA physician participate in all contracts into which GRIPA enters. Physicians may not "opt out" of any GRIPA contracts because of the deleterious effect that only partial participation would have, particularly on the clinical-improvement services program.

Although all GRIPA physicians must participate in all GRIPA contracts, GRIPA will not attempt to force payers to contract with it. If GRIPA and a payer with which it is negotiating cannot reach an agreement on a contract or if a payer notifies GRIPA that it does not wish to contract with GRIPA, GRIPA physicians will be completely free to negotiate with the payer on an individual basis and decide unilaterally whether to participate in the payer's network. If a GRIPA physician has contracted on an individual basis with a payer that subsequently contracts with GRIPA, the individual contract will terminate, or if not terminated by either of the parties, become subordinate to the GRIPA contract, which will control the relationship between the payer and physician.

The GRIPA staff, based on guidelines and parameters established by the GRIPA Board in conjunction with the staff, will negotiate the terms and conditions of the contracts, including the price for the integrated product. Using its knowledge of competitive physician-fee levels in the Rochester area based on GRIPA's risk-sharing-contract program and understanding that area payers have options other than GRIPA, the GRIPA staff will formulate and negotiate competitive proposals based on conversion factors or dollar amounts that will be multiplied by the Relative Value Units set by the Center for Medicare and Medicaid Services for its Resource-Based Relative Value Scale payment system. The negotiated offers will then require approval by the GRIPA Board prior to execution of the contract. The negotiated prices will constitute full and complete payment due GRIPA physicians for provision of the integrated product. GRIPA's physician participation agreement will prohibit its physicians from balance-billing GRIPA patients.

## B. GRIPA's Need To Contract on Behalf of its Physicians[33]

GRIPA intends to contract on behalf of its participating physicians simply because it cannot integrate and provide its clinical-improvement services efficiently without doing so. In general, as explained below, this is because that program cannot function efficiently (if at all) unless all GRIPA physicians participate in all GRIPA contracts. The only way to ensure that this occurs is for GRIPA to require all its physicians to participate in all contracts it enters. The only way to ensure this result is for GRIPA to contract on behalf of all its physicians and, through its participation agreements, require them to participate in those contracts.

For the reasons we explained before, we think there can be no doubt that the GRIPA clinical-improvement services, when implemented, should generate significant efficiencies. The quality of medical services provided by GRIPA physicians will increase, and health-care resources will be utilized more efficiently. GRIPA physicians will easily and quickly access real-time clinical information about GRIPA patients, which will save physician time in patient treatment, lessen medical errors, help ensure that tests and procedures are not duplicated, and help ensure that the most appropriate medical modalities are provided. GRIPA physicians will increase the efficiency of intra-network referrals, as well as lab test and pharmacy ordering. The guidelines developed by and implemented among the GRIPA physicians themselves should lead to consistent and optimal care decisions and treatments, decreasing the level of unnecessary or duplicative services. The program provides a process for actually improving the performance of physicians who, for any reason, fail to achieve the network's quality and resource-use benchmarks. In addition, efficiencies will flow from GRIPA's contracting on behalf of its

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[33] For purposes of this letter, we believe FTC staff should assume that GRIPA's negotiating fee-for-service contracts on behalf of its physicians would constitute "inherently suspect" conduct under the PolyGram/North Texas Specialty Physicians standard. See Polygram Holding, Inc., FTC Dkt. No. 9298 (Jul. 21, 2003), Slip Op. at 29-35, reprinted in 5 Trade Reg. Rep. (CCH) ¶ 15,453 at 22,458-22,460 ("Polygram"); N. Tex. Specialty Physicians, FTC Dkt. No. 9312 (Nov. 29, 2005), Slip Op. at 10-14, reprinted in 2005-2 Trade Cas. (CCH) ¶ 75,032 at 101,463-101,465 (2005) ("NTSP").

Under this standard, the analysis then examines whether GRIPA integrates its physicians' practices in ways likely to generate significant efficiencies and, if so, whether GRIPA articulates cognizable and plausible "legitimate justifications" for its joint contracting. GRIPA articulates cognizable and plausible legitimate justifications for its joint contracting if it articulates how its joint contracting helps increase output and a "specific link" between its joint contracting and its efficiency-enhancing program, and if a more detailed factual inquiry is necessary to assess the validity of its justifications. In sum, as the FTC staff advisory opinion to Suburban Health Organization explains, the questions in determining whether GRIPA's negotiating on behalf of its physicians should be summarily condemned are whether the overall GRIPA program results in integration likely to result in significant efficiencies and, if so, whether the joint contracting is ancillary to achieving those efficiencies. Cf. ABA Section of Antitrust Law, Joint Ventures: Antitrust Analysis of Collaborations Among Competitors 11 (2006) ("Joint Ventures") ("joint marketing collaborations supported by actual integrative efficiencies will be evaluated under the rule of reason"). If so, the analysis proceeds under a traditional rule-of-reason examination, requiring definition of the relevant market; assessment of GRIPA's market power, if any; assessment of efficiencies from the program; and a balancing of effects to determine whether consumers will be better or worse off.

physicians. Both purchasers and GRIPA physicians will benefit from significant transactions-cost savings flowing from single-signature contracting.[34]

Moreover, for a number of interrelated reasons, it is difficult to discern how GRIPA's clinical-improvement services program could operate successfully absent GRIPA's contracting for its member physicians; that is GRIPA's contracting on behalf of its physicians will be ancillary for the following reasons:[35]

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[34] Notwithstanding suggestions otherwise in NTSP, see 2005-2 Trade Cas. (CCH) at 103,474, these efficiencies are "cognizable," see generally, Broadcast Music, Inc. v. Columbia Broadcasting System, 441 U.S. 1 (1979) ("Broadcast Music"), although, depending on the facts, they may be insufficient by themselves to justify joint contracting.

[35] The precise standard for determining whether a restraint is ancillary is not completely clear. See generally Joint Ventures at 90 ("In particular, the courts have differed in how they categorize 'ancillary' versus 'naked' restraints in defining the degree to which a restraint must relate to the venture's potentially procompetitive effects, and in assessing whether the availability of a less restrictive alternative renders the restraint unlawful."). Many authorities, for example, state that the restraint must be "reasonably necessary" for the achievement of the venture's efficiencies. E.g., Federal Trade Commission & U.S. Department of Justice, Antitrust Guidelines for Collaboration Among Competitors § 3.2 (2000) ("Collaboration Guidelines") (an ancillary restraint is an "agreement that is reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits").

Other authorities, however, explain that the restraint, to be ancillary, must merely be "part of a larger pro-competitive joint venture," Augusta News Co. v. Hudson News Co., 69 F.3d 41, 47, 48 (1st Cir. 2001) (Boudin, J.) (also noting that "it is a standard form of joint venture for local firms to provide offerings—here one-stop service for large buyers—that none could as easily provide by itself, and a joint venture often entails setting a single price for the joint offering"); see also Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 224, 227, 229 n.11, 230 (D.C. Cir. 1986) (Bork, J.) ("Rothery Storage") (an ancillary restraint is one that "serves to make the main transaction more effective in accomplishing its purpose"; an ancillary restraint is "related to the efficiency sought to be achieved"; an ancillary restraint makes the venture "more efficient"; also noting that the "Supreme Court [did not] intend[ ] that lower courts should calibrate degrees of reasonable necessity" in determining whether a restraint is ancillary); Polk Bros. v. Forest City Enters., 776 F.2d 185, 188, 189, 190 (7th Cir. 1985) (Easterbrook, J.) (an ancillary restraint is one that "facilitate[s] productivity activity"; an ancillary restraint is "part of a larger endeavor whose success they promote"; an ancillary restraint "may contribute to the success of a cooperative venture that promises greater productivity and output"; an ancillary restraint "may promote the success of this more extensive cooperation"; an ancillary restraint "play[s]) an important role in inducing [venturers] to cooperate"; the ancillary restraint "made the cooperation possible"); General Leaseways, Inc. v. Nat'l Truck Leasing Ass'n, 744 F.2d 588, 595 (7th Cir. 1984) (Posner, J.) (for a restraint to be ancillary, there needs to be "a plausible connection between the specific restriction and the essential character of the product" or an "organic connection between the restraint and the cooperative needs of the enterprise"); NTSP, 2005-2 Trade Cas. (CCH) at 103,465 n.20 (an ancillary restraint is one that is "reasonably related" to the efficiency-enhancing integration).

See also 11 Herbert Hovenkamp, Antitrust Law §§ 1904, 1906, at 227, 235 (2d ed. 2005) (ancillary restraints are "an essential or at least an important part of some arrangement that has potentially redeeming virtues"; "a restraint is ancillary if its objectively intended purpose or likely effect is lower prices or increased quantity or quality"); Susan B. Creighton, Director, Bureau of Competition, FTC, "Diagnosing Physician-Hospital Organizations," Prepared Remarks Before the AHLA Program on Legal Issues Affecting Academic Medical Centers and Other Teaching Institutions (Jan. 22, 2004) ("Creighton Speech") (for a restraint to be ancillary, there must be a "logical nexus . . . between the restraint and the efficiency" and "the restraint must serve to make the integration more effective in achieving its goals").

1. First, for GRIPA's integrated-product offering to operate, it is important, if not imperative, that all GRIPA physicians participate in all GRIPA contracts with purchasers. The only way that GRIPA can ensure this result is for it to contract on behalf of all its physicians, while requiring them to participate in all contracts that it enters.

Participation by all GRIPA physicians in all GRIPA contracts (which will embody the new integrated product) is necessary for several reasons. First, purchasers will choose to contract with GRIPA in part because they desire the efficiencies from single-signature contracting with a defined and known network of providers. To provide its customers with a certain, defined network of physicians, GRIPA must be able to ensure its customers participation by a defined set of providers. When a purchaser chooses to contract with GRIPA, it wants all GRIPA providers, not some subset who might choose to participate while others choose not to participate. GRIPA must contract on behalf of all its physicians for this result to occur.

Second, the FTC staff was correct when it told MedSouth that "the doctors need to be able to rely on the participation of other members of the group in the network and its activities on a continuing basis," and that "[t]his does not appear possible if contracting for the sale of services is done individually."[36] This is true for several reasons. For example, GRIPA PCPs need to know that the SCPs to whom they refer are participants in contracts since those PCPs will be bound to refer to in-network specialists except in unusual circumstances. The same is true to the extent there are referrals among the SCPs. In addition, if the physicians were able, and chose, not to participate in GRIPA contracts, they would be less likely to participate in GRIPA clinical-improvement-service activities, such as developing care guidelines and participating in the performance-monitoring and correction functions.

Third, the administration of a program where some physicians were "in" for some contracts and "out" for others would be extremely difficult, if not impossible. With respect to each contract, GRIPA staff and physician committees would have to differentiate between participating and non-participating physicians, applying the program's requirements to the former but not the latter. Physicians and their offices would have to make the same distinction in

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The more lenient standard appears appropriate because, even if the restraint passes the first test—that is, is ancillary and thus not condemned summarily—it still must pass the second, lack-of-market-power, test. The more stringent test would condemn activities that, on balance, are procompetitive because it would condemn restraints that, while not "reasonably necessary," make the arrangement more efficient while having no anticompetive effect because the parties lack market power. This conclusion also comports with Judge Bork's holding in Rothery Storage that courts should not attempt to "calibrate degrees of reasonable necessity" in determining whether a restraint is ancillary.

[36] Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, FTC, to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002) ("MedSouth FTC Staff Advisory Opinion"); see also Thomas B. Leary, The Antitrust Implications of "Clinical Integration": An Analysis of the FTC Staff's Advisory Opinion in MedSouth, 47 St. Louis Univ. L.Rev. 223, 226-27 (2003) (agreeing with staff's conclusion and rationale in MedSouth that joint contracting would be ancillary); Creighton Speech (same).

complying with the program's referral requirements, having to check participation lists for each GRIPA contract before making a referral. This is simply not administratively feasible.

Fourth, the requirement that all physicians participate in all GRIPA contracts alleviates (but admittedly does not obviate) the customer free-rider problem of payers benefiting from some aspects of the GRIPA physicians' clinical-improvement activities without paying for them by contracting with GRIPA physicians on an individual basis.[37] To the extent that GRIPA physicians must participate in GRIPA contracts rather than contracting individually, purchasers cannot free-ride.

Finally, if all GRIPA physicians are not required to participate in all GRIPA contracts, GRIPA cannot be assured that there will be sufficient compliance information from the physicians with respect to GRIPA contracts for the monitoring and corrective-action functions of the program to operate and thus achieve the efficiencies that GRIPA envisions the network will generate.

2. Second, and related to the above, if GRIPA does not contract on behalf of its physicians and establish the price for its integrated product, it is difficult to discern how that price would be established. In antitrust lingo, there is no "less restrictive alternative" method by which prices for the integrated product could be determined.[38] As a theoretical matter, GRIPA could implement a messenger arrangement or its physicians could contract with customers on an individual basis. But in neither situation could GRIPA guarantee participation by its entire network or require its physicians to participate in all contracts into which it enters.[39] Moreover, real-life experience shows that a messenger arrangement is simply not administratively feasible for a network with some 600-700 physicians. There are substantial diseconomies of scale or X-inefficiencies.

Related to this is the fact that, while GRIPA's integrated product may not, under the Broadcast Music or Maricopa County Medical Society standards, technically result in a "different" or "new" product from that sold by its physicians individually (a point we concede

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[37] Because GRIPA will operate as a non-exclusive network, it cannot eliminate this free-rider problem completely. For example, GRIPA physicians contracting with payers individually might apply the GRIPA guidelines to their non-GRIPA patients. Most activities in life, however, generate some positive externalities for which participants cannot be compensated.

[38] Cf. Collaboration Guidelines §3.36(b) ("if the parties could . . . achieve similar efficiencies by practical, significantly less restrictive means, then the Agencies conclude that the relevant agreement is not reasonably necessary to their achievement").

[39] See MedSouth FTC Staff Advisory Opinion ("The price for professional services rendered under the health plan contracts needs to be established, and if it is done through individual negotiation and contracting, then no one can count on the full participation of the group's members."). In essence, it is not the price fixing by itself that is "reasonably necessary," but rather the need for all GRIPA physicians to participate in all GRIPA contracts. The problem is that the only way this can be assured is if GRIPA "fixes" the price.

only for purposes of this letter), the clinical-improvement services that GRIPA is integrating into its physicians' medical services certainly result in a "differentiated" product from anything its physicians could produce and sell individually. Indeed, one of GRIPA's major goals is to differentiate the product it sells from those sold by its individual members and other competitors in the hope that customers will willingly pay more for a product differentiated on the basis of quality[40] that integrates its physicians' services and an "aggregating service" similar to that sold by the defendant groups in Broadcast Music.[41] To be sure, certain parts of GRIPA's program, such as its case- and disease-management programs, could be disaggregated and sold separately from its physicians services. But the physicians' services and other parts of the clinical-improvement-services program are indivisible and thus must be priced together. It is impossible to see, for example, how the protocol reporting, monitoring, and corrective-action portions of the program could be priced and sold separately without the GRIPA physician services. Accordingly, they should be sold (and thus priced) as a package.

3. Third, as in any joint venture, GRIPA needs to align the incentives of its venturers as much as it can so that, to the extent possible, they pursue the venture's collective interest rather than their own, separate individual interests. By definition, joint venturers "pursu[e] a common objective"[42]—here, developing and selling a premium form of medical services. Admittedly, because GRIPA will be a non-exclusive network, it cannot align those incentives completely as the joint venturers did in the Dagher case.[43] If the GRIPA physicians were to compete against one another on the basis of price when providing services through a GRIPA contract, their interests would diverge, and they would function less like a single entity pursuing a unified goal[44]—meeting the network's benchmark efficiency and utilization standards. The physicians'

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[40] Cf. Thomas B. Leary, Special Challenges for Antitrust in Health Care, Antitrust, Spring 2004, at 26 (approving of "an association that seeks to increase its bargaining power by improving the quality of its services"); Thomas B. Leary, The Antitrust Implications of "Clinical Integration": An Analysis of FTC Staff's Advisory Opinion to MedSouth, 42 St. Louis Univ. L.J. 223, 232 (2003) ("Payers may be willing to pay MedSouth doctors more for fewer services simply because these doctors are better at deciding when services are necessary and get better results when they perform those services."). See also Robert Pitofsky, Chairman, FTC, "Thoughts on 'Leveling the Playing Field' in Health Care Markets," Prepared Remarks Before the AHLA Antitrust in the Health Care Field Seminar (Feb. 13, 1997) ("[o]ne response [for physician networks] is to create a product that is designed to be more attractive to consumers").

[41] Broadcast Music, 441 U.S. at 21.

[42] Joint Ventures at 5.

[43] Texaco, Inc. v. Dagher, 126 S.Ct. 1276 (2006) (analogous to exclusive network, joint venture completely aligned venturers' incentives because it ended all competition between them; accordingly, price-fixing agreement between them was not per se unlawful). Risk contracting or a total merger of all the GRIPA physicians' practices could align the incentives within GRIPA further. GRIPA examined both options but neither was feasible. Area payers appear uninterested in continuing to contract on a risk basis, and a merger of all practices presented insurmountable business and political problems. Thus, the program proposed in this letter presents the only feasible alternative.

[44] Cf. Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984) (parent and wholly-owed subsidiary deemed a single entity because their interests are totally aligned through the parent's control).

interests and GRIPA's in ensuring GRIPA's success in achieving its efficiency goals through the joint venture are most closely aligned when the physicians do not compete against one another within the context of the joint venture based on price.

4. Fourth, the fact that GRIPA will operate on a non-exclusive basis shows that GRIPA's contracting on behalf of its members is not a practice that "facially appears to be one that would always or almost always tend to restrict competition and decrease output" rather than "one designed to 'increase economic efficiency and render markets more, rather than less competitive',"[45] the classic standard for summary condemnation. Although this fact is logically more relevant to the question of whether GRIPA would have market power rather than whether the market-power question is even reached, the Commission has indicated that likely effects on competition in the particular circumstances under consideration are a significant factor in determining whether a legitimate justification exists for an inherently suspect restraint.[46] The Supreme Court did the same in Broadcast Music; the fact that the composers could sell their compositions on an individual basis was one reason for applying the rule of reason rather than the per se rule to the group's price fixing through the blanket-license mechanism. Here, as in Broadcast Music, GRIPA's contracting on behalf of its physicians merely provides customers with an additional competitive option they otherwise would not have.[47]

The implementation, operation, and success of the GRIPA program demand that GRIPA contract on behalf of its physicians—that is, the joint contracting is "essential." It is difficult, if not impossible, to see how the program could operate, and generate the anticipated efficiencies, if payers contracted with GRIPA and its physicians individually.[48] But even if joint contracting is not "essential" to the program's success, joint contracting will clearly support the program, make it more effective, and result in its operating more efficiently than it otherwise could. Thus,

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[45] Broadcast Music, 441 U.S. at 19-20 (quoting United States v. U. S. Gypsum Co., 438 U.S. 422, 441 n.16 (1978)).

[46] See Polygram, Slip Op. at 29 ("Such justifications may consist of plausible reasons why practices that are competitively suspect as a general matter may not be expected to have adverse consequences in the context of the particular market in question; or they may consist of reasons why the practices are likely to have beneficial effects for consumers), petition for review denied, 416 F.3d 29, 36 (D.C. Cir. 2005) (if the restraint is inherently suspect, "defendant must either identify some reason the restraint is unlikely to harm consumers or identify some competitive benefit that plausibly offsets the apparent or anticipated harm").

[47] Cf. Broadcast Music, 441 U.S. at 6 (agreeing with district court that "since direct negotiation with individual copyright owners is available and feasible, there is no undue restraint of trade"); Wis. Music Network v. Muzak Ltd. P'ship, 5 F.3d 218, 222-23 (7th Cir. 1993) ("Wisconsin Music") (explaining that a network of Muzak franchisees offering a single-signature national contract at a negotiated and then agreed-upon price would "increase consumer choice and interbrand competition" and thus that the per se rule was inapplicable).

[48] GRIPA's network will be non-exclusive, and so it may be that its physicians will contract with payers individually and the program will fail. If so, so be it; let the market work. GRIPA hopes, however, that its integrated product and the ability of payers to single-signature contract with GRIPA are sufficiently attractive that payers will contract with it. But if a payer informs GRIPA that it wishes to contract with physicians individually rather than with the network, GRIPA will take no action to dissuade its physicians from so doing.

there is certainly a "'specific link between the . . . restraint and the purported justification to merit a more searching inquiry'" under the rule of reason.[49] GRIPA's contracting for its members "is subordinate and collateral in the sense that it makes the main transaction more effective in accomplishing its purpose."[50]

### C. GRIPA Will Lack Market Power

Of course, even sufficient integration and the ancillarity of GRIPA's contracting on behalf of its members do not mean that the joint contracting necessarily passes antitrust muster. Rather, the question becomes whether, given the nature of GRIPA's operations and membership and the characteristics of the market, it will be able to exercise market power.

If GRIPA is a truly de facto non-exclusive network, the answer is no, and no further analysis is even necessary. Rather, as noted before, GRIPA's contracting for its members will merely add a competitive option for customers that otherwise would be absent; not only will its joint contracting not reduce competition, it will increase it.[51] For purposes of responding to this request for advisory opinion, staff should assume that GRIPA will operate in a non-exclusive manner. GRIPA will take several steps to help ensure that it actually does operate as a non-exclusive network. First, it will advise its members that they are free to contract individually with payers (or contract with payers through other lawfully operating contracting organizations) and that they have no obligation to contract only through GRIPA unless GRIPA has contracted with the payer in question. Second, although GRIPA will certainly market its network to payers and attempt to persuade payers to contract with it, if a payer notifies GRIPA that it wishes to contract with physicians individually or through another organization, GRIPA will take no action to dissuade its members from negotiating or contracting with payers through other channels.

Although GRIPA's lack of exclusivity should be determinative of the market-power question, its participation percentages (*i.e.*, by medical specialty, the number of physicians in GRIPA divided by total number of physicians in that specialty in the market) is relevant. Participation percentages, in an exclusive network, can serve as a rough surrogate for market shares. Short of litigation, market shares would be impossible to accurately calculate.

We made no effort to define precisely any relevant markets for GRIPA or its physicians because the necessary data was simply not available. Rather, we attempted to calculate GRIPA participation percentages in the three-county area in which GRIPA physicians are located

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[49] NTSP, 2005-2 Trade Cas. (CCH) at 103,465.

[50] Rothery Storage, 792 F.2d at 224.

[51] Cf. Wisconsin Music, 5 F.3d at 222 (the "program enhances competition by increasing the available choices for . . . customers").

(Monroe, Wayne, and Ontario Counties) and in each county separately.[52] In some specialties, GRIPA participation percentages are relatively high. As Exhibit 22 shows, in the three-county area, GRIPA includes more than 35 percent of area physicians in some 14 of 44 medical specialties. Its percentage of participating PCPs, however, is 30 percent. In Monroe County, which includes Rochester itself and the closely surrounding area, its participation percentages are above 35 percent in 15 of 44 specialties; its participation percentage for PCPs is 31 percent. In the much more sparsely populated Wayne County, GRIPA includes more than 35 percent of physicians in 14 medical specialties. In seven of those specialties, however, there is only one practice or one physician. GRIPA includes some 68 percent of all PCPs in Wayne County. Finally, in Ontario County, where GRIPA physicians practice, GRIPA only includes more than 35 percent of physicians in five of the 44 specialties and 1.3 percent of all PCPs located in the county.

Even though some of GRIPA's participation percentages are high, given its non-exclusivity and the power of area payers, GRIPA could not exercise market power.[53]

## IV. Conclusion

GRIPA's overarching goal, in part a response to demands from area payers, is to develop and implement collaborative programs among its physicians that will improve the quality of care they deliver and improve resource-use efficiency leading to lower (or at least less rapidly escalating) costs. A collateral goal is to improve physician reimbursement through the physicians' collaborative work to provide a premium product differentiated from that of their competitors. To meet these goals, GRIPA needs to ensure that all physicians participating in its programs participate in all its contracts, except to the extent that payers wish to contract with physicians individually. GRIPA can ensure full participation in its network and in its programs only by contracting on behalf of its members, which necessitates its negotiating prices with its customers, and then requiring that its physicians participate in all contracts into which it enters. After examining the program, we hope staff will conclude that it would not recommend an enforcement action against GRIPA if it were to implement its program and, as part of that program, contract on behalf of its physicians.

Pursuant to Federal Trade Commission Procedure Rule 1.4, 16 C.F.R. § 1.4 (2006), GRIPA requests that portions of this letter, as well as certain documents attached as exhibits hereto, be treated as confidential under Federal Trade Commission Procedure Rule 4.10, 16

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[52] We used Excellus' provider directory to identify the available providers in the area. Due to Excellus' coverage of a large portion of the population, most physicians contract with Excellus. Because we identified some GRIPA physicians who were not in Excellus' database, we believe it is likely there were also non-GRIPA physicians not included in our calculations. This was the best available source, and we apologize for any resulting inaccuracy.

[53] It is worth noting that the commercial-payer market in the Rochester area is highly concentrated. Cf. Dennis W. Carlton & Jeffrey M. Perloff, Modern Industrial Organization, 348 (2d ed. 1994) ("When buyers are large and powerful, their concentration can offset the power of sellers.").

C.F.R. § 4.10(a)(2) (2006), and § 6(f) of the Federal Trade Commission Act, 15 U.S.C. § 46(f) (2006). All information to be withheld is competitively sensitive information, including pricing, costs and information subject to confidentiality agreements, patents, or copyright protection.

Sincerely yours,

Christi J. Braun

John J. Miles

# CERTIFICATE OF INCORPORATION

# OF

# GREATER ROCHESTER INDEPENDENT PRACTICE ASSOCIATION, INC.

Under Section 402 of the Business Corporation Law

The undersigned, for the purpose of forming a corporation pursuant to Section 402 of the New York Business Corporation Law, hereby certifies:

1. The name of the corporation is: Greater Rochester Independent Practice Association, Inc.

2. The corporation is organized and shall be operated exclusively as an independent practice association within the meaning of N.Y. Comp. Codes R. & Regs. tit. 10, § 98 et seq. To this end, the corporation's purpose shall be limited to arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between the corporation and one or more health maintenance organizations which have been granted certificates of authority pursuant to the provisions of article 44 of the Public Health Law of the State of New York, as amended.

3. The corporation may exercise the general powers and purposes contained in this certificate of incorporation, as authorized by Section 202 of the Business Corporation Law, but only as such powers and purposes are incidental to accomplishing the primary independent practice association powers and purposes of the corporation.

4. Notwithstanding any other provision of this certificate of incorporation to the contrary, nothing contained herein shall authorize the corporation to establish, operate, construct, lease or maintain a hospital or to provide hospital services or health-related services or to operate a drug maintenance program, a certified home health agency, a hospice, or a health maintenance organization, or to provide a comprehensive health services plan as defined and covered by articles 28, 33, 36, 40 and 44, respectively, of the Public Health Law, or to solicit, collect or otherwise raise or obtain any funds, contributions or grants from any source for the establishment or operation of any hospital.

5. The office of the corporation shall be located in the County of Monroe, State of New York.

6. No shareholders shall have any preemptive right to purchase shares or other securities to be issued or subjected to rights or options to purchase, as such preemptive right is defined and construed under the laws of the State of New York.

7. The aggregate number of shares which the corporation shall have authority to issue is Two Hundred (200), all of which are to be common shares with no par value.

8. No director of the corporation shall be personally liable to the corporation or its shareholders for damages for any breach of duty in such capacity except where a judgment or other final adjudication adverse to said director establishes: that the director's acts or omissions were in bad faith or involved intentional misconduct or a knowing violation of law or that said director personally gained a financial profit or other advantage to which he was not entitled, or the director's acts violated Section 719 of the New York Business Corporation Law.

9. The Secretary of State of the State of New York is hereby designated as the agent of the corporation upon whom process in any action or proceeding against it may be served, and the post office address to which the Secretary of State shall mail a copy of process in any action or proceeding against the corporation which may be served upon him is 1040 University Avenue, Rochester, New York 14607.

IN WITNESS WHEREOF, the undersigned has subscribed this Certificate of Incorporation this 1 day of MAY, 1996, and hereby affirms that the statements contained herein are true under the penalties of perjury.

Kenneth J. Naples
1040 University Avenue
Rochester, New York 14607

Y. S. DEPARTMENT OF STATE
VISION OF CORPORATIONS

ALBANY, NY 12231-0001

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# GRIPA Owner Physicians

| Group Practice Name | Last name | First name | Degree | Street | Street2 | city | Zip | Medical Specialty |
|---|---|---|---|---|---|---|---|---|
| Roch General Pediatric Assoc | Siegel | David M. | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | ADOLESCENT MEDICINE |
| AAIR | Deane | Peter | MD | 300 Meridian Center | Suite 305 | Rochester | 14618 | ALLERGY/IMMUNOLOGY |
| Allergy Associates of Roch | Corsello | Bruce | MD | 300 South Goodman St | Suite 200 | Rochester | 14607 | ALLERGY/IMMUNOLOGY |
| Allergy Associates of Roch | Dreyfuss | Eric M. | MD | 300 South Goodman St | Suite 200 | Rochester | 14607 | ALLERGY/IMMUNOLOGY |
| Dr. Roth's Office | Roth | Scott Leonard | MD | 1012 Elmgrove Rd | | Rochester | 14624 | ALLERGY/IMMUNOLOGY |
| GHS Allergy/Immun/Rheum | Arreaza | Eduardo E. | MD | 220 Alexander St | Suite 402 | Rochester | 14607 | ALLERGY/IMMUNOLOGY |
| GHS Allergy/Immun/Rheum | Friedman | Elizabeth | MD | 220 Alexander St | Suite 402 | Rochester | 14607 | ALLERGY/IMMUNOLOGY |
| GHS Allergy/Immun/Rheum | Jones | Douglas H. | MD | 220 Alexander St | Suite 402 | Rochester | 14607 | ALLERGY/IMMUNOLOGY |
| GHS Allergy/Immun/Rheum | Ristow | Susan C. | MD | 220 Alexander St | Suite 402 | Rochester | 14607 | ALLERGY/IMMUNOLOGY |
| Westside Allergy Care | Adler | Thomas | MD | 550 Latona Rd, Bldg D | Suite 405 | Rochester | 14626 | ALLERGY/IMMUNOLOGY |
| Westside Allergy Care | Valet | Scott B. | MD | 18 Graves St | | Brockport | 14420 | ALLERGY/IMMUNOLOGY |
| Anesthesia Associates of Roch | Barbaccia | John | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Baronos | Eleftherios | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Brodie | Hugh | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Cafarell | Robert | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Carafos | Michael | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Catanzaro | Francis A. | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Comella | Stephen | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Cortese | Dominick | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Detraglia | Michael | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Dotson | Eric | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Douglas | Robert D.. | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Giriyappa | Sudhir | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Green | Donald | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Guadagnino | Paul L. | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Kleene | Bruce | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Lanni | Alan | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Marin | Ernesto | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Mauro | Salvatore | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Narayan | Kariappa | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Oskoui | Gassem | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Patel | Harshadrai | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Perez-Johnson | Christie | MD | 1680 Empire Blvd | Suite 300 | Rochester | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Prairie | Lyle | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Anesthesia Associates of Roch | Proper | Gilbert P. | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Rosenberg | Jeffrey | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | SanFilippo | Angelo | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Szczurek | Roberta | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Taylor | David | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Tonetti | John | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Villareale | Michael | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Wasserman | Jeffrey | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Young | Robert | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Zhavoronkov | Ilya G. | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Anesthesia Associates of Roch | Zigarowicz | Georgianne | MD | 1680 Empire Blvd | Suite 300 | Webster | 14580 | ANESTHESIOLOGY |
| Pain Treatment Medicine of the Finger Lakes | Nemani | Ajai K. | MD | 30 Hagen Dr | Suite 230 | Rochester | 14625 | ANESTHESIOLOGY |
| RGH SICU | Chhangani | Sanjeev V. | MD, MBA | 1425 Portland Ave | | Rochester | 14621 | ANESTHESIOLOGY |
| Cardiology Clinical Group | Doling | M. James | MD | 4 Coulter Rd | 2nd Floor | Clifton Springs | 14432 | CARDIOLOGY |
| Cardiology Clinical Group | Goldstein | David J. | MD | 377 White Spruce Blvd | | Rochester | 14623 | CARDIOLOGY |
| De. LePage's Office | LePage | Theodore L. | MD | 2664 Ridgeway Ave | | Rochester | 14626 | CARDIOLOGY |
| Dr. Davidsons's Office | Davidson | Kenneth H. | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Dr. Farrokh's Office | Farrokh | Alinaghi | MD | 1790 Long Pond Rd | | Rochester | 14606 | CARDIOLOGY |
| Dr. Henion's Office | Henion | William A. | MD | 1445 Portland Ave | Suite G07 | Rochester | 14621 | CARDIOLOGY |
| Dr. Huang's Office | Huang | Milch | MD | 1561 Long Pond Rd | Suite 311 | Rochester | 14626 | CARDIOLOGY |
| Dr. Masood's Office | Masood | Anwer U. | MD | 1445 Portland Ave | Suite G03 | Rochester | 14621 | CARDIOLOGY |
| Dr. Ryan's Office | Ryan | Gerald | MD | 1561 Long Pond Rd | Suite 316 | Rochester | 14626 | CARDIOLOGY |
| Heart Associates of Finger Lakes | Zugibe Jr | Frederick T. | MD | 201 Frey St | | Newark | 14513 | CARDIOLOGY |
| Heart Associates of Rochester | Mathew | Theckedath M. | MD | 1445 Portland Ave | Suite 208 | Rochester | 14621 | CARDIOLOGY |
| Heart Care of the Finger Lakes | Scortichini | Doria A. | MD | 821 Pre-Emption Rd | Suite 202 | Geneva | 14456 | CARDIOLOGY |
| Northside Echocardiography | Von Doenhoff | Laura J. | MD | 1415 Portland Ave | Suite 555 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Arazoza | Eduardo A. | MD | 30 Hagen Dr | Suite 100 | Rochester | 14625 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Berlowitz | Michael | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Curran | Thomas P. | MD | 30 Hagen Dr | Suite 100 | Rochester | 14625 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Fitzpatrick | Patricia | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Gacioch | Gerald | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Gage | Lawrence E. | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Hamer | Mark E. | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Jacobson | Seth | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Roch Cardiopulmonary Group | Kunis | Richard | MD | 30 Hagen Dr | Suite 100 | Rochester | 14625 | CARDIOLOGY |
| Roch Cardiopulmonary Group | McGrody | Kevin | MD | 30 Hagen Dr | Suite 100 | Rochester | 14625 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Rao | Krishna M. | MD | 30 Hagen Dr | Suite 100 | Rochester | 14625 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Reddeck | Cynthia | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Stuver | Thomas P. | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Vaughan | Maurice J. | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | CARDIOLOGY |
| Roch Cardiopulmonary Group | Wiener | Roy S. | MD | 30 Hagen Dr | Suite 100 | Rochester | 14625 | CARDIOLOGY |
| Unity Cardiology Group | DeCastro | Oscar A. | MD | 1770 Long Pond Rd | Suite 202 | Rochester | 14606 | CARDIOLOGY |
| Unity Cardiology Group | Patel | Tejan | MD | 1561 Long Pond Rd | Suite 401 | Rochester | 14626 | CARDIOLOGY |
| University Cardiovascular Assoc | Fries | David | MD | 2365 Clinton Ave South | Suite 100 | Rochester | 14618 | CARDIOLOGY |
| University Cardiovascular Assoc | Kringstein | Peter A. | MD | 2365 Clinton Ave South | Suite 100 | Rochester | 14618 | CARDIOLOGY |
| University Cardiovascular Assoc | Odorisi | Marc L. | MD | 2365 Clinton Ave South | Suite 100 | Rochester | 14618 | CARDIOLOGY |
| University Cardiovascular Assoc | Pancio II | George | MD | 2365 Clinton Ave South | Suite 100 | Rochester | 14618 | CARDIOLOGY |
| University Cardiovascular Assoc | Varon | Maurice E. | MD | 2365 Clinton Ave South | Suite 100 | Rochester | 14618 | CARDIOLOGY |
| University Cardiovascular Assoc | Williford | Daniel J. | MD, PhD | 2365 Clinton Ave South | Suite 100 | Rochester | 14618 | CARDIOLOGY |
| Westfall Cardiology | Falkoff | Michael D. | MD | 980 Westfall Rd | Suite 110 | Rochester | 14618 | CARDIOLOGY |
| Westfall Cardiology | Natarajan | Senthil | MD | 980 Westfall Rd | Suite 110 | Rochester | 14618 | CARDIOLOGY |
| Westfall Cardiology | Ong | Ling S. | MD | 980 Westfall Rd | Suite 110 | Rochester | 14618 | CARDIOLOGY |
| Westfall Cardiology | Soliman | Adel B. | MD | 980 Westfall Rd | Suite 110 | Rochester | 14618 | CARDIOLOGY |
| Roch Colon-Rectal Surgeons | Dmochowski | T. Jeffrey | MD | 125 Lattimore Rd | Suite 270 | Rochester | 14620 | COLON/RECTAL SURGERY |
| Roch Colon-Rectal Surgeons | Farid | Asim | MD | 125 Lattimore Rd | Suite 270 | Rochester | 14620 | COLON/RECTAL SURGERY |
| Roch Colon-Rectal Surgeons | Graney | Michael | MD | 125 Lattimore Rd | Suite 270 | Rochester | 14620 | COLON/RECTAL SURGERY |
| Roch Colon-Rectal Surgeons | Ognibene | Steven J. | MD | 125 Lattimore Road | Suite 270 | Rochester | 14620 | COLON/RECTAL SURGERY |
| Roch Colon-Rectal Surgeons | O'Neill | Mary Lou | MD | 125 Lattimore Rd | Suite 270 | Rochester | 14620 | COLON/RECTAL SURGERY |
| Roch Colon-Rectal Surgeons | Rauh | Stephen | MD | 125 Lattimore Rd | Suite 270 | Rochester | 14620 | COLON/RECTAL SURGERY |
| Roch Surgical Associates | Kurchin | Alexander | MD | 1415 Portland Ave | Suite 155 | Rochester | 14621 | COLON/RECTAL SURGERY |
| RGH Dept of Surgery | Porhomayon | Jahan | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | CRITICAL CARE MEDICINE |
| Advanced Dermatology Assoc | Presser | Stephen E. | MD | 1815 Clinton Ave South | Suite 530 | Rochester | 14618 | DERMATOLOGY |
| Barrington Park Derm Assoc | Francis | Elizabeth Pelton | MD | 220 Linden Oaks | Suite 300 | Rochester | 14625 | DERMATOLOGY |
| Barrington Park Derm Assoc | Larson | Pamela L. | MD | 220 Linden Oaks | Suite 300 | Rochester | 14625 | DERMATOLOGY |
| Barrington Park Derm Assoc | Martin | Robert E. | MD | 220 Linden Oaks | Suite 300 | Rochester | 14625 | DERMATOLOGY |
| Barrington Park Derm Assoc | Peachey | John C. | MD | 220 Linden Oaks | Suite 300 | Rochester | 14625 | DERMATOLOGY |
| Barrington Park Derm Assoc | Pelton | Stephen L. | MD | 220 Linden Oaks | Suite 300 | Rochester | 14625 | DERMATOLOGY |
| Dermatology & Cosmetic Center | Donsky | Howard J. | MD | 1665 Ridge Rd East | | Rochester | 14621 | DERMATOLOGY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Dermatology Associates of Roch | Englert | Deborah Ann | MD | 100 White Spruce Blvd | | Rochester | 14623 | DERMATOLOGY |
| Dermatology Associates of Roch | Loss Jr | Robert W. | MD | 100 White Spruce Blvd | | Rochester | 14623 | DERMATOLOGY |
| Dermatology Partners of WNY | Holm | Allison L. | MD | 30 North Union St | Suite 105 | Rochester | 14607 | DERMATOLOGY |
| Dermatology Partners of WNY | Psaila | Susan | MD | 30 North Union St | Suite 105 | Rochester | 14607 | DERMATOLOGY |
| Dermatology Partners of WNY | Wojciechowski | Joseph M. | MD | 30 North Union St | Suite 105 | Rochester | 14607 | DERMATOLOGY |
| Dr. Xenias's Office | Xenias | Stephen J. | MD | 1716 Ridge Rd East | | Rochester | 14621 | DERMATOLOGY |
| Greece Dermatological Assoc | Bobrow | Michael | MD | 730 Weiland Rd | | Rochester | 14626 | DERMATOLOGY |
| Greece Dermatological Assoc | Brooks | Walter S. | MD | 730 Weiland Rd | | Rochester | 14626 | DERMATOLOGY |
| Greece Dermatological Assoc | Condry | Patrick J. | MD | 730 Weiland Rd | | Rochester | 14626 | DERMATOLOGY |
| Helendale Dermatology & Medical Spa | Arthur | Elizabeth A. | MD | 500 Helendale Rd | Suite 100 | Rochester | 14609 | DERMATOLOGY |
| Lifetime Health - Folsom Center | Shulman | Brett | MD | 1850 Brighton-Henrietta TL Rd | | Rochester | 14623 | DERMATOLOGY |
| Perinton Dermatology | Miller | Catherine A. | MD | 6800 Pittsford-Palmyra Rd | Suite 300 | Fairport | 14450 | DERMATOLOGY |
| Pittsford Dermatology PLLC | Strapko | Helen | MD | 1050 Pittsford-Victor Rd | Suite B | Pittsford | 14534 | DERMATOLOGY |
| Dr. Ginsberg's Office | Ginsberg | Gerald S. | MD | 501 Beahan Rd | | Rochester | 14624 | ENDOCRINOLOGY |
| GHS Endocrine-Metabolism Division | Bingham | R. James | MD | 222 Alexander St | Suite 5500 | Rochester | 14607 | ENDOCRINOLOGY |
| GHS Endocrine-Metabolism Division | Freedman | Zachary R. | MD | 222 Alexander St | Suite 5500 | Rochester | 14607 | ENDOCRINOLOGY |
| RGH Dept of Endocrinology | Heinig | Robert E. | MD | 1425 Portland Ave | Box 100 | Rochester | 14621 | ENDOCRINOLOGY |
| Arcadia Family Practice | Blasczak | David | MD | 1202 Driving Park Ave | Suite B | Newark | 14513 | FAMILY PRACTICE |
| Arcadia Family Practice | Hannan | David T. | MD | 1202 Driving Park Ave | Suite B | Newark | 14513 | FAMILY PRACTICE |
| Brandon Family Medicine | Brandon | Robert J. | MD | 2550 Baird Rd | | Penfield | 14526 | FAMILY PRACTICE |
| Clinton Family Health Center | Chang | Teresa | MD | 309 Upper Falls Blvd | | Rochester | 14605 | FAMILY PRACTICE |
| Clinton Family Health Center | Greiner-Devries | Abigail | MD | 309 Upper Falls Blvd | | Rochester | 14605 | FAMILY PRACTICE |
| Clinton Family Health Center | Mancini | Joseph | MD | 220 Alexander Street | Suite 406 | Rochester | 14607 | FAMILY PRACTICE |
| Dr. Kachoria's Office | Kachoria | Raj | MD | 1033 Pittsford-Palmyra Rd | | Macedon | 14502 | FAMILY PRACTICE |
| Dr. Plansky's Office | Plansky | Bernard | MD | 61F Monroe Ave | | Pittsford | 14534 | FAMILY PRACTICE |
| Dr. Stern's Office | Stern | Carolyn R. | MD | 58 Eastland Ave | | Rochester | 14618 | FAMILY PRACTICE |
| Genesee Valley Family Medicine | Grannum | Edith | MD | 3900 Dewey Ave | | Rochester | 14616 | FAMILY PRACTICE |
| Lifetime Health | Cole | Robert | MD | 1880 Ridge Rd East | Suite 8 Upper Level | Rochester | 14622 | FAMILY PRACTICE |
| Lifetime Health | Flaherty | Daniel | DO | 1880 Ridge Rd East | Suite 8 Upper Level | Rochester | 14622 | FAMILY PRACTICE |
| Lifetime Health | Hira | Bruce | MD | 1880 Ridge Rd East | Suite 8A Lower Level | Rochester | 14622 | FAMILY PRACTICE |
| Lifetime Health | Stornelli | Leo F. | MD | 1880 Ridge Rd East | Suite 7 | Rochester | 14622 | FAMILY PRACTICE |
| Lifetime Health - Folsom Center | Malia | Timothy G. | MD | 6720 Pittsford- Palmyra rd | | Fairport | 14450 | FAMILY PRACTICE |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Lifetime Health - Folsom Center | McKee | Michael | MD | 1850 Brighton-Henrietta TL Rd | | Rochester | 14623 | FAMILY PRACTICE |
| Neal Smith MD & Jeannine Dolan MD | Dolan | Jeannine L. | MD | 5973 Walworth Ontario Rd | PO Box 368 | Ontario | 14519 | FAMILY PRACTICE |
| Neal Smith MD & Jeannine Dolan MD | Smith | Neal T. | MD | 5973 Walworth Ontario Rd | PO Box 368 | Ontario | 14519 | FAMILY PRACTICE |
| Webster Family Practice | Robb | Stephen | MD | 630 Bay Rd | | Webster | 14580 | FAMILY PRACTICE |
| Webster Medical Group | Venci | Nicolas A. | MD | 45 Webster Commons Blvd | Suite 200 | Webster | 14580 | FAMILY PRACTICE |
| Dr. Baratta's Office | Baratta | Anthony V. | MD | 1065 Senator Keating Blvd | Suite 220 | Rochester | 14618 | GASTROENTEROLOGY |
| Dr. Kornfield's Office | Kornfield | Robert N. | MD | 1401 Stone Rd | Suite 302 | Rochester | 14615 | GASTROENTEROLOGY |
| Gastroenterology Associates | Madan | Manish K. | MD | 995 Senator Keating Blvd | Bldg E, #3100 | Rochester | 14618 | GASTROENTEROLOGY |
| Gastroenterology Associates | Pereira | Mark C. | MD | 1561 Long Pond Rd | Suite 133 | Rochester | 14626 | GASTROENTEROLOGY |
| Gastroenterology Associates | Strapko | Andrej | MD | 995 Senator Keating Blvd | Bldg E, #3100 | Rochester | 14618 | GASTROENTEROLOGY |
| Gastroenterology Group of Roch | Dziwis | Paul S. | MD | 919 Westfall Rd, Bldg C | Suite 100 | Rochester | 14618 | GASTROENTEROLOGY |
| Gastroenterology Group of Roch | Kunze | George | MD | 919 Westfall Rd, Bldg C | Suite 100 | Rochester | 14618 | GASTROENTEROLOGY |
| RGH Dept of Gastroenterology | Casey | Kevin J. | MD | 1425 Portland Ave | Box 283 | Rochester | 14621 | GASTROENTEROLOGY |
| RGH Dept of Gastroenterology | Dunnigan | Karin J. | MD | 1425 Portland Ave | Box 283 | Rochester | 14621 | GASTROENTEROLOGY |
| RGH Dept of Gastroenterology | Goldstein | Jeffrey | MD | 1425 Portland Ave | Box 283 | Rochester | 14621 | GASTROENTEROLOGY |
| Roch Gastroenterology Assoc | Kothari | Tarun | MD | 1445 Portland Ave | Suite 203 | Rochester | 14621 | GASTROENTEROLOGY |
| Roch Gastroenterology Assoc | Penmetsa | Prasad Varma | MD | 1561 Long Pond Rd | Suite 308 | Rochester | 14626 | GASTROENTEROLOGY |
| Roch Gastroenterology Assoc | Thanik | Krishan D. | MD | 1561 Long Pond Rd | Suite 308 | Rochester | 14626 | GASTROENTEROLOGY |
| Tobey Village Medical Group | Kim | Chung Hoon | MD | 130 Office Park Way | Suite B | Pittsford | 14534 | GASTROENTEROLOGY |
| William Y Chey & Associates | Chey | William | MD | 222 Alexander St | Suite 3100 | Rochester | 14607 | GASTROENTEROLOGY |
| Palmyra Gen Medicine Practice | Riggs | Malcolm McBurney | MD | 201 East Main St | | Palmyra | 14522 | GENERAL PRACTICE |
| Dr. Beltrano's Office | Beltrano | Alberto C. | MD | 12 Leach Rd | | Lyons | 14489 | GENERAL SURGERY |
| Dr. Chang's Office | Chang | Vincent | MD | 1299 Portland Ave | Suite 3 | Rochester | 14621 | GENERAL SURGERY |
| Dr. Ejaife's Office | Ejaife | John A. | MD | 2211 Lyell Ave | | Rochester | 14606 | GENERAL SURGERY |
| Dr. Lanzafame's Office | Lanzafame | Raymond J. | MD | 1445 Portland Ave | Suite 202 | Rochester | 14621 | GENERAL SURGERY |
| Dr. Rube's Office | Rube | Joseph A. | MD | 1445 Portland Ave | Suite 307 | Rochester | 14621 | GENERAL SURGERY |
| Dr. Shemirani's Office | Shemirani | Mehdi | MD | 1360 Portland Ave | Suite 202 | Rochester | 14621 | GENERAL SURGERY |
| Dr. Walker's Office | Walker | Allan R. | MD | 4 Coulter Rd | | Clifton Springs | 14432 | GENERAL SURGERY |
| Genesee Surgical Associates | Caldwell | Christopher | MD | 10 Hagen Drive | Suite 240 | Rochester | 14625 | GENERAL SURGERY |
| Genesee Surgical Associates | Tripp | Robert J. | MD | 10 Hagen Drive | Suite 240 | Rochester | 14626 | GENERAL SURGERY |
| Irondequoit General Surgery | Chodoff | Mark | MD | 485 Titus Ave | Suite E | Rochester | 14617 | GENERAL SURGERY |
| Irondequoit General Surgery | Kuranda | David | MD | 485 Titus Ave | Suite E | Rochester | 14617 | GENERAL SURGERY |
| RGH Dept of Surgery | Al-Mahayri | Abdullah | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |
| RGH Dept of Surgery | Block | Peter | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |
| RGH Dept of Surgery | Doerr | Ralph | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| RGH Dept of Surgery | Dynski SSJ | Marguerite | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |
| RGH Dept of Surgery | Galvin | Daniel | DO | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |
| RGH Dept of Surgery | Gusmano | Flavia | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |
| RGH Dept of Surgery | Miller | Dana | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | GENERAL SURGERY |
| RGH Emergency Dept | Shmigel | Boris | MD | 1425 Portland Ave | Box 318 | Rochester | 14621 | GENERAL SURGERY |
| Roch Surgical Associates | George | Robert | MD | 1415 Portland Ave | Suite 155 | Rochester | 14621 | GENERAL SURGERY |
| Roch Surgical Associates | Oates II | Theodore | MD | 1415 Portland Ave | Suite 155 | Rochester | 14621 | GENERAL SURGERY |
| Roch Surgical Associates | Ramanath | Hassan | MD | 1415 Portland Ave | Suite 155 | Rochester | 14621 | GENERAL SURGERY |
| Roch Surgical Associates | Yellin | Joel A. | MD | 1415 Portland Ave | Suite 155 | Rochester | 14621 | GENERAL SURGERY |
| Maplewood Nursing Home | Pingree | Thomas | MD | 100 Daniel Dr | | Webster | 14580 | GERIATRICS |
| Gynecologic Oncology | Angel | Cynthia | MD | 125 Lattimore Rd | Suite 258 | Rochester | 14620 | GYNECOLOGIC ONCOLOGY |
| Gynecologic Oncology | DuBeshter | Brent | MD | 125 Lattimore Rd | Suite 258 | Rochester | 14620 | GYNECOLOGIC ONCOLOGY |
| Gynecologic Oncology | Toy | Eugene | MD | 125 Lattimore Rd | Suite 258 | Rochester | 14620 | GYNECOLOGIC ONCOLOGY |
| Dr. Pulvino's Office | Pulvino | A. Thomas | MD | Route 88 South | PO Box 430 | Newark | 14513 | GYNECOLOGY |
| Panorama Valley/Greece OB/GYN | Sweeney | Thomas R. | MD | 120 Erie Canal Dr | Suite 200 | Rochester | 14626 | GYNECOLOGY |
| Women's Continence Ctr | Cholhan | Hilary J. | MD | 500 Helendale Rd | Suite 265 | Rochester | 14609 | GYNECOLOGY |
| Women's Continence Ctr | Julia | Jimmy J. | MD | 500 Helendale Rd | Suite 265 | Rochester | 14609 | GYNECOLOGY |
| Lipson Cancer and Blood Center | Sham | Ronald | MD | 1425 Portland Ave | Box 233 | Rochester | 14621 | HEMATOLOGY |
| Finger Lakes Hematology & Oncology | Ignaczak | Stephen M. | MD | 6 Ambulance Dr | | Clifton Springs | 14432 | HEMATOLOGY/ONCOLOGY |
| Finger Lakes Hematology & Oncology | Yirinec | Bruce | MD | 6 Ambulance Dr | | Clifton Springs | 14432 | HEMATOLOGY/ONCOLOGY |
| Interlakes Oncology & Hematology | Asbury | Robert F. | MD | 211 White Spruce Blvd | | Rochester | 14623 | HEMATOLOGY/ONCOLOGY |
| Interlakes Oncology & Hematology | Boros | Laszlo | MD | 211 White Spruce Blvd | | Rochester | 14623 | HEMATOLOGY/ONCOLOGY |
| Interlakes Oncology & Hematology | Fetten | James V. | MD | 211 White Spruce Blvd | | Rochester | 14623 | HEMATOLOGY/ONCOLOGY |
| Lipson Cancer and Blood Center | Kouides | Peter A. | MD | 1425 Portland Ave | Box 233 | Rochester | 14621 | HEMATOLOGY/ONCOLOGY |
| Lipson Cancer and Blood Center | Kramer | Zachary B. | MD | 1425 Portland Ave | Box 233 | Rochester | 14621 | HEMATOLOGY/ONCOLOGY |
| Lipson Cancer and Blood Center | Phatak | Pradyumna D. | MD | 1425 Portland Ave | Box 233 | Rochester | 14621 | HEMATOLOGY/ONCOLOGY |
| Pluta Cancer Center | Yirinec | Brian D. | MD | 125 Red Creek Dr | Suite 101 | Rochester | 14623 | HEMATOLOGY/ONCOLOGY |
| RGH Dept of Hematology/Med Onc | Phelan II | John T. | MD | 1425 Portland Ave | Box 304 | Rochester | 14621 | HEMATOLOGY/ONCOLOGY |
| RGH Dept of Internal Medicine | Zsenits | Balazs | MD | 1425 Portland Ave | Box 287 | Rochester | 14621 | HOSPITALIST |
| RGH Dept of Infectious Diseases | Dumyati | Ghinwa | MD | 1425 Portland Ave | Box 246 | Rochester | 14621 | INFECTIOUS DISEASES |
| RGH Dept of Infectious Diseases | Falsey | Ann R. | MD | 1425 Portland Ave | Box 246 | Rochester | 14621 | INFECTIOUS DISEASES |
| RGH Dept of Infectious Diseases | Walsh | Edward E. | MD | 1425 Portland Ave | Box 246 | Rochester | 14621 | INFECTIOUS DISEASES |
| Bay Creek Medical Group | Burki | Anjum | MD | 2000 Empire Blvd | Suite 120 | Webster | 14580 | INTERNAL MEDICINE |
| Bay Creek Medical Group | Huselton | John | MD | 2000 Empire Blvd | Suite 120 | Webster | 14580 | INTERNAL MEDICINE |
| Bay Creek Medical Group | McGrail | Kathleen | MD | 2000 Empire Blvd | Suite 120 | Webster | 14580 | INTERNAL MEDICINE |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Bay Creek Medical Group | Myers | Michael | MD | 2000 Empire Blvd | Suite 120 | Webster | 14580 | INTERNAL MEDICINE |
| Calkins Medical Group | Aziz | Haris | MD | 125 Red Creek Dr | Suite 201 | Rochester | 14623 | INTERNAL MEDICINE |
| Cross Keys Internal Medicine | Genier | John | MD | 420 Cross Keys Office Pk | Suite C5 | Fairport | 14450 | INTERNAL MEDICINE |
| Cross Keys Internal Medicine | Howard | Steven | MD | 420 Cross Keys Office Pk | Suite C5 | Fairport | 14450 | INTERNAL MEDICINE |
| Dr Guzman's Office | Guzman | Ronald | MD | 100 Cross Keys Office Pk | | Fairport | 14450 | INTERNAL MEDICINE |
| Dr. Anderson's Office | Anderson | Ernest | MD | 780 Blossom Rd | | Rochester | 14610 | INTERNAL MEDICINE |
| Dr. Changkakoti's Office | Changkakoti | Narendra C. | MD | 1404 Portland Ave | | Rochester | 14621 | INTERNAL MEDICINE |
| Dr. Constantino's Office | Constantino | Richard | MD | 1445 Portland Ave | Suite 302 | Rochester | 14621 | INTERNAL MEDICINE |
| Dr. Dixon- Gordon's Office | Dixon-Gordon | Robert | MD | 2005 Lyell Ave | Suite 110 | Rochester | 14606 | INTERNAL MEDICINE |
| Dr. Hovey's Office | Hovey | Daniel | MD | 570 Perinton Hills Office Pk | | Fairport | 14450 | INTERNAL MEDICINE |
| Dr. Hur's Office | Hur | Seung | MD | 215 Fair St | | Newark | 14513 | INTERNAL MEDICINE |
| Dr. Hwang's Office | Chang | Hwang Nam | MD | 165 East Union St | Suite 202 | Newark | 14513 | INTERNAL MEDICINE |
| Dr. Iannucci's Office | Iannucci | Brenda | MD | 1880 Ridge Rd East | Suite 5 Upper | Rochester | 14622 | INTERNAL MEDICINE |
| Dr. Iyer's Office | Iyer | Ramakrishna | MD | 564 Ridge Rd East | Suite 204 | Rochester | 14621 | INTERNAL MEDICINE |
| Dr. Jackson's Office | Jackson | Dewey | MD | 2828 Baird Rd | Suite 4 | Fairport | 14450 | INTERNAL MEDICINE |
| Dr. Jagadish's Office | Jagadish | Grama | MD | 1401 Stone Rd | Suite 103 | Rochester | 14615 | INTERNAL MEDICINE |
| Dr. Koretz's Office | Koretz | Daniel | MD | 6200 Slocum Rd | | Ontario | 14519 | INTERNAL MEDICINE |
| Dr. Kurian's Office | Kurian | Lisa | MD | 220 Alexander St | Suite 704 | Rochester | 14607 | INTERNAL MEDICINE |
| Dr. Lederman's Office | Lederman | David | MD | 35 North Goodman St | | Rochester | 14607 | INTERNAL MEDICINE |
| Dr. Liberman's Office | Liberman | Jeffrey A. | DO | 485 Titus Ave | Suite D | Rochester | 14617 | INTERNAL MEDICINE |
| Dr. Luczynska's Office | Luczynska | Halina | MD | 1151 Titus Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| Dr. Malik's Office | Malik | Sarwat S. | MD | 2050 S Clinton Ave | | Rochester | 14618 | INTERNAL MEDICINE |
| Dr. Nihalani's Office | Nihalani | Rajendra K. | MD | 3900 Dewey Ave | | Rochester | 14616 | INTERNAL MEDICINE |
| Dr. Piro's Office | Piro Jr | Louis | MD | 165 East Union St | | Newark | 14513 | INTERNAL MEDICINE |
| Dr. Potter's Office | Potter | Douglas | MD | 1742 Ridge Road East | | Rochester | 14622 | INTERNAL MEDICINE |
| Dr. Saha's Office | Saha | Sushil | MD | 2828 Baird Rd | | Fairport | 14450 | INTERNAL MEDICINE |
| Dr. Solazzo's Office | Solazzo | Anthony | MD | 710 Cross Keys Office Pk | | Fairport | 14450 | INTERNAL MEDICINE |
| Dr. Sorrentino's Office | Sorrentino Jr | Sandy | MD | 1570 Long Pond Rd | | Rochester | 14626 | INTERNAL MEDICINE |
| Dr. Stewart's Office | Stewart | Christine | MD | 30 Hagen Dr | Suite 305 | Rochester | 14625 | INTERNAL MEDICINE |
| Dr. Stolarczyk's Office | Stolarczyk | Richard | MD | 1151 Titus Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| Dr. Tarkinhton's Office | Tarkington | Pamela | MD | 71 Park Ave | | Rochester | 14607 | INTERNAL MEDICINE |
| Dr. Tyner's Office | Tyner | J. Richard | MD | 4 Coulter Rd | | Clifton Springs | 14432 | INTERNAL MEDICINE |
| Dr. VanBrunt's Office | Van Brunt | Peter | MD | 1445 Portland Ave | Suite 302 | Rochester | 14621 | INTERNAL MEDICINE |
| Dr.Umansky's Office | Umansky | Ronald J. | MD | 1445 Portland Ave | Suite 206 | Rochester | 14621 | INTERNAL MEDICINE |

# GRIPA Owner Physicians

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Drs Stahl, Dobmeier, Potter, Lopez | Dobmeier | Michael | MD | 425 Titus Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| Drs Stahl, Dobmeier, Potter, Lopez | Lopez | Jose | MD | 425 Titus Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| Drs Stahl, Dobmeier, Potter, Lopez | Stahl | Peter | MD | 425 Titus Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| Elmwood Medical Associates | Ghazoly | Waseem | MD | 220 Linden Oaks | Suite 100 | Rochester | 14625 | INTERNAL MEDICINE |
| Elmwood Medical Associates | Marino | Joseph | MD | 220 Linden Oaks | Suite 100 | Rochester | 14625 | INTERNAL MEDICINE |
| Elmwood Medical Associates | Meloni | Stephen | MD | 220 Linden Oaks | Suite 100 | Rochester | 14625 | INTERNAL MEDICINE |
| Elmwood Medical Associates | Woldeyohannes | Mentesinot | MD | 220 Linden Oaks | Suite 100 | Rochester | 14625 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Dlugozima | Maureen | MD | 220 Alexander St | Suite 603 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Ippolito | Charles | MD | 220 Alexander St | Suite 702 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Leas | Martha J. | MD | 220 Alexander St | Suite 704 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Miraloglu | Didem | MD | 220 Alexander St | Suite 702 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Nguyen | Tai | MD | 220 Alexander St | Suite 703 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Pellittieri | Arthur D. | MD | 220 Alexander St | Suite 704 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Rodrigues-Garvin | Regina | MD | 220 Alexander St | Suite 703 | Rochester | 14607 | INTERNAL MEDICINE |
| GHS Internal Medicine Group | Schlageter | David A. | MD | 220 Alexander St | Suite 603 | Rochester | 14607 | INTERNAL MEDICINE |
| Greater Roch Internal Med | Ragusa | Anthony | MD | 1401 Stone Rd | Suite 201 | Rochester | 14615 | INTERNAL MEDICINE |
| Highlands Living Center | Wood | James B. | MD | 500 Hahnemann Trail | | Pittsford | 14534 | INTERNAL MEDICINE |
| Hill Haven Nursing Home | Schabel | Scott | MD | 1550 Empire Blvd | | Webster | 14580 | INTERNAL MEDICINE |
| Internal Med Assoc of Webster | Roethlisberger | Mirko | MD | 45 North Ave | | Webster | 14580 | INTERNAL MEDICINE |
| Internal Med Assoc of Webster | Seaford | John | MD | 45 North Ave | | Webster | 14580 | INTERNAL MEDICINE |
| Internal Med Assoc of Webster | Wolpiuk | Alice | MD | 45 North Ave | | Webster | 14580 | INTERNAL MEDICINE |
| Lifetime Health - Artemis Health | Woluchem | Miltona | MD | 2561 Lac de Ville Blvd | Suite 202 | Rochester | 14618 | INTERNAL MEDICINE |
| Lifetime Health - Folsom Center | Thakur | Shivender K. | MD | 1850 Brighton-Henrietta TL Rd | | Rochester | 14623 | INTERNAL MEDICINE |
| Lifetime Health - Greece Center | Apostol | Jesus | MD | 470 Long Pond Rd | | Rochester | 14612 | INTERNAL MEDICINE |
| Lifetime Health - Greece Center | Deshmukh | Sudipt | MD | 470 Long Pond Rd | | Rochester | 14612 | INTERNAL MEDICINE |
| Lifetime Health - Greece Center | Robb | John | MD | 470 Long Pond Rd | | Rochester | 14612 | INTERNAL MEDICINE |
| Lifetime Health - Perinton Center | Culbertson | Charles E. | MD | 77 Sully's Trail | Suite 200 | Pittsford | 14534 | INTERNAL MEDICINE |
| Lifetime Health - Perinton Center | Rich | Steven A. | MD | 77 Sully's Trail | Suite 200 | Pittsford | 14534 | INTERNAL MEDICINE |
| Lifetime Health - Perinton Center | Weiss | Jerome | MD | 77 Sully's Trail | Suite 200 | Pittsford | 14534 | INTERNAL MEDICINE |
| Lifetime Health - Wilson Center | Bala | Virinchi | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |
| Lifetime Health - Wilson Center | Bavibidila | Berthollet | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |
| Lifetime Health - Wilson Center | Foroozesh-Banej | Farokh | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |
| Lifetime Health - Wilson Center | Santana | Ernesto | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |
| Lifetime Health - Wilson Center | Slobard | James A. | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |
| Lifetime Health - Wilson Center | Terwilliger | Megan | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |

# GRIPA Owner Physicians

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Lifetime Health - Wilson Center | Weber | Karl | MD | 800 Carter St | | Rochester | 14621 | INTERNAL MEDICINE |
| Linden Medical Group | Dale | Edith L. | MD | 30 Hagen Dr | Suite 300 | Rochester | 14625 | INTERNAL MEDICINE |
| Linden Medical Group | Ehrenberg | Mitchell | MD | 30 Hagen Dr | Suite 300 | Rochester | 14625 | INTERNAL MEDICINE |
| Linden Medical Group | Lee | Charis A. | MD | 30 Hagen Dr | Suite 300 | Rochester | 14625 | INTERNAL MEDICINE |
| Linden Medical Group | Lisciandro | Kelly | DO | 30 Hagen Dr | Suite 300 | Rochester | 14625 | INTERNAL MEDICINE |
| Linden Medical Group | Vuillequez | Jeffrey J. | MD | 30 Hagen Dr | Suite 300 | Rochester | 14625 | INTERNAL MEDICINE |
| Linden Oaks Internal Medicine | Kukfa | Michael A. | MD | 10 Hagen Dr | Suite 350 | Rochester | 14625 | INTERNAL MEDICINE |
| Long Pond Medical Group | Connors-Adler | Ann | MD | 2350 Ridgeway Ave | Suite A | Rochester | 14626 | INTERNAL MEDICINE |
| Long Pond Medical Group | Devlin | Albert | DO | 2350 Ridgeway Ave | Suite A | Rochester | 14626 | INTERNAL MEDICINE |
| Long Pond Medical Group | Peterson | Kimberly Anne | MD | 2350 Ridgeway Ave | Suite A | Rochester | 14626 | INTERNAL MEDICINE |
| Long Pond Medical Group | Richardson | Louise | MD | 2350 Ridgeway Ave | Suite A | Rochester | 14626 | INTERNAL MEDICINE |
| Long Pond Medical Group | Salamone | Jane | MD | 2350 Ridgeway Ave | Suite A | Rochester | 14626 | INTERNAL MEDICINE |
| Medical Associates at Genesee | Burns | Paul C. | MD | 222 Alexander St | Suite 3000 | Rochester | 14607 | INTERNAL MEDICINE |
| Medical Associates at Genesee | Chessin | Lawrence N. | MD | 222 Alexander St | Suite 3000 | Rochester | 14607 | INTERNAL MEDICINE |
| Northgate Medical Group | Agostinelli | Robert | MD | 1401 Stone Rd | Suite 202 | Rochester | 14615 | INTERNAL MEDICINE |
| Northgate Medical Group | Barrett | Josephine | MD | 1401 Stone Rd | Suite 202 | Rochester | 14615 | INTERNAL MEDICINE |
| Northgate Medical Group | Farnand | Bernard | MD | 1401 Stone Rd | Suite 202 | Rochester | 14626 | INTERNAL MEDICINE |
| Northgate Medical Group | Nolan | Timothy | MD | 1401 Stone Rd | Suite 202 | Rochester | 14615 | INTERNAL MEDICINE |
| Northridge Medical Group | Roberts | Thomas | MD | 1850 Ridge Rd East | Suite 11 | Rochester | 14622 | INTERNAL MEDICINE |
| Northridge Medical Group | Rolls | William | MD | 1850 Ridge Rd East | Suite 11 | Rochester | 14622 | INTERNAL MEDICINE |
| Partners in Internal Medicine-Hagen Drive | Algase | Leslie F. | MD | 30 Hagen Dr | Suite 310 | Rochester | 14625 | INTERNAL MEDICINE |
| Partners in Internal Medicine-Hagen Drive | Jurik | John A. | MD | 30 Hagen Dr | Suite 310 | Rochester | 14625 | INTERNAL MEDICINE |
| Partners in Internal Medicine-Hagen Drive | Kurnath | Joseph F. | MD | 30 Hagen Dr | Suite 310 | Rochester | 14625 | INTERNAL MEDICINE |
| Partners in Internal Medicine-Hagen Drive | Miner | Edward | MD | 30 Hagen Dr | Suite 310 | Rochester | 14625 | INTERNAL MEDICINE |
| Partners in Internal Medicine-Red Creek | Brachman | Laura | MD | 125 Red Creek Dr | Suite 211 | Rochester | 14623 | INTERNAL MEDICINE |
| Partners in Internal Medicine-Red Creek | Nemetz | Sarah Beth | MD | 125 Red Creek Dr | Suite 211 | Rochester | 14623 | INTERNAL MEDICINE |
| Pittsford Internal Medicine | Garber | Holly | MD | 59 Monroe Ave | Suite E | Pittsford | 14534 | INTERNAL MEDICINE |
| RGH Dept of Internal Medicine | Morse | Diane S. | MD | 1425 Portland Ave | Box 287 | Rochester | 14621 | INTERNAL MEDICINE |
| RGH Dept of Internal Medicine | Polashenski | Walter A. | MD | 1425 Portland Ave | Box 287 | Rochester | 14621 | INTERNAL MEDICINE |
| Ridgeplex Commons Medical Group | Jay | Manjula | MD | 1726 Ridge Rd East | | Rochester | 14621 | INTERNAL MEDICINE |
| Ridgeplex Commons Medical Group | Shamsie | Faisal | MD | 1726 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |
| Ridgeplex Internal Medicine | Rice | Linda | MD | 1742 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |
| Ridgeview Internal Med Group | Caifano | Robert | MD | 1850 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |
| Ridgeview Internal Med Group | DiPoala Jr | Joseph | MD | 1850 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |
| Ridgeview Internal Med Group | Kane | Shelly | MD | 1850 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |

# GRIPA Owner Physicians

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ridgeview Internal Med Group | Shedd | Nancy | MD | 1850 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |
| Ridgeview Internal Med Group | Thomson | Robert C. | MD | 1850 Ridge Rd East | | Rochester | 14622 | INTERNAL MEDICINE |
| Ridgewood Medical Group | Hellems | Stephen | MD | 3101 Ridge Rd West | Bldg B | Rochester | 14626 | INTERNAL MEDICINE |
| Wayne Medical Group - Lyons | Hong | Dong Gi | MD | 12 Leach Rd | Lyons Health Ctr | Lyons | 14489 | INTERNAL MEDICINE |
| Wayne Medical Group - Newark | DaSilva | Anthony J. | MD | 1208 Driving Park Ave | Newark Med Ctr | Newark | 14513 | INTERNAL MEDICINE |
| Wayne Medical Group - Newark | Deshommes | Beatrice | MD | 1208 Driving Park Ave | Newark Med Ctr | Newark | 14513 | INTERNAL MEDICINE |
| Wayne Medical Group - Newark | Heasley | Paul | MD | 1208 Driving Park Ave | Newark Med Ctr | Newark | 14513 | INTERNAL MEDICINE |
| Wayne Medical Group - Newark | Heeb | Gregory | MD | 1208 Driving Park Ave | Newark Med Ctr | Newark | 14513 | INTERNAL MEDICINE |
| Wayne Medical Group - Sodus | Starck-McLean | Linda | MD | 6692 Middle Rd | PO Box 9 | Sodus | 14551 | INTERNAL MEDICINE |
| Wayne Medical Group - Williamson | Zachariah | Mano | MD | 4425 Old Ridge Road | PO Box 934 | Williamson | 14589 | INTERNAL MEDICINE |
| Wayne Medical Group - Wolcott | Choudhury | Arif | MD | 6254 Lawville Rd | | Wolcott | 14590 | INTERNAL MEDICINE |
| Wayne Medical Group - Wolcott | Nagendra | Thambirajah | MD | 6254 Lawville Rd | | Wolcott | 14590 | INTERNAL MEDICINE |
| Wayne Medical Group - Wolcott | Wadsworth | Rebecca | MD | 6254 Lawville Rd | | Wolcott | 14590 | INTERNAL MEDICINE |
| Webster Medical Group | Patel | Kartik | MD | 45 Webster Commons Blvd | Suite 200 | Webster | 14580 | INTERNAL MEDICINE |
| Webster Medical Group | Samikkannu | Periasamy | MD | 45 Webster Commons Blvd | Suite 200 | Webster | 14580 | INTERNAL MEDICINE |
| White Pines Medical Group | Brigandi | Angelo | MD | 2118 Hudson Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| White Pines Medical Group | Hausle | John | MD | 2118 Hudson Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| White Pines Medical Group | Masood | G. Rana | MD | 2118 Hudson Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| White Pines Medical Group | Tarantino | Benedetto | MD | 2118 Hudson Ave | | Rochester | 14617 | INTERNAL MEDICINE |
| Zito & Goldstein MDs | Goldstein | Marshall | MD | 61A Monroe Ave | | Pittsford | 14534 | INTERNAL MEDICINE |
| Zito & Goldstein MDs | Zito | Gene M. | MD | 61A Monroe Ave | | Pittsford | 14534 | INTERNAL MEDICINE |
| Lifetime Health - Perinton Center | Cohen | Mark | MD | 77 Sully's Trail | Suite 200 | Pittsford | 14534 | INTERNAL MEDICINE/PEDS |
| Ridgewood Med Peds | Chamberlain | John | MD | 3101 Ridge Rd West | Bldg C | Rochester | 14626 | INTERNAL MEDICINE/PEDS |
| Ridgewood Med Peds | Mikus | Paul | MD | 3101 Ridge Rd West | Bldg C | Rochester | 14626 | INTERNAL MEDICINE/PEDS |
| Ridgewood Med Peds | Smith | Lisa | MD | 3101 Ridge Rd West | Bldg C | Rochester | 14626 | INTERNAL MEDICINE/PEDS |
| Strong Perinatal Associates | Curtin | William M. | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | MATERNAL & FETAL MEDICINE |
| Strong Perinatal Associates | Fry III | A. Gordon | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | MATERNAL & FETAL MEDICINE |
| Strong Perinatal Associates | Pressman | Eva | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | MATERNAL & FETAL MEDICINE |
| Strong Perinatal Associates | Queenan | Ruth Anne | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | MATERNAL & FETAL MEDICINE |
| University OB/Perinatology Group | Ozcan | Tulin | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | MATERNAL & FETAL MEDICINE |

# GRIPA Owner Physicians

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| RGH Dept of Nephrology | Bernstein | Paul L. | MD | 1425 Portland Ave | Box 230 | Rochester | 14621 | NEPHROLOGY |
| RGH Dept of Nephrology | Grieff | Marvin | MD | 1425 Portland Ave | Box 230 | Rochester | 14621 | NEPHROLOGY |
| RGH Dept of Nephrology | Mayo | Robert R. | MD | 1425 Portland Ave | Box 230 | Rochester | 14621 | NEPHROLOGY |
| RGH Dept of Nephrology | Silver | Stephen M. | MD | 1425 Portland Ave | Box 230 | Rochester | 14621 | NEPHROLOGY |
| RGH Dept of Nephrology | Sterns | Richard H. | MD | 1425 Portland Ave | Box 247 | Rochester | 14621 | NEPHROLOGY |
| RGH Dept of Nephrology | Veverbrants | Egils | MD | 1425 Portland Ave | Box 230 | Rochester | 14621 | NEPHROLOGY |
| Rochester General Hospital | Hix | John Kevin | MD | 1425 Portland Ave | | Rochester | 14621 | NEPHROLOGY |
| Dr. Cotanch's Office | Cotanch | William W. | MD | 1445 Portland Ave | Suite 305 | Rochester | 14621 | NEUROLOGICAL SURGERY |
| Dr. Maurer's Office | Maurer | Paul K. | MD | 1401 Stone Rd | Suite 303 | Rochester | 14615 | NEUROLOGICAL SURGERY |
| Dr. Maxwell's Office | Maxwell | James T. | MD | 1445 Portland Ave | Suite 304 | Rochester | 14621 | NEUROLOGICAL SURGERY |
| Dr. Silberstein's Office | Silberstein | Howard J. | MD | 1445 Portland Ave | Suite 305 | Rochester | 14621 | NEUROLOGICAL SURGERY |
| Dr. Lesser's Office | Lesser | Harold D. | MD | 1415 Portland Ave | Suite 480 | Rochester | 14621 | NEUROLOGY |
| Dr. O'Sullivan's Office | O'Sullivan | John A. | MD | 1401 Stone Rd | Suite 101 | Rochester | 14615 | NEUROLOGY |
| Dr. Pardee's Office | Pardee | Lawrence Allen | MD | 1415 Portland Ave | Suite 480 | Rochester | 14621 | NEUROLOGY |
| Neurology Associates of Roch | Gajaweera | Ashanthi | MD | 1415 Portland Ave | Suite 575 | Rochester | 14621 | NEUROLOGY |
| Neurology Associates of Roch | Moss | Anne M. | MD | 1415 Portland Ave | Suite 575 | Rochester | 14621 | NEUROLOGY |
| Neurology Associates of Roch | Stern | Andrew | MD | 1415 Portland Ave | Suite 575 | Rochester | 14621 | NEUROLOGY |
| Ontario Neurology Associates | Kingston | William J. | MD | 4 Coulter Rd | | Clifton Springs | 14432 | NEUROLOGY |
| Ontario Neurology Associates | Knapp | Robert S. | MD | 199 Parrish St | | Canandaigua | 14424 | NEUROLOGY |
| RGH Dept of Neurology | Hollander | Joshua | MD | 1425 Portland Ave | Box 220 | Rochester | 14621 | NEUROLOGY |
| RGH Dept of Neurology | Honch | Gerald | MD | 1425 Portland Ave | Box 220 | Rochester | 14621 | NEUROLOGY |
| RGH Dept of Neurology | Samkoff | Lawrence | MD | 1425 Portland Ave | Box 220 | Rochester | 14621 | NEUROLOGY |
| RGH Dept of Neurology | Schmidt | John | MD | 1425 Portland Ave | Box 220 | Rochester | 14621 | NEUROLOGY |
| U of R Neurology | Wang | David | MD | 601 Elmwood Ave | Box 631 | Rochester | 14642 | NEUROLOGY |
| Dr. Janardhan's Office | Janardhan | Haldipur V. | MD | 1299 Portland Ave | Suite 7 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| Center for Women's Health | Hess | Henry M. | MD | 2255 Clinton Ave South | | Rochester | 14618 | OBSTETRICS/GYNECOLOGY |
| DiNolfo, Howitt, Urban | DiNolfo | Tamara | MD | 1283 Portland Ave | | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| DiNolfo, Howitt, Urban | Howitt | Jacquelyn C. | MD | 1283 Portland Ave | | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| DiNolfo, Howitt, Urban | Urban | Richard | MD | 1283 Portland Ave | | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| Dr. Edelstein's Office | Edelstein | Arthur V. | MD | 171 Park Ave | | Rochester | 14607 | OBSTETRICS/GYNECOLOGY |
| Dr. Morgos's Office | Morgos | Faig W. | MD | 6692 Middle Rd | PO Box 153 | Sodus | 14551 | OBSTETRICS/GYNECOLOGY |
| Dr. Tatelbaum's Office | Tatelbaum | Robert C. | MD | 1295 Portland Ave | Suite 9 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| GHS OB/GYN | Grace | William F | MD | 220 Alexander St | Suite 602 | Rochester | 14607 | OBSTETRICS/GYNECOLOGY |
| GHS OB/GYN | Thomas | Earlando | MD | 220 Alexander St | Suite 602 | Rochester | 14607 | OBSTETRICS/GYNECOLOGY |
| Greater Roch OB/GYN | Eigg | Marc H. | MD | 1295 Portland Ave | Suite 9 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |

# GRIPA Owner Physicians

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Greater Roch OB/GYN | Jacobs | Michael L. | MD | 1295 Portland Ave | Suite 9 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| Highland Hospital OB/GYN | McNanley | Thomas J. | MD | 1000 South Ave | Box 116 | Rochester | 14620 | OBSTETRICS/GYNECOLOGY |
| Institute for Reproductive Health | Hayes | Rosalind A. | MD | 1561 Long Pond Rd | Suite 410 | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| Institute for Reproductive Health | Mroueh | Jamil | MD | 1561 Long Pond Rd | Suite 410 | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| Panorama Valley/Greece OB/GYN | Anissi | Darushe | MD | 120 Erie Canal Dr | Suite 200 | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| Panorama Valley/Greece OB/GYN | Lammers | Katherine S. | MD | 120 Erie Canal Dr | Suite 200 | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| Panorama Valley/Greece OB/GYN | Mirwald | Michael R. | MD | 120 Erie Canal Dr | Suite 200 | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| Penfield OB/GYN | Dass | Tripta | MD | 43 Willow Pond Way | Suite 200 | Penfield | 14526 | OBSTETRICS/GYNECOLOGY |
| Penfield OB/GYN | Dickinson | Karin R. | MD | 43 Willow Pond Way | Suite 200 | Penfield | 14526 | OBSTETRICS/GYNECOLOGY |
| Penfield OB/GYN | Grove | Jeanne E. | DO | 43 Willow Pond Way | Suite 200 | Penfield | 14526 | OBSTETRICS/GYNECOLOGY |
| Penfield OB/GYN | Klimek | Waldemar | DO | 43 Willow Pond Way | Suite 200 | Penfield | 14526 | OBSTETRICS/GYNECOLOGY |
| Penfield OB/GYN | Laroia | Rahul | MD | 43 Willow Pond Way | Suite 200 | Penfield | 14526 | OBSTETRICS/GYNECOLOGY |
| Penfield OB/GYN | Piquion-Joseph | Johann | MD | 43 Willow Pond Way | Suite 200 | Penfield | 14526 | OBSTETRICS/GYNECOLOGY |
| RGH Women's Center | Gordon | Jeffrey B. | MD | 1415 Portland Ave | Suite 490 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| RGH Women's Center | Newcomb | Patricia | MD | 1415 Portland Ave | Suite 490 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| RGH Women's Center | Vill | Maggie D. | MD | 1415 Portland Ave | Suite 400 | Rochester | 14621 | OBSTETRICS/GYNECOLOGY |
| Strong OB/GYN Group | Howard | Fred M. | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | OBSTETRICS/GYNECOLOGY |
| Strong OB/GYN Group | Woods | James R. | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | OBSTETRICS/GYNECOLOGY |
| University OB/Perinatology Group | Glantz | J. Christopher | MD | 601 Elmwood Ave | Box 668 | Rochester | 14642 | OBSTETRICS/GYNECOLOGY |
| Wayne Medical / Women's Care | Druff | Gerald H. | MD | 1250 Driving Park Ave | Newark Med Ctr | Newark | 14513 | OBSTETRICS/GYNECOLOGY |
| Wayne Medical / Women's Care | Okoniewski-Philips | Susan | MD | 1250 Driving Park Ave | Newark Med Ctr | Newark | 14513 | OBSTETRICS/GYNECOLOGY |
| Wayne Medical / Women's Care | Somaskanda | Ambalavanar | MD | 6600 Middle Rd | Sodus Health Ctr | Sodus | 14551 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Bharucha | Jeroo K. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Dwyer-Albano | Wendy | MD | 3101 West Ridge Road | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Gabel | Donald J. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Herron | Michelle M. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Herron | Kelly | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Kerpelman | Judith E. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Morgan | Elizabeth | MD | 3101Ridge Road West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Ogden | Edward B. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | Poleshuck | Victor A. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |
| West Ridge OB/GYN | TenHoopen | Derek J. | MD | 3101 Ridge Rd West | Bldg D | Rochester | 14626 | OBSTETRICS/GYNECOLOGY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Interlakes Oncology & Hematology | Solky | Alexander | MD | 211 White Spruce Blvd | | Rochester | 14623 | ONCOLOGY |
| Lipson Cancer and Blood Center | Bushunow | Peter | MD | 1425 Portland Ave | Box 233 | Rochester | 14621 | ONCOLOGY |
| Lipson Cancer and Blood Center | Smith | Julia L. | MD | 1425 Portland Ave | Box 233 | Rochester | 14621 | ONCOLOGY |
| Dr. Fox's Office | Fox | James W. | MD | 1400 Portland Ave | | Rochester | 14621 | OPHTHALMOLOGY |
| Dr. Lerner's Office | Lerner | Hobart | MD | 720 East Ave | Suite 200 | Rochester | 14607 | OPHTHALMOLOGY |
| Dr. Zazulak's Office | Zazulak | O. Gregory | MD | 890 Westfall Rd | Suite E | Rochester | 14618 | OPHTHALMOLOGY |
| Lakeview Eye Care | Platt | Christine | MD | 1 Lakeview Park | | Rochester | 14613 | OPHTHALMOLOGY |
| Metro Eyecare | Crofts | John W. | MD | 2354 Monroe Ave | | Rochester | 14618 | OPHTHALMOLOGY |
| Ocusight Eye Care Center | Rosenberg | Paul N. | MD | 1081 Long Pond Rd | Suite 240 | Rochester | 14626 | OPHTHALMOLOGY |
| Ocusight Eye Care Center | Seeger | Richard J. | MD | 1081 Long Pond Rd | Suite 240 | Rochester | 14626 | OPHTHALMOLOGY |
| Ocusight Eye Care Center | Tingley | Donald | MD | 1081 Long Pond Rd | Suite 240 | Rochester | 14626 | OPHTHALMOLOGY |
| Park & Siebold Eye Care | Park | Steve | MD | 2300 Buffalo Rd | Bldg 700 | Rochester | 14624 | OPHTHALMOLOGY |
| Reed Eye Associates | Reed | Ronald | MD | 500 Kreag Rd | | Pittsford | 14534 | OPHTHALMOLOGY |
| Retina Associates of WNY | Rose | Steven | MD | 890 Westfall Rd | Suite D | Rochester | 14618 | OPHTHALMOLOGY |
| Retina Specialists of the Finger Lakes | Chang | Shi-Hwa (William) | MD | 2300 Buffalo Rd | Suite 700B | Rochester | 14624 | OPHTHALMOLOGY |
| RGH Dept of Ophthalmology | Sterns | Gwen K. | MD | 1425 Portland Ave | Box 224 | Rochester | 14621 | OPHTHALMOLOGY |
| Roch Eye Associates | Asselin | Dennis A. | MD | 2301 Lac de Ville Blvd | | Rochester | 14618 | OPHTHALMOLOGY |
| Roch Eye Associates | Markowitz | Gary | MD | 2301 Lac de Ville Blvd | | Rochester | 14618 | OPHTHALMOLOGY |
| Roch Eye Associates | Olsen | Robert | MD | 2301 Lac de Ville Blvd | | Rochester | 14618 | OPHTHALMOLOGY |
| Roch Eye Associates | Williams | Kyle | MD | 2301 Lac de Ville Blvd | | Rochester | 14618 | OPHTHALMOLOGY |
| Roch Eye Care Group | Presberg | Saul L. | MD | 30 North Union St | Suite 101 | Rochester | 14607 | OPHTHALMOLOGY |
| Strong Eye Care | Ching | Steven | MD | 601 Elmwood Ave | Box 659 | Rochester | 14642 | OPHTHALMOLOGY |
| Strong Eye Care | Chung | Mina | MD | 601 Elmwood Ave | Box 659 | Rochester | 14642 | OPHTHALMOLOGY |
| Strong Eye Care | DiLoreto | David | MD | 601 Elmwood Ave | Box 659 | Rochester | 14642 | OPHTHALMOLOGY |
| Strong Eye Care | Gearinger | Matthew | MD | 601 Elmwood Ave | Box 659 | Rochester | 14642 | OPHTHALMOLOGY |
| Strong Eye Care | Plotnik | Ronald | MD | 601 Elmwood Ave | Box 659 | Rochester | 14642 | OPHTHALMOLOGY |
| Wayne Regional Eye Center | Napolean | Mary Susan | MD | 1210 Driving Park Ave | Suite 1 | Newark | 14513 | OPHTHALMOLOGY |
| Wayne Regional Eye Center | Panthagani | Prasad | MD | 1210 Driving Park Ave | Suite 1 | Newark | 14513 | OPHTHALMOLOGY |
| Dr. Orbach'sOffice | Orbach | Stan | DDS | 6819 Pittsford-Palmyra Rd | | Fairport | 14450 | ORAL SURGERY |
| Dr. Ruckert's Office | Ruckert | Eric W. | DDS | 6800 Pittsford-Palmyra Rd | Suite 120 | Fairport | 14450 | ORAL SURGERY |
| Roch Oral/Maxillofacial Surgery Assoc | Salahuddin | Mohammed | DDS, PhD | 1415 Portland Ave | Suite 590 | Rochester | 14621 | ORAL SURGERY |
| Dr. Dolan's Office | Dolan | William | MD | 880 Westfall Rd | Suite A | Rochester | 14618 | ORTHOPEDICS |
| Dr. Kunze's Office | Kunze | Wilfried | MD | 1445 Portland Ave | Suite 210 | Rochester | 14621 | ORTHOPEDICS |
| Dr. Tanner's Office | Tanner | Edward | MD | 1445 Portland Ave | Suite 210 | Rochester | 14621 | ORTHOPEDICS |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Dr. Whitbeck's Office | Whitbeck | M. Gordon | MD | 1415 Portland Ave | Suite 560 | Rochester | 14621 | ORTHOPEDICS |
| Greater Roch Orthopaedics | Capicotto | Peter N. | MD | 30 Hagen Dr | Suite 220 | Rochester | 14625 | ORTHOPEDICS |
| Greater Roch Orthopaedics | Stein | Todd | MD | 30 Hagen Dr | Suite 220 | Rochester | 14625 | ORTHOPEDICS |
| Gymini Sports Medicine & Rehab | Washington | Reuben | MD | 1204 Driving Park Ave | | Newark | 14513 | ORTHOPEDICS |
| Interlakes Orthopaedic Surgery | Banwar | Nitin | MD | 1300 Driving Park Ave | | Newark | 14513 | ORTHOPEDICS |
| Orthopaedic Associates of Roch | Colucci | Michael A. | MD | 2410 Ridgeway Ave | | Rochester | 14626 | ORTHOPEDICS |
| Orthopaedic Associates of Roch | Klibanoff | John | MD | 2410 Ridgeway Ave | | Rochester | 14626 | ORTHOPEDICS |
| Orthopaedic Associates of Roch | Little Jr | Robert | MD | 2410 Ridgeway Ave | | Rochester | 14626 | ORTHOPEDICS |
| Portland Orthopaedic Associates | Niles | Michael | MD | 1299 Portland Ave | Suite 16 | Rochester | 14621 | ORTHOPEDICS |
| Red Creek Orthopaedics | Daino | Terrance | MD | 125 Red Creek Dr | Suite 205 | Rochester | 14623 | ORTHOPEDICS |
| Red Creek Orthopaedics | Klotz | Michael | MD | 125 Red Creek Dr | Suite 205 | Rochester | 14623 | ORTHOPEDICS |
| Red Creek Orthopaedics | Loveys | Luke | MD | 125 Red Creek Dr | Suite 205 | Rochester | 14623 | ORTHOPEDICS |
| Roch Community Orthopaedics | Bessette | Gary | MD | 1415 Portland Ave | Suite 500 | Rochester | 14621 | ORTHOPEDICS |
| Roch Community Orthopaedics | Carrier | David | MD | 1415 Portland Ave | Suite 500 | Rochester | 14621 | ORTHOPEDICS |
| Roch Community Orthopaedics | Clader | Timothy | MD | 1415 Portland Ave | Suite 500 | Rochester | 14621 | ORTHOPEDICS |
| Roch Community Orthopaedics | Rashid | Rola | MD | 1415 Portland Ave | Suite 500 | Rochester | 14621 | ORTHOPEDICS |
| Wayne Regional Orthopaedics | Kaempffe | Frederick | MD | 4425 Old Ridge Rd | PO Box 897 | Williamson | 14589 | ORTHOPEDICS |
| Birken & Yates ENT | Birken | Eric A. | MD | 231 Parrish St | | Canandaigua | 14424 | OTOLARYNGOLOGY |
| Center for Surgery Head/Neck | Coniglio | John U. | MD | 1065 Senator Keating Blvd | Suite 240 | Rochester | 14618 | OTOLARYNGOLOGY |
| Dr. Musinger's Office | Musinger | Jules | MD | 121 Erie Canal Dr | Suite E | Rochester | 14626 | OTOLARYNGOLOGY |
| Finger Lakes Otolaryngology | Centonze | John F. | MD | 1206 Driving Park Ave | | Newark | 14513 | OTOLARYNGOLOGY |
| Finger Lakes Otolaryngology | DeCicco | Michael | MD | 1206 Driving Park Ave | | Newark | 14513 | OTOLARYNGOLOGY |
| Finger Lakes Otolaryngology | Simmons | W. Bradley | MD | 1206 Driving Park Ave | | Newark | 14513 | OTOLARYNGOLOGY |
| Greater Roch Ear, Nose, Throat | Topf | Paul | MD | 1295 Portland Ave | Suite 7 | Rochester | 14621 | OTOLARYNGOLOGY |
| Lakeside Ear/Nose/Throat/Allergy | Carnevale | Gregory | MD | 784 Pre-Emption Rd | | Geneva | 14456 | OTOLARYNGOLOGY |
| Roch Otolaryngology Group | Harrington | Paul C. | MD | 2561 Lac de Ville Blvd | Suite 100 | Rochester | 14618 | OTOLARYNGOLOGY |
| Roch Otolaryngology Group | Mulbury | Peter E. | MD | 2561 Lac de Ville Blvd | Suite 100 | Rochester | 14618 | OTOLARYNGOLOGY |
| Roch Otolaryngology Group | Oliver | Robert H. | MD | 2561 Lac de Ville Blvd | Suite 100 | Rochester | 14618 | OTOLARYNGOLOGY |
| Roch Otolaryngology Group | Salamone | Frank N. | MD | 2561 Lac de Ville Blvd | Suite 100 | Rochester | 14618 | OTOLARYNGOLOGY |
| University Otolaryngology Assoc | Hadley | James A. | MD | 2365 Clinton Ave South | Suite 200 | Rochester | 14618 | OTOLARYNGOLOGY |
| University Otolaryngology Assoc | Miller | Chase | MD | 2365 Clinton Ave South | Suite 200 | Rochester | 14618 | OTOLARYNGOLOGY |
| RGH Dept of Pathology | Cramer | Stewart | MD | 1425 Portland Ave | Box 400 | Rochester | 14621 | PATHOLOGY |
| RGH Dept of Pathology | Fricke | William | MD | 1425 Portland Ave | Box 400 | Rochester | 14621 | PATHOLOGY |
| RGH Dept of Pathology | Markowitch Jr | Walter | MD | 1425 Portland Ave | Box 400 | Rochester | 14621 | PATHOLOGY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Behavioral Pediatric Program | Smith | Scott | MD | 1445 Portland Ave | Suite 204 | Rochester | 14621 | PEDIATRIC DEVELOPMENTAL DISABILITIES |
| Bay Creek Pediatric Group | Kanthor | Harold A. | MD | 2000 Empire Blvd | Suite 200 | Webster | 14580 | PEDIATRICS |
| Bay Creek Pediatric Group | Stein | Julia | MD | 2000 Empire Blvd | Suite 200 | Webster | 14580 | PEDIATRICS |
| Calkins Medical Group | Aziz | Farideh T. | MD | 125 Red Creek Dr | Suite 201 | Rochester | 14623 | PEDIATRICS |
| Dr. Garcia's Office | Garcia | Sonia | MD | 1401 Stone Rd | Suite 304 | Rochester | 14615 | PEDIATRICS |
| Dr. Grossman's Office | Grossman | Joseph | MD | 1400 Portland Ave | Suite 44 | Rochester | 14621 | PEDIATRICS |
| Dr. Masood's Office | Masood | Syed Siraj | MD | 1295 Portland Ave | Suite 17 | Rochester | 14621 | PEDIATRICS |
| Fairport Pediatrics | Bloom | Richard A. | MD | 460 Cross Keys Office Pk | | Fairport | 14450 | PEDIATRICS |
| Fairport Pediatrics | Eisenberg | Jeffrey C. | MD | 460 Cross Keys Office Pk | | Fairport | 14450 | PEDIATRICS |
| Fairport Pediatrics | Mscichowski | Bogdan | MD | 460 Cross Keys Office Pk | | Fairport | 14450 | PEDIATRICS |
| Fairport Pediatrics | Sokolow | Saul K. | MD | 460 Cross Keys Office Pk | | Fairport | 14450 | PEDIATRICS |
| GHS Pediatric Group | Banghart | Maria-Elena C. | MD | 222 Alexander St | Suite 4200 | Rochester | 14607 | PEDIATRICS |
| GHS Pediatric Group | Colpoys | Margaret | MD | 222 Alexander St | Suite 4100 | Rochester | 14607 | PEDIATRICS |
| GHS Pediatric Group | Jacobs-Perkins | Andree | MD | 222 Alexander St | Suite 4200 | Rochester | 14607 | PEDIATRICS |
| GHS Pediatric Group | Kotok | David | MD | 222 Alexander St | Suite 4100 | Rochester | 14607 | PEDIATRICS |
| GHS Pediatric Group | Lawrence | Richard A. | MD | 222 Alexander St | Suite 4100 | Rochester | 14607 | PEDIATRICS |
| GHS Pediatric Group | Mangold | Albert H. | MD | 222 Alexander St | Suite 4100 | Rochester | 14607 | PEDIATRICS |
| GHS Pediatric Group | Webb | Stephen R. | MD | 222 Alexander St | Suite 4200 | Rochester | 14607 | PEDIATRICS |
| Gladbrook Pediatrics | Martin | Michael G. | MD | 300 White Spruce Blvd | | Rochester | 14623 | PEDIATRICS |
| Greece Pediatrics | Vora | Ramnik | MD | 888 Long Pond Rd | | Rochester | 14626 | PEDIATRICS |
| Irondequoit Pediatrics | Bennett | Douglas | MD | 564 Ridge Rd East | Suite 204B | Rochester | 14621 | PEDIATRICS |
| Irondequoit Pediatrics | Holt | Andrew | MD | 564 Ridge Rd East | Suite 204B | Rochester | 14621 | PEDIATRICS |
| Irondequoit Pediatrics | Savage | Kristen | MD | 564 Ridge Rd East | Suite 204B | Rochester | 14621 | PEDIATRICS |
| Lifetime Health - Chili Pediatrics | Christian | Kristen | MD | 849 Paul Rd | Suite 110 | Rochester | 14624 | PEDIATRICS |
| Lifetime Health - Greece Center | Hessert | Timothy | MD | 470 Long Pond Rd | | Rochester | 14612 | PEDIATRICS |
| Lifetime Health - Greece Center | Khaled | Shireen | MD | 470 Long Pond Rd | | Rochester | 14612 | PEDIATRICS |
| Lifetime Health - Perinton Center | Carrier | Lauri | MD | 77 Sully's Trail | Suite 200 | Pittsford | 14534 | PEDIATRICS |
| Lifetime Health - Perinton Center | Yirinec | Robin | MD | 77 Sully's Trail | Suite 200 | Pittsford | 14534 | PEDIATRICS |
| Lifetime Health - Wilson Center | Falkovich | Ruvim | MD | 800 Carter St | | Rochester | 14621 | PEDIATRICS |
| Lifetime Health - Wilson Center | Kadakia | Pradip R. | MD | 800 Carter St | | Rochester | 14621 | PEDIATRICS |
| Long Pond Pediatrics | Kiernan | Mary Anne | MD | 2350 Ridgeway Ave | Suite B | Rochester | 14626 | PEDIATRICS |
| Long Pond Pediatrics | Leddy | Sarah | MD | 2350 Ridgeway Ave | Suite B | Rochester | 14626 | PEDIATRICS |
| Long Pond Pediatrics | O'Brien | Elizabeth | MD | 2350 Ridgeway Ave | Suite B | Rochester | 14626 | PEDIATRICS |
| Long Pond Pediatrics | Williams | Diana R. | MD | 2350 Ridgeway Ave | Suite B | Rochester | 14626 | PEDIATRICS |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Ogden Pediatrics | Bruchl | Charles L. | MD | 4415 Buffalo Rd | Suite 1B | North Chili | 14514 | PEDIATRICS |
| Panorama Pediatric Group | Chesley | Eric | DO | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Colton | Lisa | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Ingerowski | Eric F. | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Klein | Suzanne W. | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Machiele | Elizabeth | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Pardee | Jane | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Seaman | John | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Shipley | Laura | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Panorama Pediatric Group | Tuite | Robert | MD | 220 Linden Oaks | Suite 200 | Rochester | 14625 | PEDIATRICS |
| Penn Fair Med/Pediatric Group | Hernady | Andrea H. | MD | 401 Penbrooke Dr | Bldg 3 | Penfield | 14526 | PEDIATRICS |
| Penn Fair Med/Pediatric Group | Katlic | Kerry | MD | 401 Penbrooke Dr | Bldg 3 | Penfield | 14526 | PEDIATRICS |
| Penn Fair Med/Pediatric Group | Klossner | Kevin E. | MD | 401 Penbrooke Dr | Bldg 3 | Penfield | 14526 | PEDIATRICS |
| Portland Pediatric Group | Bosco | John | MD | 1700 Hudson Ave | | Rochester | 14617 | PEDIATRICS |
| Portland Pediatric Group | Davis | Roderick | MD | 1700 Hudson Ave | | Rochester | 14617 | PEDIATRICS |
| Portland Pediatric Group | Holmes | Michael | MD, PhD | 1700 Hudson Ave | | Rochester | 14617 | PEDIATRICS |
| Ridgewood Med Peds | Sullivan | Richard P. | MD | 3101 Ridge Rd West | Bldg C | Rochester | 14626 | PEDIATRICS |
| Roch General Pediatric Assoc | Campbell | James | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Christy | Cynthia | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Denk | Larry | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Garfunkel | Lynn | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Howard | Cynthia | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Khan | Imad | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Khatri-Dua | Anamika | MD | 1425 Portland Ave | | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Lehoullier | Paul F. | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Mehra | C. Mohini | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Mullin | Suzanne | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Roch General Pediatric Assoc | Yawman | Daniel | MD | 1425 Portland Ave | Box 238 | Rochester | 14621 | PEDIATRICS |
| Rochester General Pediatric Associates | Buchanan | Ann | MD | 1425 Portand Ave | | Rochester | 14621 | PEDIATRICS |
| Wayne Medical / Pediatrics | Bjorseth | Caryl E. | MD | 1200 Driving Park Ave | Newark Med Ctr | Newark | 14513 | PEDIATRICS |
| Wayne Medical / Pediatrics | Galutia | Steven | MD | 1200 Driving Park Ave | Newark Med Ctr | Newark | 14513 | PEDIATRICS |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Wayne Medical / Pediatrics | Jordan | Michael | MD | 1200 Driving Park Ave | Newark Med Ctr | Newark | 14513 | PEDIATRICS |
| Wayne Medical / Pediatrics | Orlowski | Beth A. | DO | 1200 Driving Park Ave | Newark Med Ctr | Newark | 14513 | PEDIATRICS |
| Wayne Medical / Pediatrics | Prabhu | Nivedita P. | MD | 1200 Driving Park Ave | Newark Med Ctr | Newark | 14513 | PEDIATRICS |
| Wayne Medical Group - Sodus | Endres | Richard F. | MD | 6692 Middle Rd | PO Box 9 | Sodus | 14551 | PEDIATRICS |
| Wayne Medical Group - Sodus | Kincaid | Martha | MD | 6692 Middle Rd | PO Box 9 | Sodus | 14551 | PEDIATRICS |
| Wayne Medical Group - Sodus | Prestwich | Suzanne V. | MD | 6692 Middle Rd | PO Box 9 | Sodus | 14551 | PEDIATRICS |
| Wayne Medical Group - Williamson | Hellmann | Sandra | MD | 4425 Old Ridge Rd | PO Box 934 | Williamson | 14589 | PEDIATRICS |
| Wayne Medical Group - Williamson | Kontor | Annamaria | MD | 4425 Old Ridge Rd | PO Box 934 | Williamson | 14589 | PEDIATRICS |
| Wayne Medical Group - Wolcott | Shoemaker | Michael | MD | 6254 Lawville Rd | | Wolcott | 14590 | PEDIATRICS |
| Webster Medical Group | Kaplan | Barton W. | MD | 45 Webster Commons Blvd | Suite 200 | Webster | 14580 | PEDIATRICS |
| Webster Medical Group | Menon | Sharada P. | MD | 45 Webster Commons Blvd | Suite 200 | Webster | 14580 | PEDIATRICS |
| Rehab Associates of Roch | Aggarwal | Uma | MD | 1425 Portland Ave | Box 374 | Rochester | 14621 | PHYSICAL MEDICINE/REHAB |
| Rehab Associates of Roch | Nickels | Jean L. | MD | 1425 Portland Ave | Box 374 | Rochester | 14621 | PHYSICAL MEDICINE/REHAB |
| De. Capuano's Office | Capuano | Donald J. | MD | 2640 Ridgeway Ave | | Rochester | 14626 | PLASTIC SURGERY |
| Dr. Evangelesti's Office | Evangelisti | Stephen | MD | 220 Alexander St | Suite 611 | Rochester | 14607 | PLASTIC SURGERY |
| Dr.Sbitany's Office | Sbitany | Usama | MD | 1561 Long Pond Rd | Suite 315 | Rochester | 14626 | PLASTIC SURGERY |
| Plastic Surgery Assoc of Roch | Herrera | H. Raul | MD | 1445 Portland Ave | Suite 101 | Rochester | 14621 | PLASTIC SURGERY |
| Plastic Surgery Group of Roch | Carrasquillo | Ines | MD | 10 Hagen Dr | Suite 310 | Rochester | 14625 | PLASTIC SURGERY |
| Plastic Surgery Group of Roch | Davenport | Mark | MD | 10 Hagen Dr | Suite 310 | Rochester | 14625 | PLASTIC SURGERY |
| Plastic Surgery Group of Roch | Fink | Jeffrey A. | MD | 10 Hagen Dr | Suite 310 | Rochester | 14625 | PLASTIC SURGERY |
| Plastic Surgery Group of Roch | O'Connor | Timothy | MD | 10 Hagen Dr | Suite 310 | Rochester | 14625 | PLASTIC SURGERY |
| Plastic Surgery Group of Roch | Pennino | Ralph P. | MD | 10 Hagen Dr | Suite 310 | Rochester | 14625 | PLASTIC SURGERY |
| Center for Children & Youths | Challapalli | Vishnu | MD | 224 Alexander St | West Wing 2 | Rochester | 14607 | PSYCHIATRY |
| Dr. Lawrence's Office | Lawrence | Timothy L. | MD | 1815 Clinton Ave South | Suite 445 | Rochester | 14618 | PSYCHIATRY |
| Dr. Lewek's Office | Lewek | William T. | MD | 27 Rowley St | | Rochester | 14607 | PSYCHIATRY |
| Dr. Remington's Office | Remington | Frederick | MD | 326 Garnsey Rd | | Pittsford | 14534 | PSYCHIATRY |
| Dr. Schubmehl's Office | Schubmehl | James Q. | MD | 2541 Monroe Ave | Suite B7 | Rochester | 14618 | PSYCHIATRY |
| Dr. Young's Office | Young | Robert B. | MD | 953 Pittsford-Mendon Ctr Rd | | Pittsford | 14534 | PSYCHIATRY |
| Genesee Mental Health Center | Seeger | Gregory L. | MD | 224 Alexander St | East Wing 1 | Rochester | 14607 | PSYCHIATRY |
| Linden Oaks Therapy | Tariot | Alice M. | MD | 100 Linden Oaks | Suite 200 | Rochester | 14625 | PSYCHIATRY |
| Roch Mental Health Center | Ortega | Tulio | MD | 490 Ridge Rd East | | Rochester | 14621 | PSYCHIATRY |
| Roch Mental Health Center | Patil | Kashinath B. | MD | 490 Ridge Rd East | | Rochester | 14621 | PSYCHIATRY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Roch Mental Health Center | Rennert | Eric | MD | 490 Ridge Rd East | | Rochester | 14621 | PSYCHIATRY |
| Rochester General Hospital | Grumet | Gerald | MD | 1425 Portland Ave | | Rochester | 14621 | PSYCHIATRY |
| Strong Psychiatry Faculty Practice | Leibovici | Adrian | MD | 300 Crittenden Blvd | Box PSYCH | Rochester | 14642 | PSYCHIATRY |
| ViaHealth Behavioral Health Network | Vasile | Joseph | MD | 490 Ridge Rd East | | Rochester | 14621 | PSYCHIATRY |
| Highland Hospital | Ortiz | Carlos R. | MD | 1000 South Ave | Box 85 | Rochester | 14620 | PULMONARY |
| Mary M Parkes Asthma/Pulmonary Ctr | Finigan | Michael | MD | 400 Red Creek Dr | Suite 110 | Rochester | 14623 | PULMONARY |
| RGH Dept of Pulmonary Disease | Chow | Ming Yan | MD | 1425 Portland Ave | Box 202 | Rochester | 14621 | PULMONARY |
| RGH Dept of Pulmonary Disease | Fedullo | Anthony | MD | 1425 Portland Ave | Box 202 | Rochester | 14621 | PULMONARY |
| RGH Dept of Pulmonary Disease | Lee | David | MD | 1425 Portland Ave | Box 202 | Rochester | 14621 | PULMONARY |
| RGH Dept of Pulmonary Disease | Sondhi | Damanpaul | MD | 1425 Portland Ave | Box 202 | Rochester | 14621 | PULMONARY |
| RGH Dept of Pulmonary Disease | Swinburne | Andrew | MD | 1425 Portland Ave | Box 202 | Rochester | 14621 | PULMONARY |
| RGH Dept of Pulmonary Disease | Wahl | Gary W. | MD | 1425 Portland Ave | Box 202 | Rochester | 14621 | PULMONARY |
| Roch Cardiopulmonary Group | Dale | Robert | MD | 1445 Portland Ave | Suite 104 | Rochester | 14621 | PULMONARY |
| Batavia Radiation Oncology | Mudd | Kevin J. | MD | 262 Bank St | | Batavia | 14020 | RADIATION ONCOLOGY |
| Finger Lakes Radiation Oncology | Albrecht | Charles H. | MD | 7 Ambulance Dr | | Clifton Springs | 14432 | RADIATION ONCOLOGY |
| Finger Lakes Radiation Oncology | Sobel | Sidney H. | MD | 7 Ambulance Dr | | Clifton Springs | 14432 | RADIATION ONCOLOGY |
| RGH Dept of Radiation Oncology | Casey | William B. | MD | 1425 Portland Ave | Box 223 | Rochester | 14621 | RADIATION ONCOLOGY |
| RGH Dept of Radiation Oncology | Daconceicao | Alberto Lopes | MD | 1425 Portland Ave | Box 223 | Rochester | 14621 | RADIATION ONCOLOGY |
| RGH Dept of Radiation Oncology | Liu | Bingren | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIATION ONCOLOGY |
| Borg Imaging Group | Cole | Bradley A. | MD | 1815 Clinton Ave South | Suite 320 | Rochester | 14618 | RADIOLOGY |
| Borg Imaging Group | Danahy | Susan | MD | 1815 Clinton Ave South | Suite 320 | Rochester | 14618 | RADIOLOGY |
| Borg Imaging Group | Iyer | Radha S. | MD | 1815 Clinton Ave South | Suite 320 | Rochester | 14618 | RADIOLOGY |
| Borg Imaging Group | Lorenzetti | Robert J. | MD | 1815 Clinton Ave South | Suite 320 | Rochester | 14618 | RADIOLOGY |
| IDE Imaging Group | Belton | Ruby L. | MD | 2263 Clinton Ave South | | Rochester | 14618 | RADIOLOGY |
| Roch Radiology Associates | Arseneau | Marianne | MD | PO Box 111 | | Newark | 14513 | RADIOLOGY |
| Roch Radiology Associates | Avanzato | Cheryl | MD | PO Box 111 | | Newark | 14513 | RADIOLOGY |
| Roch Radiology Associates | Backenstoss | Martine | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Broder | Jonathan | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Gupta | Atul | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Ifthikharuddin | Sarah | MD | 1415 Portland Ave | Suite 190 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Jacobson | Daniel | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Kowalchuk | Roman | MD | 1415 Portland Ave | Suite 190 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Lerner | Robert | MD | 1415 Portland Ave | Suite 190 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Monajati | Ahmad | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Montesinos | James | MD | 1415 Portland Ave | Suite 190 | Rochester | 14621 | RADIOLOGY |

# GRIPA Owner Physicians

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|---|---|---|---|---|---|---|---|---|
| Roch Radiology Associates | O'Connell | Avice M. | MD | 170 Cross Keys Office Pk | | Fairport | 14450 | RADIOLOGY |
| Roch Radiology Associates | Russo | Nicholas C. | MD | 1415 Portland Ave | Suite 190 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Segal | Arthur J. | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Spitzer | Eric | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Taneja | Sanjeev | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Zinkin | Edward B. | MD | 1415 Portland Ave | Suite 190 | Rochester | 14621 | RADIOLOGY |
| Roch Radiology Associates | Zinkin | Adam | MD | 1425 Portland Ave | Box 226 | Rochester | 14621 | RADIOLOGY |
| The Arthritis Center of Rochester | Ahmed | Aitezaz | MD | 2210 Monroe Ave | | Rochester | 14618 | RHEUMATOLOGY |
| RGH Dept of Surgery | Ettinghausen | Stephen | MD | 1445 Portland Ave | Suite 301 | Rochester | 14621 | SURGICAL ONCOLOGY |
| Genesee Valley Cardiothoracic | Becker | Eli J. | MD | 1415 Portland Ave | Suite 240 | Rochester | 14621 | THORACIC SURGERY |
| Genesee Valley Cardiothoracic | Cheeran | David | MD | 1415 Portland Ave | Suite 240 | Rochester | 14621 | THORACIC SURGERY |
| Genesee Valley Cardiothoracic | Kirshner | Ronald | MD | 1415 Portland Ave | Suite 240 | Rochester | 14621 | THORACIC SURGERY |
| University Cardiothoracic Surgery | Knight | Peter | MD | 601 Elmwood Ave | Box SURG | Rochester | 14642 | THORACIC SURGERY |
| Center for Urology | Butler | Melanie | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Center for Urology | DiMarco | Paul L. | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Center for Urology | Eichel | Louis | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Center for Urology | Glazer | Abraham | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Center for Urology | Oleyourryk | Gregory | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Center for Urology | Tonetti | Frederick | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Center for Urology | Valvo | John | MD | 2615 Culver Rd | | Rochester | 14609 | UROLOGY |
| Dr. Ashman's Office | Ashman | P. Miller | MD | 209 South Goodman St | | Rochester | 14607 | UROLOGY |
| Dr. Guthinger's Office | Guthinger | William P. | MD | 209 South Goodman St | | Rochester | 14607 | UROLOGY |
| Dr. Hulbert's Office | Hulbert | William | MD | 1445 Portland Ave | Suite 309 | Rochester | 14621 | UROLOGY |
| Dr. Mevorach's Office | Mevorach | Robert | MD | 1445 Portland Ave | Suite 309 | Rochester | 14621 | UROLOGY |
| Dr. Rabinowitz's Office | Rabinowitz | Ronald | MD | 1445 Portland Ave | Suite 309 | Rochester | 14621 | UROLOGY |
| Dr. Saraf's Office | Saraf | Pradeep G. | MD | 6600 Middle Rd, Suite 1700 | PO Box 98 | Sodus | 14551 | UROLOGY |
| Roch Urology Group | Gentile | David | MD | 400 White Spruce Blvd | Suite B | Rochester | 14623 | UROLOGY |
| Urology Associates of Roch | Dever | David P. | MD | 995 Senator Keating Blvd | Suite 330 | Rochester | 14618 | UROLOGY |
| Urology Associates of Roch | Donahue | Laurence | MD | 995 Senator Keating Blvd | Suite 330 | Rochester | 14618 | UROLOGY |
| Greater Roch Vascular/Gen Surg | Penn | Thomas E. | MD | 30 Hagen Dr | Suite 320 | Rochester | 14625 | VASCULAR SURGERY |
| Section of Vascular Surgery | Singh | Michael | MD | 601 Elmwood Ave | Box SURG | Rochester | 14642 | VASCULAR SURGERY |
| U of R Vascular Surgery | Illig | Karl | MD | 601 Elmwood Ave | Box 652 | Rochester | 14642 | VASCULAR SURGERY |
| Vascular Surgery | Rhodes | Jeffrey | MD | 1415 Portland Ave | Suite 125 | Rochester | 14621 | VASCULAR SURGERY |
| Vascular Surgery Associates | Geary | Kevin | MD | 1445 Portland Ave | Suite 108 | Rochester | 14621 | VASCULAR SURGERY |
| Vascular Surgery Associates | Riggs | Patrick N. | MD | 1445 Portland Ave | Suite 108 | Rochester | 14621 | VASCULAR SURGERY |

GRIPA Contract Providers

| Group Practice Name | Lname | Fname | Medical Specialty |
|---|---|---|---|
| Genesee Valley Laser Centre | McMeekin | Thomas 0. | DERMATOLOGY |
| University Dermatology Assoc | Brown | Marc D. | DERMATOLOGY |
| Muhlbauer Dermatopathology | Muhlbauer | Jan E. | DERMATOPATHOLOGY |
| Park Ridge Hospital | Cave Jr | William T. | ENDOCRINOLOGY |
| Strong Memorial Hospital | Ureles | Alvin L. | ENDOCRINOLOGY |
| Dr. Ryan's Office | Ryan | Stephen D. | INTERNAL MEDICINE |
| Medical Associates at Genesee | Yong | Arlene | INTERNAL MEDICINE |
| Medical Specialty Group | Rowley | Peter | MEDICAL GENETICS |
| Strong Memorial Hospital | Vates | George | NEUROLOGICAL |
| Strong Memorial Hospital | Holman | Paul | NEUROLOGICAL |
| Dr. Pollan's Office | Pollan | Lee D. | ORAL SURGERY |
| English Rd Pediatrics & Adolescent Medicine | Alberts | Jeffery | PEDIATRICS |
| English Rd Pediatrics & Adolescent Medicine | Knapp | Amanda | PEDIATRICS |
| English Rd Pediatrics & Adolescent Medicine | Beisheim | Melissa | PEDIATRICS |
| English Rd Pediatrics & Adolescent Medicine | Vitullo | Benedetto | PEDIATRICS |
| English Rd Pediatrics & Adolescent Medicine | Heil | Laurie | PEDIATRICS |
| Ogden Pediatrics | Klier | Mark | PEDIATRICS |
| Panorama Pediatric Group | McInerny | Thomas | PEDIATRICS |
| Penfield Pediatrics | Weinberg | Margot | PEDIATRICS |
| Penfield Pediatrics | Heintz | Barbara A. | PEDIATRICS |
| Penfield Pediatrics | Geen | Timothy | PEDIATRICS |
| Penfield Pediatrics | Kaplan | Elliot | PEDIATRICS |
| Pittsford Pediatric Associates | Hahn | Cathy | PEDIATRICS |
| Pittsford Pediatric Associates | Sengupta | Rahul J. | PEDIATRICS |
| Pittsford Pediatric Associates | Topa | David | PEDIATRICS |
| Pittsford Pediatric Associates | Goldberg | Rachel | PEDIATRICS |
| Portland Pediatric Group | Preston | Chad | PEDIATRICS |
| Westside Pediatric Group | Hughes | Molly | PEDIATRICS |
| Westside Pediatric Group | Cress | Clarene J. | PEDIATRICS |
| Westside Pediatric Group | Sharma | Piush | PEDIATRICS |
| Westside Pediatric Group | Gagnon | Carol A. | PEDIATRICS |
| Westside Pediatric Group | Volk | Gretchen R | PEDIATRICS |
| Westside Pediatric Group | Green | Michael | PEDIATRICS |
| Westside Pediatric Group | Marchini | Alejandro | PEDIATRICS |
| Dr. Fasanello's Office | Fasanello | Vincent | PSYCHIATRY |
| Dr. Kumetat's Office | Kumetat | Bernie B. | PSYCHIATRY |
| Dr. Letourneau's Office | Letourneau | Thomas G. | PSYCHIATRY |
| Dr. Pisetzner's Office | Pisetzner | Melvin K. | PSYCHIATRY |
| Dr. Schubmehl's Office | Schubmehl | John B. | PSYCHIATRY |
| Dr. Wohltmann's Office | Wohltmann | Virginia A. | PSYCHIATRY |
| Genesee Mental Health Center | Biviano | Ronald S. | PSYCHIATRY |
| Pittsford Psychiatric Group | Satloff | Aaron | PSYCHIATRY |
| Sleep Disorders Center of Roch | Israel | Robert H. | PULMONARY |
| Borg Imaging Group | Schuster | James | RADIOLOGY |
| Borg Imaging Group | Wopperer | Daniel | RADIOLOGY |
| Borg Imaging Group | Benazzi | Robert | RADIOLOGY |
| Borg Imaging Group | Cavalieri | Antoinette | RADIOLOGY |
| Borg Imaging Group | Bennett | Jane | RADIOLOGY |
| Borg Imaging Group | Fogarty | Janine | RADIOLOGY |
| Borg Imaging Group | Kurland | Christine | RADIOLOGY |
| Borg Imaging Group | Lincoln | A. James | RADIOLOGY |

GRIPA Contract Providers

| Group Practice Name | Lname | Fname | Medical Specialty |
|---|---|---|---|
| Elizabeth Wende Breast Clinic | Somerville | Patricia | RADIOLOGY |
| Elizabeth Wende Breast Clinic | Murphy | Philip | RADIOLOGY |
| Elizabeth Wende Breast Clinic | Zuley | Margarita | RADIOLOGY |
| Elizabeth Wende Breast Clinic | Seifert | Posy | RADIOLOGY |
| Elizabeth Wende Breast Clinic | Logan-Young | Wende | RADIOLOGY |
| Elizabeth Wende Breast Clinic | Destounis | Stamatia | RADIOLOGY |
| IDE Imaging Group | Gianakakis | Louis | RADIOLOGY |
| IDE Imaging Group | Utz | Rosemary | RADIOLOGY |
| IDE Imaging Group | Gadziala | Nancy Ann | RADIOLOGY |
| IDE Imaging Group | Stringer | Bruce | RADIOLOGY |
| IDE Imaging Group | Khalid | M. Atif | RADIOLOGY |
| IDE Imaging Group | Hainen | Ronald L. | RADIOLOGY |
| IDE Imaging Group | Chung | James | RADIOLOGY |
| IDE Imaging Group | Storch | Alan | RADIOLOGY |
| IDE Imaging Group | Gopal | Hari | RADIOLOGY |
| IDE Imaging Group | Haymes | Allyson | RADIOLOGY |
| IDE Imaging Group | DeMocker | John C. | RADIOLOGY |
| IDE Imaging Group | Cohn | Frederick S. | RADIOLOGY |
| IDE Imaging Group | Bowers | Michael G. | RADIOLOGY |
| IDE Imaging Group | Barnett | Ted D. | RADIOLOGY |
| IDE Imaging Group | Femia | Ronald | RADIOLOGY |
| IDE Imaging Group | Schroeder | Keith | RADIOLOGY |
| IDE Imaging Group | Hantman | Stuart | RADIOLOGY |
| IDE Imaging Group | Schrank | W. Winslow | RADIOLOGY |
| IDE Imaging Group | Wolf | David M. | RADIOLOGY |
| IDE Imaging Group | Jacoby | Mel | RADIOLOGY |
| IDE Imaging Group | Herbert | Steven G. | RADIOLOGY |
| Rheumatology Assoc of Roch | Shlotzhauer | Tammi L. | RHEUMATOLOGY |
| Rheumatology Assoc of Roch | Pryhuber | Keith | RHEUMATOLOGY |
| University Cardiothoracic Surgery | Massey | Howard Todd | THORACIC SURGERY |

GRIPA Physicians' Secondary Specialties

| Lname | Fname | Group Practice Name | Medical Specialty |
|---|---|---|---|
| Challapalli | Vishnu | Center for Children & Youths | CHILD PSYCHIATRY |
| Tariot | Alice M. | Linden Oaks Therapy | CHILD PSYCHIATRY |
| Stolarczyk | Richard | Dr. Stolarczyk's Office | ENDOCRINOLOGY |
| Iannucci | Brenda | Dr. Iannucci's Office | GERIATRICS |
| Jurik | John A. | Partners in Internal Medicine-Hagen Drive | GERIATRICS |
| Algase | Leslie F. | Partners in Internal Medicine-Hagen Drive | GERIATRICS |
| Kurnath | Joseph F. | Partners in Internal Medicine-Hagen Drive | GERIATRICS |
| McGrail | Kathleen | Bay Creek Medical Group | GERIATRICS |
| Meloni | Stephen | Elmwood Medical Associates | GERIATRICS |
| Blasczak | David | Arcadia Family Practice | GERIATRICS |
| Heasley | Paul | Wayne Medical Group - Newark | GERIATRICS |
| Ryan | Stephen D. | Dr. Ryan's Office | GERIATRICS |
| Slobard | James A. | Lifetime Health - Wilson Center | GERIATRICS |
| Schabel | Scott | Hill Haven Nursing Home | GERIATRICS |
| Stornelli | Leo F. | Lifetime Health | GERIATRICS |
| Wood | James B. | Highlands Living Center | GERIATRICS |
| Potter | Douglas | Dr. Potter's Office | GERIATRICS |
| Rich | Steven A. | Lifetime Health - Perinton Center | GERIATRICS |
| Rice | Linda | Ridgeplex Internal Medicine | GERIATRICS |
| Chessin | Lawrence N. | Medical Associates at Genesee | INFECTIOUS DISEASES |
| Nagendra | Thambirajah | Wayne Medical Group - Wolcott | INFECTIOUS DISEASES |
| McNanley | Thomas J. | Highland Hospital OB/GYN | MATERNAL & FETAL MEDICINE |
| Woods | James R. | Strong OB/GYN Group | MATERNAL & FETAL MEDICINE |
| Howitt | Jacquelyn C. | DiNolfo, Howitt, Urban | MATERNAL & FETAL MEDICINE |
| Glantz | J. Christopher | University OB/Perinatology Group | MATERNAL & FETAL MEDICINE |
| Guadagnino | Paul L. | Anesthesia Associates of Roch | PAIN MANAGEMENT |
| Proper | Gilbert P. | Anesthesia Associates of Roch | PAIN MANAGEMENT |
| Dotson | Eric | Anesthesia Associates of Roch | PAIN MANAGEMENT |
| Nemani | Ajai K. | Pain Treatment Medicine of the Finger Lakes | PAIN MANAGEMENT |
| Mroueh | Jamil | Institute for Reproductive Health | REPRODUCTIVE ENDOCRINOLOGY |
| Hayes | Rosalind A. | Institute for Reproductive Health | REPRODUCTIVE ENDOCRINOLOGY |
| Deane | Peter | AAIR | RHEUMATOLOGY |
| Jones | Douglas H. | GHS Allergy/Immun/Rheum | RHEUMATOLOGY |

## *Monroe County Health System Market Report - 3Q05*

Current Quarter vs. Prior Quarter

### Quarterly Update - 3Q05

| Total Inpatient | 3Q05 | | | 2Q05 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 7,766 | 29.2% | 5.03 | 8,161 | 29.1% | 4.83 | -4.8% | 0.1% | 0.19 |
| Strong Health | 14,167 | 53.2% | 5.64 | 14,293 | 50.9% | 5.52 | -0.9% | 2.3% | 0.12 |
| Strong | 9,551 | 35.9% | 6.32 | 9,708 | 34.6% | 6.20 | -1.6% | 1.3% | 0.11 |
| Highland | 4,616 | 17.3% | 4.24 | 4,585 | 16.3% | 4.08 | 0.7% | 1.0% | 0.16 |
| Unity | 4,159 | 15.6% | 5.88 | 4,429 | 15.8% | 5.59 | -6.1% | -0.2% | 0.30 |
| Lakeside | 547 | 2.1% | 5.53 | 616 | 2.2% | 5.94 | -11.2% | -0.1% | -0.41 |
| Total | 26,639 | 100.0% | 5.50 | 28,092 | 100.0% | 5.31 | -5.2% | 0.0% | 0.19 |

| Medical | 3Q05 | | | 2Q05 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 4,034 | 36.9% | 5.13 | 4,404 | 35.8% | 4.99 | -8.4% | 1.1% | 0.14 |
| Strong Health | 4,480 | 41.0% | 6.58 | 4,621 | 37.6% | 6.14 | -3.1% | 3.4% | 0.44 |
| Strong | 2,796 | 25.6% | 6.78 | 3,018 | 24.5% | 6.23 | -7.4% | 1.1% | 0.55 |
| Highland | 1,684 | 15.4% | 6.25 | 1,603 | 13.0% | 5.98 | 5.1% | 2.4% | 0.27 |
| Unity | 1,964 | 18.0% | 5.72 | 2,181 | 17.7% | 5.51 | -9.9% | 0.3% | 0.21 |
| Lakeside* | 445 | 4.1% | 6.28 | 524 | 4.3% | 6.60 | -15.1% | -0.2% | -0.32 |
| Total | 10,923 | 100.0% | 5.88 | 12,301 | 100.0% | 5.55 | -11.2% | 0.0% | 0.33 |

*** Lakeside reports Med/Surg together as medical**

| Surgical | 3Q05 | | | 2Q05 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 2,075 | 26.9% | 5.35 | 2,044 | 26.5% | 5.12 | 1.5% | 0.4% | 0.22 |
| Strong Health | 4,620 | 60.0% | 5.42 | 4,627 | 60.0% | 5.20 | -0.2% | -0.1% | 0.22 |
| Strong | 3,409 | 49.4% | 5.96 | 3,351 | 48.6% | 5.80 | 1.7% | 0.8% | 0.16 |
| Highland | 1,211 | 17.6% | 3.89 | 1,276 | 18.5% | 3.61 | -5.1% | -0.9% | 0.28 |
| Unity | 1,010 | 13.1% | 3.86 | 1,039 | 13.5% | 3.71 | -2.8% | -0.4% | 0.16 |
| Lakeside* | 0 | 0.0% | #DIV/0! | 0 | 0.0% | #DIV/0! | 0.0% | 0.0% | #DIV/0! |
| Total | 7,705 | 100.0% | 5.20 | 7,710 | 100.0% | 4.98 | -0.1% | 0.0% | 0.22 |

*Source: Rochester Regional Healthcare Association (RRHA) Hospital Utilization Graph (HUG) Report, 2003-2004.*

Prepared by Karen Bernhardt, Performance Improvement Coordinator

## *Monroe County Health System Market Report - 3Q05*

Current Quarter vs. Prior Quarter

### Quarterly Update - 3Q05

| Obstetrics | 3Q05 | | | 2Q05 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 669 | 24.2% | 2.68 | 684 | 24.4% | 2.66 | -2.2% | -0.1% | 0.02 |
| Strong Health | 1,777 | 64.4% | 3.04 | 1,717 | 61.1% | 3.05 | 3.5% | 3.3% | -0.01 |
| Strong | 912 | 33.0% | 3.33 | 855 | 30.4% | 3.39 | 6.7% | 2.6% | -0.07 |
| Highland | 865 | 31.3% | 2.73 | 862 | 30.7% | 2.70 | 0.3% | 0.7% | 0.03 |
| Unity | 264 | 9.6% | 2.60 | 297 | 10.6% | 2.59 | -11.1% | -1.0% | 0.01 |
| Lakeside | 50 | 1.8% | 2.40 | 45 | 1.6% | 2.36 | 11.1% | 0.2% | 0.04 |
| Total | 2,760 | 100.0% | 2.90 | 2,809 | 100.0% | 2.90 | -1.7% | 0.0% | -0.01 |

| Pediatrics | 3Q05 | | | 2Q05 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 172 | 17.8% | 4.34 | 204 | 19.0% | 4.08 | -15.7% | -1.2% | 0.26 |
| Strong Health | 796 | 82.2% | 8.30 | 872 | 81.0% | 8.04 | -8.7% | 1.2% | 0.25 |
| Strong | 796 | 82.2% | 8.30 | 872 | 81.0% | 8.04 | -8.7% | 1.2% | 0.25 |
| Highland | 0 | 0.0% | #DIV/0! | 0 | 0.0% | #DIV/0! | 0.0% | 0.0% | #DIV/0! |
| Unity | 0 | 0.0% | #DIV/0! | 0 | 0.0% | #DIV/0! | 0.0% | 0.0% | #DIV/0! |
| Lakeside | 0 | 0.0% | #DIV/0! | 0 | 0.0% | #DIV/0! | 0.0% | 0.0% | #DIV/0! |
| Total | 968 | 100.0% | 7.59 | 1,076 | 100.0% | 7.29 | -10.0% | 0.0% | 0.30 |

| Psychiatric | 3Q05 | | | 2Q05 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 200 | 17.7% | 13.09 | 218 | 19.3% | 11.02 | -8.3% | -1.6% | 2.06 |
| Strong Health | 644 | 57.1% | 11.12 | 629 | 55.8% | 12.76 | 2.4% | 1.3% | -1.65 |
| Strong | 644 | 57.1% | 11.12 | 629 | 55.8% | 12.76 | 2.4% | 1.3% | -1.65 |
| Highland | 0 | 0.0% | #DIV/0! | 0 | 0.0% | #DIV/0! | 0.0% | 0.0% | #DIV/0! |
| Unity | 283 | 25.1% | 11.96 | 280 | 24.8% | 11.69 | 1.1% | 0.3% | 0.27 |
| Lakeside | 0 | 0.0% | #DIV/0! | 0 | 0.0% | #DIV/0! | 0.0% | 0.0% | #DIV/0! |
| Total | 1,127 | 100.0% | 11.68 | 1,127 | 100.0% | 12.16 | 0.0% | 0.0% | -0.48 |

*Source: Rochester Regional Healthcare Association (RRHA) Hospital Utilization Graph (HUG) Report, 2003-2004.*

Prepared by Karen Bernhardt, Performance Improvement Coordinator

## *Monroe County Health System Market Report - 3Q05*

Current Quarter vs. Prior Quarter

### Quarterly Update - 3Q05

**** As of 7/02 Unity reports cases instead of procedures for ASU.**
**Procedures for Unity on this report are estimated at 1.4 procedures per case based on Unity's 2001-2003 data.**

| ASU | 3Q05 | | 2Q05 | | Change | |
|---|---|---|---|---|---|---|
| | Surgeries | MS% | Surgeries | MS% | % Surgeries | MS Points |
| ViaHealth RGH | 3,703 | 32.8% | 3,763 | 31.4% | -1.6% | 1.4% |
| Strong Health | 4,333 | 38.4% | 4,461 | 37.3% | -2.9% | 1.1% |
| Strong | 2,894 | 25.6% | 2,989 | 25.0% | -3.2% | 0.7% |
| Highland | 1,439 | 12.7% | 1,472 | 12.3% | -2.2% | 0.4% |
| Unity** | 3,146 | 27.8% | 3,332 | 27.8% | -5.6% | 0.0% |
| Lakeside | 349 | 3.1% | 353 | 2.9% | -1.1% | 0.1% |
| Total | 11,297 | 100.0% | 11,974 | 100.0% | -5.7% | 0.0% |

| ED | 3Q05 | | 2Q05 | | Change | |
|---|---|---|---|---|---|---|
| | Visits | MS% | Visits | MS% | % Visits | MS Points |
| ViaHealth RGH | 20,688 | 30.7% | 20,582 | 29.7% | 0.5% | 1.0% |
| Strong Health | 31,616 | 46.9% | 31,798 | 46.0% | -0.6% | 1.0% |
| Strong | 24,299 | 36.1% | 24,745 | 35.8% | -1.8% | 0.3% |
| Highland | 7,317 | 10.9% | 7,053 | 10.2% | 3.7% | 0.7% |
| Unity | 11,273 | 16.7% | 10,547 | 15.2% | 6.9% | 1.5% |
| Lakeside | 3,808 | 5.7% | 3,851 | 5.6% | -1.1% | 0.1% |
| Total | 67,385 | 100.0% | 69,195 | 100.0% | -2.6% | 0.0% |

*Source: Rochester Regional Healthcare Association (RRHA) Hospital Utilization Graph (HUG) Report, 2003-2004.*

Prepared by Karen Bernhardt, Performance Improvement Coordinator

## *Monroe County Health System Market Report - 3Q05*

Current Quarter vs. Same Quarter Prior Year

### Quarterly Update - 3Q05

| Total Inpatient | 3Q05 | | | 3Q04 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 7,766 | 29.2% | 5.03 | 8,155 | 29.3% | 5.01 | -4.8% | -0.2% | 0.02 |
| Strong Health | 14,167 | 53.2% | 5.64 | 13,690 | 49.2% | 5.73 | 3.5% | 3.9% | -0.09 |
| Strong | 9,551 | 35.9% | 6.32 | 9,399 | 33.8% | 6.42 | 1.6% | 2.1% | -0.11 |
| Highland | 4,616 | 17.3% | 4.24 | 4,291 | 15.4% | 4.19 | 7.6% | 1.9% | 0.04 |
| Unity | 4,159 | 15.6% | 5.88 | 4,440 | 16.0% | 5.72 | -6.3% | -0.4% | 0.16 |
| Lakeside | 250 | 2.1% | 5.53 | 703 | 2.5% | 5.16 | -64.4% | -0.5% | 0.37 |
| Total | 26,639 | 100.0% | 5.50 | 27,806 | 100.0% | 5.45 | -4.2% | 0.0% | 0.05 |

| Medical | 3Q05 | | | 3Q04 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 4,034 | 36.9% | 5.13 | 4,428 | 37.0% | 5.05 | -8.9% | 0.0% | 0.08 |
| Strong Health | 4,480 | 41.0% | 6.58 | 4,353 | 36.4% | 6.61 | 2.9% | 4.7% | -0.03 |
| Strong | 2,796 | 25.6% | 6.78 | 2,887 | 24.1% | 6.65 | -3.2% | 1.5% | 0.12 |
| Highland | 1,684 | 15.4% | 6.25 | 1,466 | 12.2% | 6.53 | 14.9% | 3.2% | -0.27 |
| Unity | 1,964 | 18.0% | 5.72 | 2,153 | 18.0% | 5.67 | -8.8% | 0.0% | 0.04 |
| Lakeside* | 445 | 4.1% | 6.28 | 518 | 4.3% | 6.35 | -14.1% | -0.3% | -0.06 |
| Total | 10,923 | 100.0% | 5.88 | 11,975 | 100.0% | 5.76 | -8.8% | 0.0% | 0.12 |

*** Lakeside reports Med/Surg together as medical**

| Surgical | 3Q05 | | | 3Q04 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 2,075 | 26.9% | 5.35 | 2,087 | 27.6% | 5.50 | -0.6% | -0.7% | -0.15 |
| Strong Health | 4,620 | 60.0% | 5.42 | 4,451 | 58.9% | 5.48 | 3.8% | 1.1% | -0.06 |
| Strong | 3,409 | 49.4% | 5.96 | 3,336 | 48.4% | 6.05 | 2.2% | 1.1% | -0.09 |
| Highland | 1,211 | 17.6% | 3.89 | 1,115 | 16.2% | 3.77 | 8.6% | 1.4% | 0.12 |
| Unity | 1,010 | 13.1% | 3.86 | 1,023 | 13.5% | 4.02 | -1.3% | -0.4% | -0.15 |
| Lakeside* | 0 | 0.0% | 0.00 | 0 | 0.0% | 0.00 | 0.0% | 0.0% | 0.00 |
| Total | 7,705 | 100.0% | 5.20 | 7,561 | 100.0% | 5.29 | 1.9% | 0.0% | -0.09 |

*Source: Rochester Regional Healthcare Association (RRHA) Hospital Utilization Graph (HUG) Report, 2003-2004.*

Prepared by Karen Bernhardt, Performance Improvement Coordinator

## *Monroe County Health System Market Report - 3Q05*

Current Quarter vs. Same Quarter Prior Year

### Quarterly Update - 3Q05

| Obstetrics | 3Q05 | | | 3Q04 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 669 | 24.2% | 2.68 | 677 | 23.6% | 2.56 | -1.2% | 0.6% | 0.12 |
| Strong Health | 1,777 | 64.4% | 3.04 | 1,698 | 59.3% | 2.93 | 4.7% | 5.1% | 0.11 |
| Strong | 912 | 33.0% | 3.33 | 827 | 28.9% | 3.36 | 10.3% | 4.2% | -0.03 |
| Highland | 865 | 31.3% | 2.73 | 871 | 30.4% | 2.53 | -0.7% | 0.9% | 0.20 |
| Unity | 264 | 9.6% | 2.60 | 318 | 11.1% | 2.43 | -20.5% | -1.5% | 0.17 |
| Lakeside | 50 | 1.8% | 2.40 | 75 | 2.6% | 2.48 | -33.3% | -0.8% | -0.08 |
| Total | 2,760 | 100.0% | 2.90 | 2,865 | 100.0% | 2.76 | -3.7% | 0.0% | 0.14 |

| Pediatrics | 3Q05 | | | 3Q04 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 172 | 17.8% | 4.34 | 142 | 15.7% | 4.71 | 21.1% | 2.1% | -0.37 |
| Strong Health | 796 | 82.2% | 8.30 | 763 | 84.3% | 9.22 | 4.3% | -2.1% | -0.93 |
| Strong | 796 | 82.2% | 8.30 | 763 | 84.3% | 9.22 | 4.3% | -2.1% | -0.93 |
| Highland | 0 | 0.0% | 0.00 | 0 | 0.0% | 0.00 | 0.0% | 0.0% | 0.00 |
| Unity | 0 | 0.0% | 0.00 | 0 | 0.0% | 0.00 | 0.0% | 0.0% | 0.00 |
| Lakeside | 0 | 0.0% | 0.00 | 0 | 0.0% | 0.00 | 0.0% | 0.0% | 0.00 |
| Total | 968 | 100.0% | 7.59 | 905 | 100.0% | 8.51 | 7.0% | 0.0% | -0.92 |

| Psychiatric | 3Q05 | | | 3Q04 | | | Change | | |
|---|---|---|---|---|---|---|---|---|---|
| | Discharges | MS% | ALOS | Discharges | MS% | ALOS | % Disch | MS Points | ALOS Days |
| ViaHealth RGH | 200 | 17.7% | 13.09 | 190 | 17.1% | 13.51 | 5.3% | 0.6% | -0.42 |
| Strong Health | 644 | 57.1% | 11.12 | 647 | 58.3% | 11.36 | -0.5% | -1.1% | -0.24 |
| Strong | 644 | 57.1% | 11.12 | 647 | 58.3% | 11.36 | -0.5% | -1.1% | -0.24 |
| Highland | 0 | 0.0% | 0.00 | 0 | 0.0% | 0.00 | 0.0% | 0.0% | 0.00 |
| Unity | 283 | 25.1% | 11.96 | 273 | 24.6% | 12.14 | 3.7% | 0.5% | -0.19 |
| Lakeside | 0 | 0.0% | 0.00 | 0 | 0.0% | 0.00 | 0.0% | 0.0% | 0.00 |
| Total | 1,127 | 100.0% | 11.68 | 1,110 | 100.0% | 11.92 | 1.5% | 0.0% | -0.24 |

*Source: Rochester Regional Healthcare Association (RRHA) Hospital Utilization Graph (HUG) Report, 2003-2004.*

Prepared by Karen Bernhardt, Performance Improvement Coordinator

## *Monroe County Health System Market Report - 3Q05*

Current Quarter vs. Same Quarter Prior Year

### Quarterly Update - 3Q05

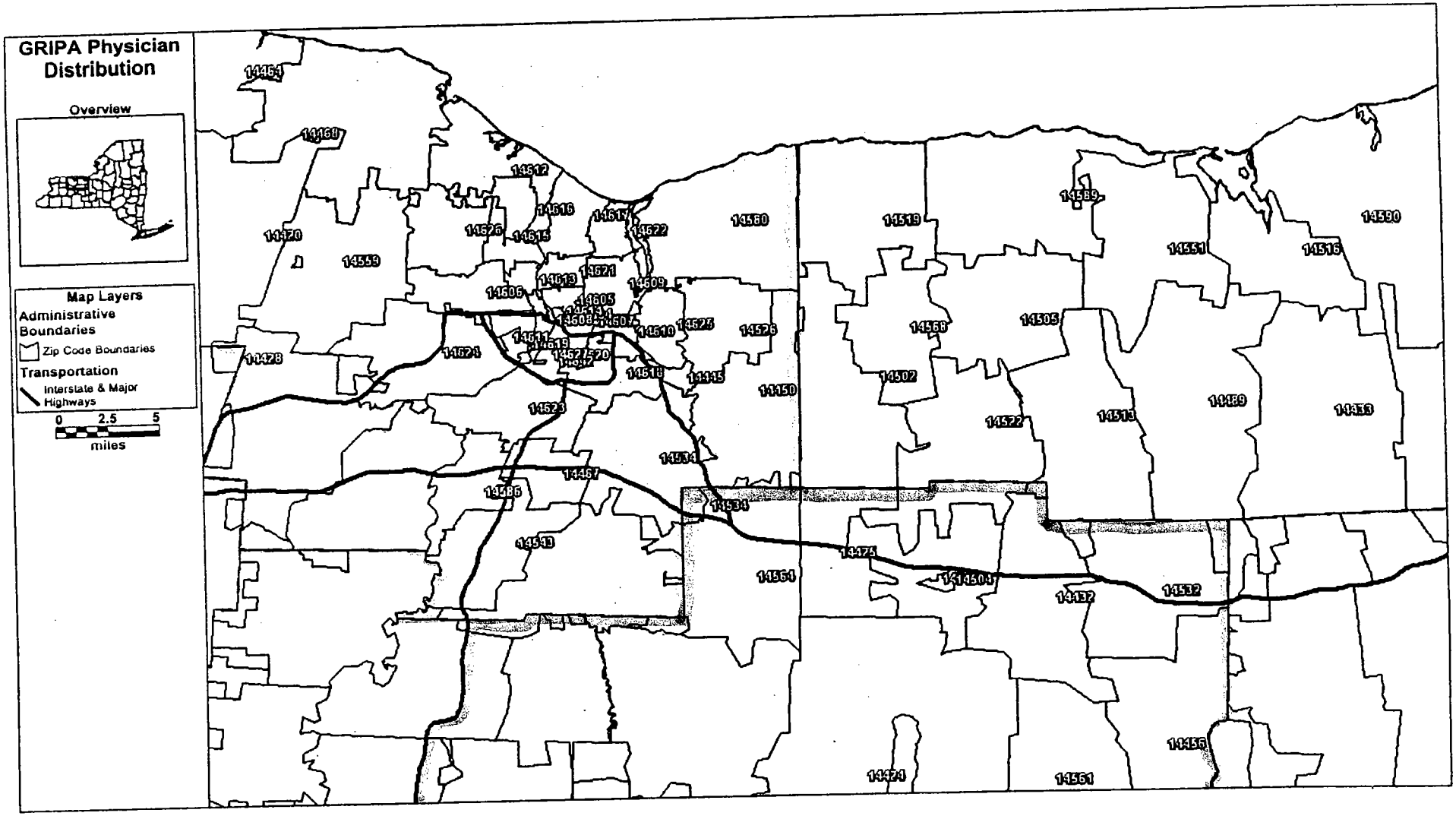
**** As of 7/02 Unity reports cases instead of procedures for ASU.**
**Procedures for Unity on this report are estimated at 1.4 procedures per case based on Unity's 2001-2003 data.**

| ASU | 3Q05 | | 3Q04 | | Change | |
|---|---|---|---|---|---|---|
| | Surgeries | MS% | Surgeries | MS% | % Surgeries | MS Points |
| ViaHealth RGH | 3,703 | 32.8% | 3,899 | 31.7% | -5.0% | 1.1% |
| Strong Health | 4,333 | 38.4% | 4,440 | 36.1% | -2.4% | 2.2% |
| Strong | 2,894 | 25.6% | 2,883 | 23.4% | 0.4% | 2.2% |
| Highland | 1,439 | 12.7% | 1,557 | 12.7% | -7.6% | 0.1% |
| Unity** | 3,146 | 27.8% | 3,445 | 28.0% | -8.7% | -0.2% |
| Lakeside | 349 | 3.1% | 318 | 2.6% | 9.7% | 0.5% |
| Total | 11,297 | 100.0% | 12,295 | 100.0% | -8.1% | 0.0% |

| ED | 3Q05 | | 3Q04 | | Change | |
|---|---|---|---|---|---|---|
| | Visits | MS% | Visits | MS% | % Visits | MS Points |
| ViaHealth RGH | 20,688 | 30.7% | 19,556 | 29.3% | 5.8% | 1.4% |
| Strong Health | 31,616 | 46.9% | 32,187 | 48.2% | -1.8% | -1.3% |
| Strong | 24,299 | 36.1% | 24,809 | 37.2% | -2.1% | -1.1% |
| Highland | 7,317 | 10.9% | 7,378 | 11.1% | -0.8% | -0.2% |
| Unity | 11,273 | 16.7% | 10,424 | 15.6% | 8.1% | 1.1% |
| Lakeside | 3,808 | 5.7% | 4,593 | 6.9% | -17.1% | -1.2% |
| Total | 67,385 | 100.0% | 66,760 | 100.0% | 0.9% | 0.0% |

*Source: Rochester Regional Healthcare Association (RRHA) Hospital Utilization Graph (HUG) Report, 2003-2004.*

Prepared by Karen Bernhardt, Performance Improvement Coordinator




= Wayne County

= Ontario County

= Monroe County

# GRIPA Participating Physicians Sorted by Specialty and Zip Code

| Specialty | Total Physicians in Area | GRIPA Owner Physicians | Zip code | County | GRIPA Owners' Primary Location | GRIPA Contracted Physicians | Zip code | County | GRIPA Contractors' Primary Location |
|---|---|---|---|---|---|---|---|---|---|
| Adolescent Medicine | 12 | 1 | 14621 | Monroe | 1 | | | | |
| Allergy and Immunology | 22 | 10 | 14626 | Monroe | 1 | | | | |
| | | | 14618 | Monroe | 1 | | | | |
| | | | 14624 | Monroe | 1 | | | | |
| | | | 14607 | Monroe | 6 | | | | |
| | | | 14420 | Monroe | 1 | | | | |
| Anesthesiology | 162 | 36 | 14580 | Monroe | 34 | | | | |
| | | | 14621 | Monroe | 1 | | | | |
| | | | 14616 | Monroe | 1 | | | | |
| Cardiology | 87 | 40 | 14606 | Monroe | 2 | | | | |
| | | | 14618 | Monroe | 10 | | | | |
| | | | 14621 | Monroe | 14 | | | | |
| | | | 14623 | Monroe | 1 | | | | |
| | | | 14625 | Monroe | 6 | | | | |
| | | | 14626 | Monroe | 4 | | | | |
| | | | 14432 | Ontario | 1 | | | | |
| | | | 14456 | Ontario | 1 | | | | |
| | | | 14513 | Wayne | 1 | | | | |
| Child & Adolescent Psychiatry | 22 | 2 | 14607 | Monroe | 1 | | | | |
| | | | 14625 | Monroe | 1 | | | | |
| Colon & Rectal Surgery | 11 | 7 | 14620 | Monroe | 6 | | | | |
| | | | 14621 | Monroe | 1 | | | | |
| Critical Care Medicine | 21 | 1 | 14621 | Monroe | 1 | | | | |
| Dermatology | 37 | 19 | 14450 | Monroe | 1 | 2 | 14642 | Monroe | 1 |
| | | | 14534 | Monroe | 1 | | 14623 | Monroe | 1 |
| | | | 14607 | Monroe | 3 | | | | |
| | | | 14609 | Monroe | 1 | | | | |
| | | | 14618 | Monroe | 1 | | | | |
| | | | 14621 | Monroe | 2 | | | | |
| | | | 14623 | Monroe | 2 | | | | |
| | | | 14625 | Monroe | 5 | | | | |
| | | | 14626 | Monroe | 3 | | | | |

# GRIPA Participating Physicians Sorted by Specialty and Zip Code

| Specialty | Total Physicians in Area | GRIPA Owner Physicians | Zip code | County | GRIPA Owners' Primary Location | GRIPA Contracted Physicians | Zip code | County | GRIPA Contractors' Primary Location |
|---|---|---|---|---|---|---|---|---|---|
| Endocrinology | 19 | 4 | 14607 | Monroe | 2 | 2 | 14612 | Monroe | 1 |
| | | | 14621 | Monroe | 1 | | 14642 | Monroe | 1 |
| | | | 14624 | Monroe | 1 | | | | |
| Family Practice | 179 | 20 | 14450 | Monroe | 1 | | | | |
| | | | 14526 | Monroe | 1 | | | | |
| | | | 14534 | Monroe | 1 | | | | |
| | | | 14580 | Monroe | 2 | | | | |
| | | | 14605 | Monroe | 2 | | | | |
| | | | 14607 | Monroe | 1 | | | | |
| | | | 14616 | Monroe | 1 | | | | |
| | | | 14618 | Monroe | 1 | | | | |
| | | | 14622 | Monroe | 4 | | | | |
| | | | 14623 | Monroe | 1 | | | | |
| | | | 14502 | Wayne | 1 | | | | |
| | | | 14513 | Wayne | 2 | | | | |
| | | | 14519 | Wayne | 2 | | | | |
| Gastroenterology | 40 | 15 | 14534 | Monroe | 1 | | | | |
| | | | 14607 | Monroe | 1 | | | | |
| | | | 14615 | Monroe | 1 | | | | |
| | | | 14618 | Monroe | 5 | | | | |
| | | | 14621 | Monroe | 4 | | | | |
| | | | 14626 | Monroe | 3 | | | | |
| General Surgery | 75 | 22 | 14606 | Monroe | 1 | | | | |
| | | | 14617 | Monroe | 2 | | | | |
| | | | 14621 | Monroe | 16 | | | | |
| | | | 14625 | Monroe | 1 | | | | |
| | | | 14626 | Monroe | 1 | | | | |
| | | | 14432 | Ontario | 1 | | | | |
| Geriatric Medicine | 49 | 16 | 14580 | Monroe | 2 | | | | |
| | | | 14513 | Wayne | 2 | | | | |
| | | | 14534 | Monroe | 1 | | | | |
| | | | 14621 | Monroe | 2 | | | | |
| | | | 14622 | Monroe | 4 | | | | |
| | | | 14617 | Monroe | 1 | | | | |
| | | | 14625 | Monroe | 4 | | | | |
| Gynecology | 10 | 4 | 14609 | Monroe | 2 | | | | |
| | | | 14626 | Monroe | 1 | | | | |
| | | | 14513 | Wayne | 1 | | | | |

# GRIPA Participating Physicians Sorted by Specialty and Zip Code

| Specialty | Total Physicians in Area | GRIPA Owner Physicians | Zip code | County | GRIPA Owners' Primary Location | GRIPA Contracted Physicians | Zip code | County | GRIPA Contractors' Primary Location |
|---|---|---|---|---|---|---|---|---|---|
| Gynecologic Oncology | 3 | 3 | 14620 | Monroe | 3 | | | | |
| Hematology / Oncology | 40 | 14 | 14621 | Monroe | 7 | | | | |
| | | | 14623 | Monroe | 5 | | | | |
| | | | 14432 | Ontario | 2 | | | | |
| Internal Medicine | 433 | 132 | 14450 | Monroe | 7 | 2 | 14617 | Monroe | 1 |
| | | | 14534 | Monroe | 7 | | 14607 | Monroe | 1 |
| | | | 14580 | Monroe | 10 | | | | |
| | | | 14606 | Monroe | 1 | | | | |
| | | | 14607 | Monroe | 14 | | | | |
| | | | 14610 | Monroe | 1 | | | | |
| | | | 14612 | Monroe | 3 | | | | |
| | | | 14615 | Monroe | 5 | | | | |
| | | | 14616 | Monroe | 1 | | | | |
| | | | 14617 | Monroe | 8 | | | | |
| | | | 14618 | Monroe | 2 | | | | |
| | | | 14621 | Monroe | 20 | | | | |
| | | | 14622 | Monroe | 11 | | | | |
| | | | 14623 | Monroe | 4 | | | | |
| | | | 14625 | Monroe | 15 | | | | |
| | | | 14626 | Monroe | 8 | | | | |
| | | | 14432 | Ontario | 1 | | | | |
| | | | 14489 | Wayne | 1 | | | | |
| | | | 14513 | Wayne | 7 | | | | |
| | | | 14519 | Wayne | 1 | | | | |
| | | | 14551 | Wayne | 1 | | | | |
| | | | 14589 | Wayne | 1 | | | | |
| | | | 14590 | Wayne | 3 | | | | |
| Infectious Disease | 28 | 5 | 14621 | Monroe | 3 | | | | |
| | | | 14607 | Monroe | 1 | | | | |
| | | | 14590 | Wayne | 1 | | | | |
| Maternal & Fetal Medicine | 12 | 5 | 14642 | Monroe | 5 | | | | |
| Medical Genetics | 4 | 0 | | | | 1 | 14642 | Monroe | 1 |
| Neonatal / Perinatal Medicine | 12 | 0 | | | | | | | |
| Nephrology | 29 | 7 | 14621 | Monroe | 7 | | | | |

# GRIPA Participating Physicians Sorted by Specialty and Zip Code

| Specialty | Total Physicians in Area | GRIPA Owner Physicians | Zip code | County | GRIPA Owners' Primary Location | GRIPA Contracted Physicians | Zip code | County | GRIPA Contractors' Primary Location |
|---|---|---|---|---|---|---|---|---|---|
| Neurological Surgery | 13 | 4 | 14615 | Monroe | 1 | 2 | 14642 | Monroe | 2 |
| | | | 14621 | Monroe | 3 | | | | |
| Neurology | 75 | 14 | 14615 | Monroe | 1 | | | | |
| | | | 14513 | Wayne | 1 | | | | |
| | | | 14456 | Ontario | 1 | | | | |
| | | | 14621 | Monroe | 8 | | | | |
| | | | 14642 | Monroe | 1 | | | | |
| | | | 14424 | Ontario | 1 | | | | |
| | | | 14432 | Ontario | 1 | | | | |
| OB/GYN | 152 | 46 | 14526 | Monroe | 6 | | | | |
| | | | 14607 | Monroe | 3 | | | | |
| | | | 14618 | Monroe | 1 | | | | |
| | | | 14620 | Monroe | 1 | | | | |
| | | | 14621 | Monroe | 10 | | | | |
| | | | 14626 | Monroe | 13 | | | | |
| | | | 14642 | Monroe | 7 | | | | |
| | | | 14513 | Wayne | 3 | | | | |
| | | | 14551 | Wayne | 2 | | | | |
| Ophthalmology | 88 | 25 | 14534 | Monroe | 1 | | | | |
| | | | 14607 | Monroe | 2 | | | | |
| | | | 14613 | Monroe | 1 | | | | |
| | | | 14618 | Monroe | 7 | | | | |
| | | | 14621 | Monroe | 2 | | | | |
| | | | 14624 | Monroe | 2 | | | | |
| | | | 14626 | Monroe | 3 | | | | |
| | | | 14642 | Monroe | 5 | | | | |
| | | | 14513 | Wayne | 2 | | | | |
| Oral Surgery | 17 | 3 | 14450 | Monroe | 2 | 1 | 14514 | Monroe | 1 |
| | | | 14621 | Monroe | 1 | | | | |
| Orthopedics | 90 | 20 | 14618 | Monroe | 1 | | | | |
| | | | 14621 | Monroe | 8 | | | | |
| | | | 14623 | Monroe | 3 | | | | |
| | | | 14625 | Monroe | 2 | | | | |
| | | | 14626 | Monroe | 3 | | | | |
| | | | 14513 | Wayne | 2 | | | | |
| | | | 14589 | Wayne | 1 | | | | |

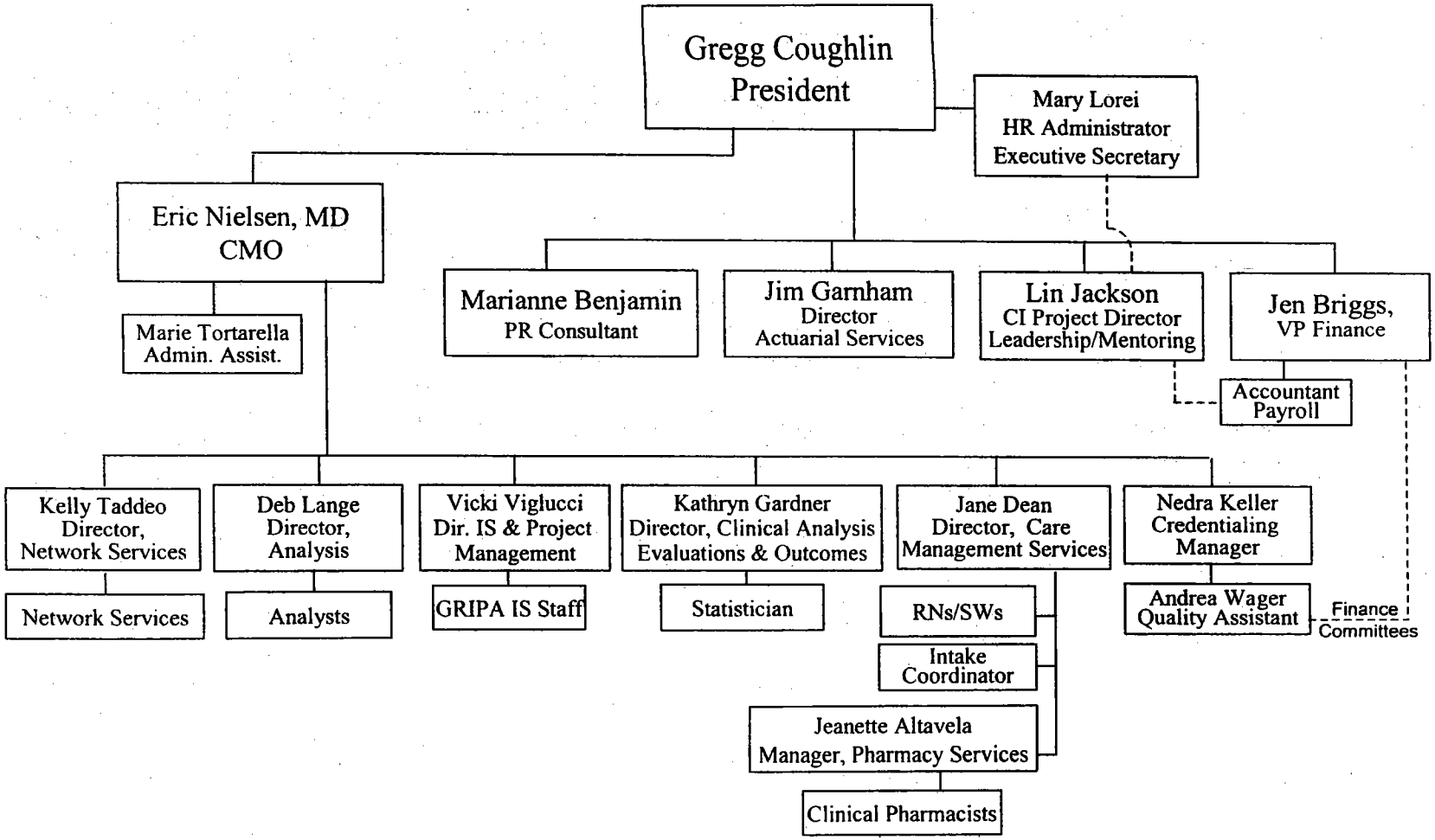
GRIPA Participating Physicians Sorted by Specialty and Zip Code

| Specialty | Total Physicians in Area | GRIPA Owner Physicians | Zip code | County | GRIPA Owners' Primary Location | GRIPA Contracted Physicians | Zip code | County | GRIPA Contractors' Primary Location |
|---|---|---|---|---|---|---|---|---|---|
| Otolaryngology | 44 | 14 | 14618 | Monroe | 7 | | | | |
| | | | 14621 | Monroe | 1 | | | | |
| | | | 14626 | Monroe | 1 | | | | |
| | | | 14424 | Ontario | 1 | | | | |
| | | | 14456 | Ontario | 1 | | | | |
| | | | 14513 | Wayne | 3 | | | | |
| Pain Management | 23 | 4 | 14580 | Monroe | 3 | | | | |
| | | | 14625 | Wayne | 1 | | | | |
| Pediatrics | 230 | 77 | 14450 | Monroe | 4 | 23 | 14514 | Monroe | 1 |
| | | | 14514 | Monroe | 1 | | 14526 | Monroe | 4 |
| | | | 14526 | Monroe | 3 | | 14534 | Monroe | 4 |
| | | | 14534 | Monroe | 2 | | 14616 | Monroe | 5 |
| | | | 14580 | Monroe | 4 | | 14617 | Monroe | 1 |
| | | | 14607 | Monroe | 7 | | 14624 | Monroe | 7 |
| | | | 14612 | Monroe | 2 | | 14625 | Monroe | 1 |
| | | | 14615 | Monroe | 1 | | | | |
| | | | 14617 | Monroe | 3 | | | | |
| | | | 14621 | Monroe | 20 | | | | |
| | | | 14623 | Monroe | 2 | | | | |
| | | | 14624 | Monroe | 1 | | | | |
| | | | 14625 | Monroe | 10 | | | | |
| | | | 14626 | Monroe | 6 | | | | |
| | | | 14513 | Wayne | 5 | | | | |
| | | | 14551 | Wayne | 3 | | | | |
| | | | 14589 | Wayne | 2 | | | | |
| | | | 14590 | Wayne | 1 | | | | |
| Physical Medicine & Rehabilitation | 20 | 2 | 14621 | Monroe | 2 | | | | |
| Plastic Surgery | 22 | 9 | 14607 | Monroe | 1 | | | | |
| | | | 14621 | Monroe | 1 | | | | |
| | | | 14625 | Monroe | 5 | | | | |
| | | | 14626 | Monroe | 2 | | | | |
| Psychiatry | 137 | 14 | 14534 | Monroe | 2 | 8 | 14534 | Monroe | 6 |
| | | | 14607 | Monroe | 3 | | 14450 | Monroe | 1 |
| | | | 14618 | Monroe | 2 | | 14607 | Monroe | 1 |
| | | | 14621 | Monroe | 5 | | | | |
| | | | 14625 | Monroe | 1 | | | | |
| | | | 14642 | Monroe | 1 | | | | |

GRIPA Participating Physicians Sorted by Specialty and Zip Code

| Specialty | Total Physicians in Area | GRIPA Owner Physicians | Zip code | County | GRIPA Owners' Primary Location | GRIPA Contracted Physicians | Zip code | County | GRIPA Contractors' Primary Location |
|---|---|---|---|---|---|---|---|---|---|
| Pulmonary | 45 | 9 | 14620 | Monroe | 1 | 1 | 14618 | Monroe | 1 |
| | | | 14621 | Monroe | 7 | | | | |
| | | | 14623 | Monroe | 1 | | | | |
| Radiology | 169 | 23 | 14450 | Monroe | 1 | 27 | 14618 | Monroe | 21 |
| | | | 14618 | Monroe | 5 | | 14620 | Monroe | 6 |
| | | | 14621 | Monroe | 15 | | | | |
| | | | 14513 | Wayne | 2 | | | | |
| Radiation Oncology | 30 | 6 | 14020 | Genesee | 1 | | | | |
| | | | 14621 | Monroe | 3 | | | | |
| | | | 14432 | Ontario | 2 | | | | |
| Reproductive Endocrinology | 6 | 2 | 14626 | Monroe | 2 | | | | |
| Rheumatology | 19 | 3 | 14607 | Monroe | 1 | 2 | 14609 | Monroe | 2 |
| | | | 14618 | Monroe | 2 | | | | |
| Thoracic Surgery | 11 | 4 | 14621 | Monroe | 3 | 1 | 14642 | Monroe | 1 |
| | | | 14642 | Monroe | 1 | | | | |
| Urology | 38 | 16 | 14607 | Monroe | 2 | | | | |
| | | | 14609 | Monroe | 7 | | | | |
| | | | 14618 | Monroe | 2 | | | | |
| | | | 14621 | Monroe | 3 | | | | |
| | | | 14623 | Monroe | 1 | | | | |
| | | | 14551 | Wayne | 1 | | | | |
| Vascular Surgery | 17 | 6 | 14621 | Monroe | 3 | | | | |
| | | | 14625 | Monroe | 1 | | | | |
| | | | 14642 | Monroe | 2 | | | | |

# Greater Rochester Independent Practice Association




Revised 5/12/06

# GRIPA/ViaHealth PPO, Inc.
# Administrative Policy & Procedure



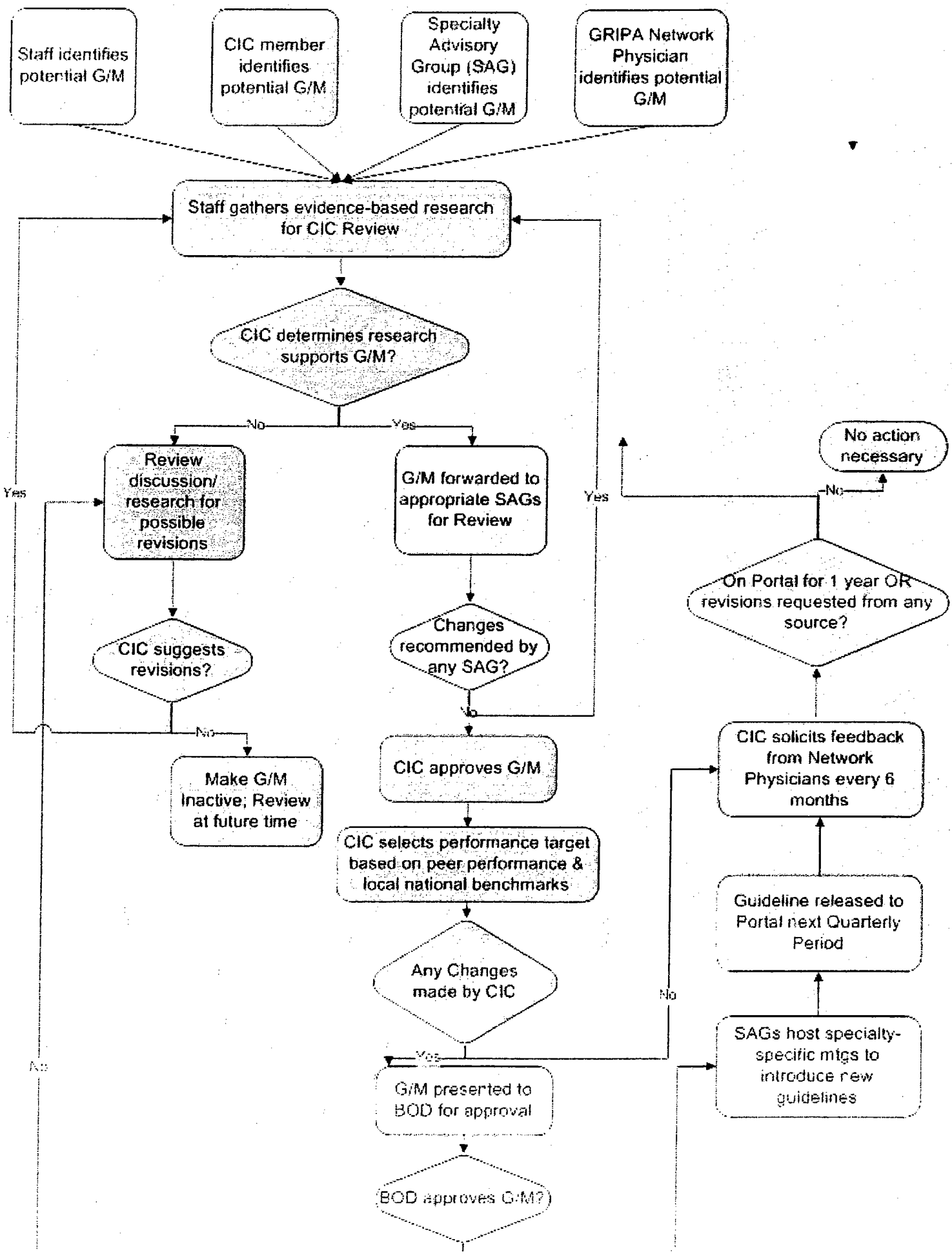
| Policy: Credentialing & Recredentialing Process | Effective Date: |
|---|---|
| | |
| New Policy: Revision: X Replaces Policies 127, 130, 202, 205, 206, 207, 208, 210, 211, 213 Policy #: 2000 | |
| Compliance Standard: Board of Director's Resolution, NCQA Standards | |
| Approved By: | |
| Chairperson, Credentialing Committee/Date | Medical Director Date |
| Board of Directors Chairperson Date | |

| Revisions | | | | | |
|---|---|---|---|---|---|
| Board of Directors Approval Date: | 11/10/04 | | | | |
| Medical Management Committee Review Date: | N/A | | | | |
| Credentialing Committee Review Date: | 10/25/04 | | | | |
| Medical Director: | EN | | | | |
| Chairperson: | DA | | | | |
| Written By: | CAC | | | | |
| Drafting Date: | 8/2/04 | | | | |

DISTRIBUTION:

| Title | Name | Signature |
|---|---|---|
| GRIPA Chief Medical Officer | Eric Nielsen, MD | |
| Credentialing Coordinator | Nedra Keller, CPCS | |
| Quality Improvement | Cheri A. Copie, RN BS CPQH | |

# Clinical Guideline/Measure Selection Process for New or Changed Measures



GREATER ROCHESTER

GRIPA

INDEPENDENT PRACTICE ASSOCIATION

# Claims Data Extract Requirements

**Version 1.0**

# TABLE OF CONTENTS

# 1. Purpose of Document

This document is to describe the basic requirements for exchanging claims data between GRIPA and its physician partners who utilize a practice management system. The intended audience will consist of end users, technical implementers, and project managers in order to gain the most knowledge of GRIPA's business requirements.

# 2. Revision History

| Date | Version | Author | Summary of Changes |
|---|---|---|---|
| 2.22.2006 | 1.0 | Kelly Brady | Created Document |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# 3. Final Signoff

| | | |
|---|---|---|
| Print Name | Signature | Date |
| Print Name | Signature | Date |
| Print Name | Signature | Date |
| Print Name | Signature | Date |
| Print Name | Signature | Date |

GREATER ROCHESTER
GRIPA
INDEPENDENT PRACTICE ASSOCIATION

# PCP PERFORMANCE PROFILE SUMMARY ©

*Measurement Period: 4/1/2004 - 3/31/2005, Paid Through 6/30/2005*

**Dr. Guy R Ipa**
**FAMILY PRACTICI**

## YOUR TOTAL SCORE IS: 97.6

| QUALITY | TOTAL SCORE |
|---|---|
| PATIENT SATISFACTION | 15.0 |
| GLYCOHEMOGLOBIN (A1C) TESTS | 5.0 |
| LIPID PROFILING (LDL-C): DIABETICS | 7.1 * |
| ANNUAL EYE EXAMS: DIABETES | 5.0 |
| DIABETIC PATIENTS VISITS | FYI |
| MAMMOGRAM (40-51) | 10.0 |
| MAMMOGRAM (52-69) | 10.0 |
| CERVICAL CANCER SCREENING | 10.0 |
| LIPID PROFILING (LDL-C): NON-DIABETICS | 0.0 |
| APPROPRIATE DRUG TREATMENT | 12.0 |
| WELL-CHILD VISIT | 9.5 * |
| PHYSICAL EXAMS FOR ADULTS | FYI |
| DEXA SCANS | FYI |
| PATIENTS WITH OSTEOPOROSIS ON APPROPRIATE MEDICATION | FYI |
| *TOTAL QUALITY SCORE* | 83.6 |

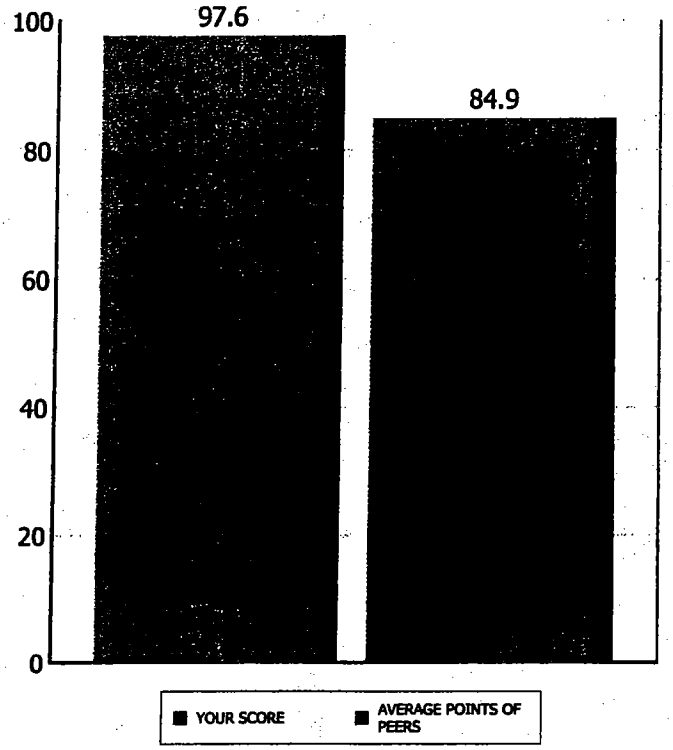
## RESOURCE MANAGEMENT

| | |
|---|---|
| ED VISIT RATE PER 1000 MEMBERS | 11.0 |
| URGENT CARE USE | FYI |
| OVERALL PER MEMBER PER MONTH (PMPM) | FYI |
| DISEASE SPECIFIC PMPM: DIABETES | 0.0 |
| *TOTAL RESOURCE MANAGEMENT SCORE* | 11.0 |

## BONUS

| | |
|---|---|
| REFERRALS TO CM/DM | 0.0 |
| CURRENT MEDICAID MEMBERS | 3.0 |
| *TOTAL BONUS SCORE* | 3.0 |

*Due to an insufficent number of eligible members, you will receive the average of your peers.




***Your average number of members:***

| | Total |
|---|---|
| PC COMMERCIAL | 275 |
| PC GOLD | 113 |
| VIAHEALTH PLAN | 44 |
| Total | 432 |

## NEW SCORING METHODOLOGY

-TOTAL SCORE IS THE SUM OF QUALITY AND IMPROVEMENT POINTS
-MEASURES CURRENTLY AT 97% OR ABOVE RECEIVED MAXIMUM POINTS AVAILABLE
-MEASURES WITH INSUFFICIENT DATA RECEIVED THE PEER AVERAGE

| QUALITY | SCORE |
|---|---|
| 2 STANDARD DEVIATIONS ABOVE TARGET OR MORE | 15 |
| 1 STANDARD DEVIATION ABOVE TO 2 STANDARD DEVIATIONS ABOVE | 12 |
| OVER TARGET TO 1 STANDARD DEVIATION ABOVE | 10 |
| 1 STANDARD DEVIATION BELOW TO TARGET | 5 |
| MORE THAN 1 STANDARD DEVIATION BELOW TARGET | 0 |

| IMPROVEMENT | SCORE |
|---|---|
| IMPROVEMENT OF OVER 2 STANDARD DEVIATIONS | 6 |
| IMPROVEMENT OF 1 TO 2 STANDARD DEVIATIONS | 3 |
| LESS THAN 1 STANDARD DEVIATION OF IMPROVEMENT | 1 |
| NO IMPROVEMENT | 0 |

Report Contact: Dr. Eric Nielsen / e-mail: eric.nielsen@viahealth.org / phone: (585) 922-3062 / fax: (585) 922-0016

GREATER ROCHESTER

GRIPA

INDEPENDENT PRACTICE ASSOCIATION

# PHYSICIAN PERFORMANCE REPORT BROCHURE

# PRIMARY CARE PHYSICIANS

## Dates of service between 4/1/2004 and 3/31/2005 paid through 6/30/2005

## What This Report Means to You

This Performance Report is a work-in-progress. We are constantly working with our physician advisors to update and enhance this Report. In conjunction with the GRIPA Clinical Services Reports (CSRs), our goal is to provide you with actionable information you can use to improve access to and delivery of evidence-based clinical services to your GRIPA patients enrolled in ViaHealth Plan, Preferred Care (Commercial and Gold), and GRIPA Choice Choice products. This Report is produced twice yearly; the next production is scheduled for March, 2006.

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# Clinical Guidelines Summary: Diabetes Mellitus

BACK TO MAIN DASHBOARD
BACK TO MEDICAL METRICS

**Measurement Period: April 2004 TO March 2005**

**MEASURES**

Differences greater than 6% below goal are highlighted in RED.

Differences greater than 6% above goal are highlighted in GREEN.

| MEASURE | MEASURE SOURCE | ELIGIBLE MEMBERS | GRIPA AVERAGE | GOAL | GOAL TYPE | DIFFERENCE FROM TARGET |
|---|---|---|---|---|---|---|
| ANNUAL EYE EXAMS: DIABETES | P4P | 5,890 | 65% | 70% | T | -5% |
| DIABETIC PATIENTS VISITS | P4P | 5,824 | 87% | 93% | T | -6% |
| Female patient(s) taking biguanide (ie metformin) containing medications that had 2 most recent serum creatinine results both | EBM | 42 | 100% | | BP | |
| GLYCOHEMOGLOBIN (A1C) TESTS | P4P | 5,787 | 65% | 72% | T | -7% |
| LIPID PROFILING (LDL-C): DIABETICS | P4P | 5,026 | 87% | 89% | B | -2% |
| Male patient(s) taking biguanide (iemetformin) containing medications that had 2 most recent serum creatinine results both>= | EBM | 54 | *100%* | 100% | BP | 0% |
| Patient(s) compliant with prescribed ACE-inhibitor (minimum compliance 70%) | EBM | 22 | 86% | | BP | |
| Patient(s) compliant with prescribed alpha-glucosidase inhibitor (eg acarbose, miglitol) (minimum compliance 70%) | EBM | 2 | 0% | | BP | |
| Patient(s) compliant with prescribed angiotensin receptor antagonist (minimum compliance 70%) | EBM | 5 | 78% | | BP | |
| Patient(s) compliant with prescribed biguanide (eg metformin) (minimum compliance 70%) | EBM | 211 | 72% | 100% | BP | -28% |
| Patient(s) compliant with prescribed D-phenylalanine (eg nateglinide) (minimum compliance 70%) | EBM | 5 | 40% | | BP | |
| Patient(s) compliant with prescribed meglitinide (eg repaglinide) (minimum compliance 70%) | EBM | 14 | 50% | | BP | |
| Patient(s) compliant with prescribed sulfonylurea (eg glipizide, glyburide, glimepiride) (minimum compliance 70%) | EBM | 111 | *74%* | 50% | BP | 24% |
| Patient(s) compliant with prescribed thiazolidinedione (eg pioglitazone, rosiglitazone) (minimum compliance 70%) | EBM | 186 | 34% | 100% | BP | -66% |
| Patient(s) taking an ACE-inhibitor or angiotensin receptor antagonist that had an annual serum potassium (K+) test | EBM | 31 | 87% | | BP | |

## Top 10 Physicians Based on Current Rate

BACK TO DASHBOARD

BACK TO MEDICAL METRICS

**ANNUAL EYE EXAMS: DIABETES**

Current Target=70%

Measure result source= P4P

Measurement Year=April 2004 TO March 2005

| NAME | PRACTICE | DENOMINATOR | CURRENT RATE | PREVIOUS RATE | DIFF. FROM PREVIOUS | DIFF. FROM TARGET |
|---|---|---|---|---|---|---|
| Dr. 1 | | 35 | 83% | 85% | -2% | 13% |
| Dr. 2 | | 24 | 83% | 86% | -3% | 13% |
| Dr. 3 | | 25 | 80% | 70% | 10% | 10% |
| Dr. 4 | | 39 | 79% | 82% | -3% | 9% |
| Dr. 5 | | 18 | 78% | 65% | 13% | 8% |
| Dr. 6 | | 36 | 78% | 81% | -3% | 8% |
| Dr. 7 | | 35 | 77% | 71% | 6% | 7% |
| Dr. 8 | | 52 | 77% | 79% | -2% | 7% |
| Dr. 9 | | 52 | 77% | 78% | -1% | 7% |
| Dr. 10 | | 25 | 76% | 86% | -10% | 6% |
| Dr. 11 | | 79 | 76% | 74% | 2% | 6% |
| Dr. 12 | | 34 | 76% | 63% | 13% | 6% |

**GRIPA/ViaHealth PPO, Inc.**
**Administrative Policy & Procedure**

| | | | | | |
|---|---|---|---|---|---|
| **Policy: Quality Assurance Action Plan** | | | | **Effective Date: 6 2006** | |
| **Product:** All Contracted Practitioners | | | | | |
| **New Policy:** | | | **Policy #2016** | | |
| **Compliance Standard:** NYS DOH Chapter 98: 98.12(c)(3), (h), NCQA Standards | | | | | |
| **Approved by:**<br><br>_____ **Chair, Quality Assurance Committee/Date**<br><br>_____ **Chair, Board of Directors/Date** | | | _____ **Chief Medical Officer/Date** | | |
| **Revisions** | | | | | |
| Board of Directors Approval Date: | | | | | |
| Quality Assurance Council Approval Date: | | | | | |
| Quality Assurance Council Chair: | | | | | |
| Chief Medical Officer: | | | | | |
| Revision Date: | | | | | |
| Creation By: | NMK | | | | |
| Creation Date: | 6/7/06 | | | | |

**DISTRIBUTION**:
GRIPA Chief Medical Officer
Chair, Quality Assurance Council
Director of Quality Improvement & Compliance

**GRIPA/ViaHealth PPO, Inc.**
**Administrative Policy & Procedure**

| Policy: **Clinical Integration Panel Expulsion** | Effective Date: |
|---|---|
| New Policy _X_ Revision:_____ Replaces Policy:_____ | |
| Compliance Standard: NCQA Standards, NYS PHL Section 4406-d, NYS DOH Chapter 98, HCQIA | |
| Approved By:<br>_____<br>Chief Medical Officer/Date<br>_____<br>Chairperson, Clinical Integration Committee/Date<br>_____<br>Board of Directors/Date | |

| **Revisions** | | | | | |
|---|---|---|---|---|---|
| BOD Approval | | | | | |
| CIC Approval | | | | | |
| CMO Approval | | | | | |
| Revision By: | | | | | |
| Revision Date: | | | | | |

DISTRIBUTION:

| **Title** | **Name** | **Signature** |
|---|---|---|
| GRIPA Chief Medical Officer | | |
| Director, Quality Improvement and Compliance | | |

Dear Dr. Guy R. Ipa:

The enclosed ***Clinical Services Report*** © provides a list of your patients who appear to have not received selected clinical services. The intent of this information is to assist you in validating the data used for your risk withhold return. We do understand that, since this information is derived from claims data, your medical records are likely more current than our data.

We provide this information on your ***Clinical Services Report*** © so that you can verify/correct patient information such as indicating if a patient received the relevant service, such as "Not Diabetic" or "Not My Patient." Corrections will be made to our database to ensure that your next Performance Report, and all subsequent reports, reflect the most accurate information.

- Since the measurement year, October 2004 to September 2005, has passed, please use this report for data corrections only.
- All data will be recorded, even if it does not apply to the current full year Performance Report.
- **Please return by February 6th to have your feedback contribute to the full year Performance Report.**

This ***Clinical Services Report*** © release is intended to help you optimize your Performance Report scores which are used to calculate your risk withhold return.

Respectfully,

Eric T. Nielsen, MD
Chief Medical Officer

# ADDENDUM 1
# CONTRACT NARRATIVE

The purpose of this narrative is to provide a plain statement of the business needs of Customer and of the particular ways in which **Health**vision, through the Agreement, will meet some of those needs.

The Agreement is to be read consistently with this Addendum; however, to the extent of any conflict between language in the Agreement and language in this Addendum, the words and intent of the Agreement control. **Health**vision has provided its responses to how and to which initiatives it will address in this Addendum.

## Background and Overarching Purpose of the Agreement

Customer is an independent practice association formed under the New York Business Corporation Law and Article 44 of the Public Health Law for the purpose of contracting with health maintenance organizations to provide or arrange for the provision of health care services under HMO subscriber contracts.

In its present state, Customer is a network of more than 500 physicians and a dozen clinical facilities. The main function of the network in carrying out its purpose is to provide a single contracting point between the network providers and the HMOs. The network also facilitates the management of health care services by collecting data from its network providers, analyzing the data, and sharing that analysis with the network providers in a way that assists the network providers in improving the quality, efficiency, and effectiveness of patient health care.

Customer has identified "clinical integration" as a critical strategic goal which is essential to Customer's long term survival as a network and a cornerstone component of Customer's effort to comply with various sets of regulations applicable to IPA networks.

Clinical integration is understood by Customer and Healthvision as an ongoing and active program for evaluating and modifying the practice patterns of network providers. It involves and requires a high degree of interdependence and clinical cooperation among the network providers. The fundamental components of a clinical integration program include:

- *the development of common practice components.* Common practice components can take many forms. Clinical practice components might include clinical protocols, algorithms, or clinical paths. Common economic practice components might include cost benchmarks or target cost levels for a particular product or service. Common practice quality components might include quality goals such as x% positive patient satisfaction on certain issues such as waiting room time, friendliness of nurses and support staff, etc. A simple example of common clinical guidance is a protocol for management of diagnosed Type II diabetes. The protocol might require (among other things) that all patients diagnosed with diabetes be monitored on a monthly basis for compliance with medication regimens for the first twelve months after diagnosis.

- *a means of monitoring compliance with clinical guidance.* Clinical integration requires a means of identifying those situations in which a network provider should be complying with a particular protocol, and also if determining whether the network provider is actually complying. To continue the above example, network administrators need a means of determining whether physician *A* has a patient with diabetes, and, if so, whether physician *A* is monitoring his or her patients on a monthly basis for patient compliance with particular medication regimens.

- *a means of enforcing compliance with common clinical guidance requirements.* The network must have a means of requiring network providers to comply with common clinical guidance. Failure to comply may, for example, result in financial penalties for network providers, or may result in expulsion from the network.

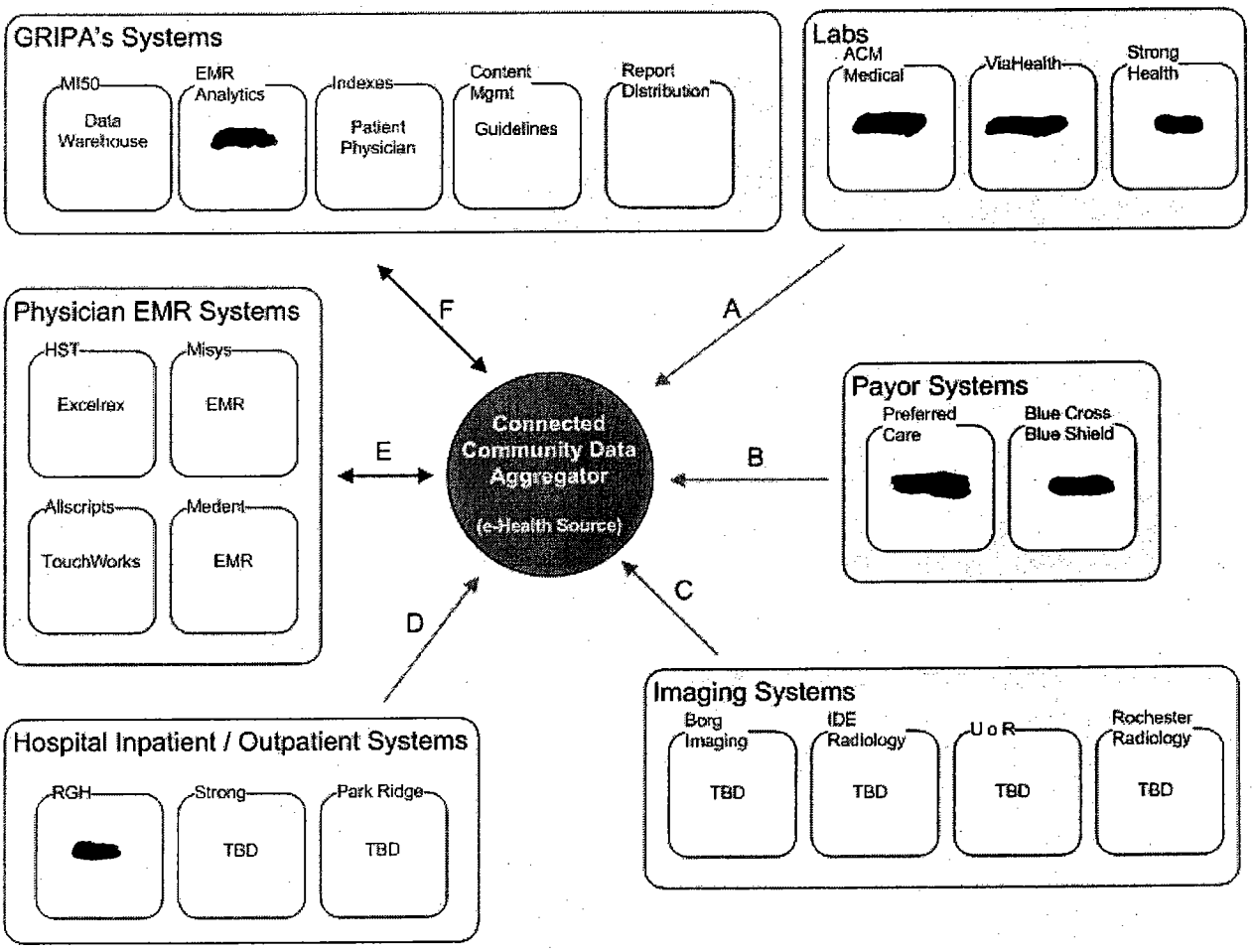
Customer seeks the knowledge and expertise of **Health**vision in implementing certain parts of the technological components of a clinical integration program. **Health**vision's responsibilities in assisting Customer in realizing its clinical integration strategies are outlined in the Agreement and as specifically outlined under **Health**vision's responses in this Addendum.

## The Connected Community Systems Concept

In its present state, the Customer network's providers are "unconnected." The information in a general practitioner's patient chart, for example, generally stays with that physician and does not follow the patient when the patient goes to

the hospital or is referred to a specialist. Information obtained by the hospital or the specialist may or may not find its way back to the general practitioner's chart. When information does flow back and forth, it is generally on paper.

The following diagram is a conceptual view that shows a "picture" of the types of information-sharing that occurs in a clinical environment. Those components of the diagram labeled A-F that **Health**vision provides are outlined in **Health**vision's responses (numbers 1-12) in this Addendum and in the Agreement.




As this illustration shows, the high-level concept is for information about patients currently housed in various segments of the health care community - - namely the hospital, imaging and lab facilities, and the payor segments such as health insurers and HMOs - - will be aggregated in a central location or "central data store," and then made available to the physicians in the network and to Customer administration. Information is also aggregated from the physicians and Customer administration into the central data store, making their relationship with the central data store a "two-way street."

## Customer Request #1.

With respect to laboratory service providers, the arrow labeled **"A"** shows the flow of lab information between various lab systems into the central data store. The goal is to have patient lab results sent to the central data store as that data is generated by the labs. This information will include typical lab information such as test names, values and information about what physician ordered the test for the patient. A mirror image of this export is to be sent directly to a database maintained by Customer administration for analytical purposes. Once in the central data store, the information will then be available to network physicians and other authorized users.

### Healthvision Response #1.

**Health**vision will accept and process data via a real-time interface between the source system and **Health**vision's data center. Availability of data is dependent on frequency of transmissions from source system(s) and the time necessary

to complete the translation of data for processing and filing within the central data store. Format and data components will be defined as part of the interface implementation process and will be in accordance to the **Health**vision [redacted] specifications.

**Health**vision will also provide a copy of each lab transaction to a database maintained by Customer. The format and data components will mirror what has been agreed to during the interface implementation process. **Health**vison will route a copy, following receipt and processing, of each transaction to Customer for further processing within the Customer data center. All translations of this data once received by Customer are the responsibility of Customer.

**Customer Request #2.**

With respect to payor data, the arrow labeled **"B"** shows the flow of patient health eligibility information from health care payors (insurers, HMOs, etc.) to the central data store. A goal of this data exchange is to allow physician offices to validate patient eligibility either directly from an eligibility clearinghouse or by allowing the physician to access the data stored on the payor's own information system.

**Healthvision Response #2.**

The **Health**vision solution is focused on the clinical side of office workflow and currently has limited connectivity with payor systems. [redacted] Within the **Health**vision e-prescribing (e-Rx) application, **Health**vision is able to check prescription eligibility using a specific standard inquiry and response transaction [redacted] through [redacted], a third party system that provides connectivity between the various parties to an electronic prescription. Within the Referral Management system, **Health**vision is able to work with payors or clearinghouse vendors to do an electronic referral certification and authorization using a different standard transaction [redacted]. **Health**vision will be adding the [redacted] transaction described above to the Referral Management service in late 2006 or early 2007.

**Customer Request #3.**

The arrow labeled **"C"** shows the flow of medical imaging reports from various imaging systems to the central data store. The goal for this information flow is to allow direct access to the text of diagnostic reports by network physicians through the central data store. The actual images (including medical imaging information such as radiology images, photographs, and scanned documents) must be available to physicians by permitting them to access the information in the imaging centers' information system without requiring additional logins, and will be scoped under a separate statement of work.

**Healthvision Response #3.**

Imaging diagnostic reports are sent to **Health**vision via a [redacted]. [redacted] The imaging report source system can include a Uniform Resource Locator address (URL) referencing the location of the image as part of the "observation" (OBX) segment of the report. If present, the report will render the URL as a link, which can be clicked on to launch a new browser window back to the image. Single sign-on and reference pointers can be combined so that when the image URL is clicked, the user is automatically logged into the imaging system and the image is displayed with no further user interaction. The ability to implement single sign-on depends on the capabilities and cooperation of the imaging system vendor.

Included in each of the ambulatory radiology system integration efforts, **Health**vision will enable the ability to link (pointers) to the image source systems. The integration effort for each radiology system includes a [redacted] to support the sharing of the radiology reports, including imbedded image links that are made available through a URL. [redacted] can support single sign-on to a picture archiving system ("PACS") or other system through a variety of technologies. The specific technology implemented will depend on the capabilities and cooperation of the PACS vendor, and will require the vendor to make the system accessible via the open Internet or for the end user to have VPN access into the system network. [redacted].

## Customer Request #4.

The arrow labeled **"D"** shows the flow of registration information from systems used by the major hospitals in Rochester and [redacted]. The goal is to have registration and patient census data, for both inpatient and outpatient hospital services, sent to the central data store as that data is generated and made available by the hospital systems. This exchange will also include reports available from the hospitals' internal information systems, such as discharge summaries, discharge instructions, consult notes, radiology images, and laboratory results.

### Healthvision Response #4.

**Health**vision will make available within the central data store all data that is received that meets the interface requirements defined during interface implementation [redacted]. Available data includes patient demographic, registration and visit information (ADT), laboratory results (discrete and textual results), radiology reports, and transcribed reports [redacted]. Availability of data is dependent on frequency of transmissions from source system(s) and the time necessary to complete the translation of data for processing and filing within the central data store.

In addition to the items listed above, **Health**vision will provide information pertaining to inpatient status (as defined within the Customer source system [redacted]).

## Customer Request #5.

The arrow labeled **"E"** shows the flow of patient information from electronic medical record (EMR) systems used in physician offices to the central data store. This data exchange involving EMR systems will be bi-directional and according to national standards of interoperability [redacted] This data exchange may include the electronic communication of Customer clinical guidelines from Customer to vendor EMR, or the guidelines may be provided in some other fashion.

### Healthvision Response #5.

**Health**vision supports the [redacted] standard to move data from EMR systems into the **Health**vision data exchange and from the **Health**vision data exchange back out to the EMR systems. We [redacted] will support all vendors that adhere to the standard and are certified by **Health**vision. In regards to the movement of clinical guidelines from Customer to the variety of EMR, **Health**vision is committed in the future to working with Customer, the EMR vendors and [redacted] to find the most cost effective solution with each EMR vendor. [redacted].

## Customer Request #6.

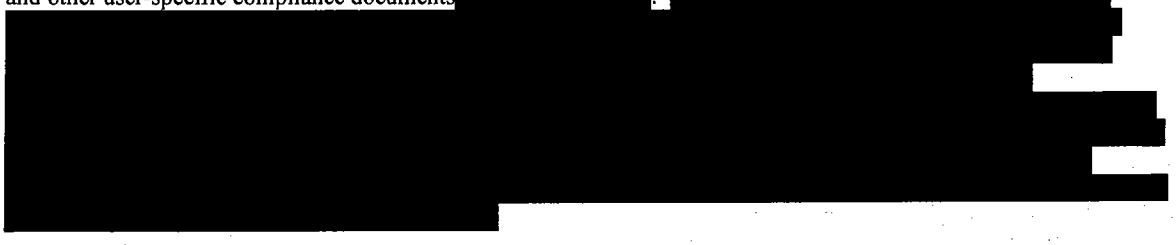
The arrow labeled **"F"** shows a potential representation of the flow of patient information from Customer's internal information systems to and from the central data store. There are two major goals that Customer has for this data exchange. One is to be able to extract data in order to create an analytics database for the purposes of analysis and reporting. The other goal is to be able to use the data exchange system as a mechanism for distributing Customer-specific information to physicians.

### Healthvision Response #6.

**Health**vision will collect lab results data [redacted] from the agreed upon source systems. These inbound lab results feeds will be matched to patient identities and sent to the **Health**vision database. In addition to populating the **Health**vision database, lab results and their unique patient identifier/s will also be sent to a separate database maintained by Customer in conjunction with its [redacted], which Customer uses for compliance reporting and analytics. Currently, this separate database contains claims data provided to Customer by health care payors. The [redacted] product will continue to be the tool used for comparative analyses and reporting, using both the existing claims data and the clinical data to be supplied from the **Health**vision lab feeds. [redacted]

Future phases of the **Health**vision/Customer project (to be specifically scoped and planned at a later date) will allow [redacted]

**Health**vision will enable physician user access to Customer-generated-and-stored physician performance report cards and other user-specific compliance documents [redacted]



## Customer Request #7.

In all of the above data transfers and data access, there must be a process that will uniquely identify each patient and ensure all data is matched to the correct patient prior to data being stored in the central data store.

### Healthvision Response #7.

**Health**vision's [redacted] application, through customized algorithms and rules, assists in the resolution of potential duplicate patients being stored within the central data store. As patient data is received, key demographic information is reviewed and stored within the [redacted] database. Possible patient matches are identified and made available within the [redacted] for processing and final determination by Customer staff. Additionally, through the configuration of the algorithms and [redacted] rules, the number of occurrences of patient matches can be managed.

Once a determination is made that there is a patient match, the [redacted] administrator can merge the patient record, [redacted] to combine patient records in down stream systems (i.e. central data store and Customer database). This ensures that all patient data is matched to the correct patient in downstream systems and that the patient record is reconciled into one patient centric record.

## Customer Request #8.

All data will be codified according to Healthvision-defined standard code sets.

### Healthvision Response #8.

Key clinical data will be stored and codified within the **Health**vision database. Codes sets are agreed to between Customer and **Health**vision during the implementation phase of the project. The cross-reference values are as follows:

- Sex
- Abnormal Flags
- Patient Type
- Admission Type
- Document Type
- Staff Type
- Discharge Disposition
- Result Status
- Document Completion Status
- Ethnic Group
- Marital Status
- Employment Status
- Accommodation Code
- Admission Source
- Hospital Service
- Relationship
- Reason for Study
- Religion
- Visit Publicity
- Visit Protection

- Handicap
- Primary Language
- Specialty
- Citizenship

Large and complex codification tables, such as those code sets required to longitudinally map lab results data, will be provided by **Healthvision** and will be adapted by Customer.

Where industry standard codification is available, national standards will be adopted. Examples of national codification standards used are: ICD-9 codes, CPT codes, and HCPC codes.

## Customer Request #9.

**Physician Access to the Centralized Data**

Physician access to the centralized data must be convenient and functional, and without significant investments of hardware and software by the individual physicians.

## Healthvision Response #9.

**Healthvision** applications are hosted in its secure data center and made available to physicians via the Internet. The only software required to access the applications is [redacted] The only hardware required by an end user is a PC capable of running [redacted] and a connection to the Internet. Depending on the applications Customer licenses, physicians may prefer to use handhelds or wireless Internet connectivity. Handhelds must be capable of running [redacted].

Performance will vary depending on the processing power and amount of memory in the PC or handheld, the speed of the Internet connection and the load on the network.

## Customer Request #10.

At a basic level, physicians must be able to access the information from their office or at other remote locations, either personally or through support staff. The information must be made available to the physician in an organized, logically appropriate manner, in a format that is easy to read and comprehend but contains all pertinent information.

It is envisioned that, on the first "live" date upon which physicians may access the central data store, at least twelve months of "back information" about patients will have been previously loaded onto the system.

## Healthvision Response #10.

A statement of work [redacted] associated with the back loading of patient data for the MPI, lab results and practice management systems, based on an estimate of [redacted] patient records, are outlined below.

Healthvision will load into the repository historical data from three (3) Customer data sources as outlined below. Healthvision and Customer will work together to explore other methods that could reduce work effort associated with the back load, including utilizing direct interfaces to the source systems.

MPI – The MPI data is maintained by Customer [redacted]. Customer will extract this data and deliver to Healthvision in a [redacted] format agreed to by both parties. Healthvision will format and load this data into the [redacted] and file in the Customer portal hosted by Healthvision. Customer will be responsible for managing the [redacted] patient resolution process for this and all data processed through the [redacted]. The back load of data will consist of two (2) file loads. The first will be an initial load of all historical data, followed by a final load to bring the data current to date. [redacted]

Lab Results – These data represent discrete observation lab results, no textual results, and is maintained by Customer. Customer will extract this data and deliver to Healthvision in [redacted] format agreed to by both parties. Customer and Healthvision will work to resolve any issues related to missing data elements to appropriately provide access to this clinical information within the Customer portal hosted by Healthvision. Customer will be responsible for managing the [redacted] patient resolution process for this and all data processed through the [redacted]. The back load of data will consist of two (2) file loads. The first will be an initial load of all historical data, followed by a final

load to bring the data current to date. [redacted]

The Customer and Healthvision will explore the possibility of extracting current and historical data directly from the lab source.

Practice Management Systems – Customer will coordinate and work with Practice Management vendors to enable extraction of patient demographic data from the various practice management systems. Customer will coordinate all work efforts with the practices and vendors related to the collection of this historical data. Customer will extract this data and deliver to **Health**vision in [redacted] format, or other format agreed to by both parties. Customer and **Health**vision will work to resolve any issues related to missing data elements to appropriately provide access to this patient demographic information within the Customer portal hosted by **Health**vision. Customer will be responsible for managing the [redacted] patient resolution process for this and all data processed through the [redacted]

The clinical data used by **Health**vision applications is acquired in two ways. Data is imported via interfaces from external clinical systems, such as laboratory or hospital systems, and data is created by **Health**vision applications directly. When erroneous data is entered into or created by a source system, in order to keep the data consistent in all of the systems from which a clinician might view it, the data must be corrected in the originating system. Corrections made in source systems that are feeding **Health**vision will be reflected in the **Health**vision applications as the corrected transactions are received by the **Health**vision interface engine. Erroneous data entered in **Health**vision systems can be corrected directly in the application; if the system is configured to export that data to other systems, the corrected clinical data will be exported as well.

## Customer Request #11.

In practices that have adopted electronic medical records applications, the exchange of information between the physician's electronic medical records system and the central data store should minimize physician office workflow changes. Thus if the physician pulls up his ordinary electronic medical records chart in preparation for a patient visit, the chart should reflect information about the patient which has been added to the central data store (such as a recent test, or a recent surgery) since the last visit. Information entered by the physician should, in turn, be added automatically to the central data store. This EMR data exchange will comply with the National Standards of Interoperability [redacted].

## Healthvision Response #11.

[redacted] **Health**vision recommends that all EMR vendors be certified with **Health**vision to allow for the acceptance of these [redacted] automatically as well so that it is part of the chart, but it will be each EMR vendor's individual decision to determine how they accept the records.

## Customer Request #12.

The system should serve as a vehicle for making Customer practice component guidelines available to network physicians. For example, if a physician knows of the diabetes management protocol, the physician should be able to easily look up and access the protocol through the product provided by **Health**vision.

Clinical guidelines must be presented in a manner that is easy to view and print by disease state. Customer will attempt to use guidelines which are regularly supplied and updated by [redacted] (which are evidence-based guidelines distilled from claims data). The guidelines will be reviewed by Customer staff, clinical integration committee, and special advisory committees, which may elect to modify the guidelines. The guidelines will then be loaded into a structured database designed by Customer and **Health**vision, populated by the guidelines as supplied and updated by Customer.

The system will display Customer clinical guidelines on the Customer physician web portal in a defined standard web document format (PDF or HTML) and will include links to the supporting documentation, clinical synopsis, and references.

In later phases of clinical integration, Customer must be able to display Customer-defined clinical care guidelines at the patient level on the **Healthvision** physician portal. Adherence to the specific guidelines will be indicated at the patient level (i.e., this patient needs these four things and the physician has done three of them).

The following diagram is a more detailed illustration of the data flow described in this request.

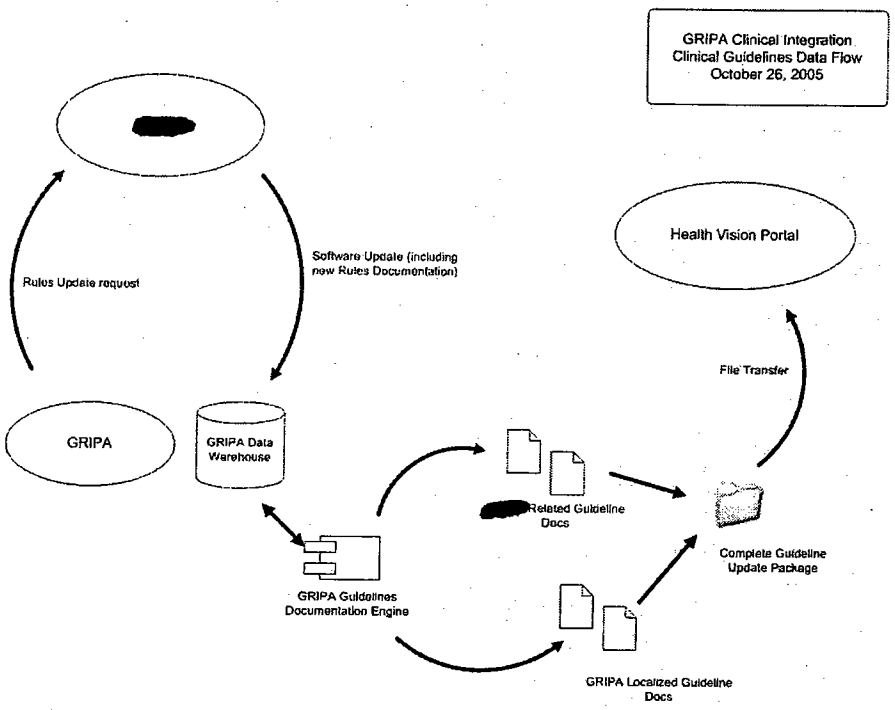



**Figure 2**

## Healthvision Response #12.

**Healthvision** will provide a content store to allow all Customer end-users to view guidelines. These guidelines will be displayed as HTML pages without active content, and may include linking to supporting documentation, synopsis, and references also housed in this content store. [redacted] Updates to these content pages will be supplied to **Healthvision** in desired HTLM format and **Healthvision** will load and update the files. [redacted]

The initial product must contemplate a structured monitoring of patient information relative to the guidelines, with possible features such as: (1) the ability to supply patient-specific prompts on the portal for guidelines not met, and (2) the ability to monitor and report (by system alert to either the physician and/or Customer administrative staff) on provider adherence to guidelines.

**Healthvision** will supply Customer's [redacted] with additional clinical data, such as laboratory results as described in response 10. [redacted] will be the tool for comparative analyses and reporting, using both existing claims data and the data supplied from the **Healthvision** lab feeds.

Practice-based EMRs, that are included as part of the global Customer health information exchange, will supply patient-specific prompts for guidelines or health maintenance reminders. Each EMR may have variable functionality for supporting the ability to imbed care reminders into the provider workflow.
Customer will be responsible for the guideline content management. The **Healthvision** product must provide a mechanism for publishing updates to the guidelines to the web portal.

**Customer Access to Centralized Data**

Customer's access to and use of the centralized data will be the key to monitoring physician compliance with practice guidelines and ensuring appropriate modifications to physician practice patterns, which is itself the keystone of a successful clinical integration program.

Customer must be able to use the data available to it through the central data store to accomplish the following:

- *measure compliance with practice component guidelines at the physician, group, and network levels.* With respect to the diabetes management protocol discussed above, for example, Customer must be able to determine how well a given provider is complying with the protocol. It must be able to measure, for each physician, how many patients the physician has with a diagnosis of diabetes, and of those, how many patients were actively monitored in each of the twelve months following diagnosis. Customer must also be able to determine how well the physician's group is complying with the protocol, and how well the entire community of physicians in the Customer network is complying. At each level, the data must be available in a way that permits Customer to conduct sophisticated statistical analyses for measuring compliance.

**Health**vision will supply and feed clinical information to the Customer [redacted]. The Customer [redacted] will be the source of comparative analyses and reporting, using both existing claims data and the data supplied from the [redacted] lab feeds

- *Monitor the compliance of a particular physician or group.*

- **Health**vision will supply and feed clinical information to the Customer [redacted]. The Customer [redacted] will be the source of comparative analyses and reporting, using both existing claims data and the data supplied from the **Health**vision lab feeds.

- *Tie revenues and expenses to patient care activities.* Customer must be able to measure efficiency in the provision of health care by tying clinical activities such as office visits, specialist visits, laboratory and pharmacy services to the claims data that result from those activities. In this way, Customer administration will be able to determine who provides the best care in the most efficient manner possible. This information will in turn be incorporated back into the practice component guidelines in way that the leaders in any given practice component will set the network standard, driving a network wide improvement process for both efficiency and quality.

- **Health**vision will supply and feed clinical information to the Customer [redacted]. The Customer [redacted] will be the source of comparative analyses and reporting, using both existing claims data and the data supplied from the **Health**vision lab feeds. **Health**vision may supply clinical data to financial reporting systems as part of the global health information exchange, but the Healthvision database will not be a source of financial information on care delivered.

### Implementation Services

Although Customer has a very clear idea of its needs with respect to the project, it will rely upon **Health**vision for technical and project management assistance in the implementation effort for those services purchased by Customer and outlined and as specified in Exhibit B in the Agreement.

### Support Services

**Health**vision will have an ongoing role in the operation of the systems contemplated by this Agreement. The central data store will be located on computer equipment controlled and maintained by **Health**vision. **Health**vision also has the expertise required to maintain the connections between the various information systems.

Reliability of the system is critical and relates directly to the value of the product and services to Customer. For this reason, the parties have agreed to specific service level response parameters outlined in Exhibit D of the Agreement.

### Summary of Functions and Services

The required features and services for the product are summarized and described in plain language in the following tables:

*Note: The "core product" is referenced in Exhibit A (Fee Schedule, page 7) of the Master Service Agreement [redacted] as the "Clinical Data Exchange (CDE)", "Basic Application" and "Support Package" Services. The Basic Application includes the Clinician Desktop with e-Results and Secure Messaging. Some of the features listed*

*below are included in other applications, which can be purchased, but are not currently included in the original Master Service Agreement* [redacted].

***Features***

| **Main** | |
|---|---|
| Patient Centric Clinical Data Repository [redacted] | This is the "central data store" referred to throughout this narrative and depicted in the illustration on page 1-2 of this Addendum. It is a single place where patient information is housed and made available to network physicians and to Customer administrative staff. [redacted] |
| e-Prescribing [redacted] | The system must permit physicians to enter and track prescriptions, and to deliver prescriptions electronically to pharmacies for filling. [redacted] |
| Referral Management [redacted] | The system must permit physicians to share Customer designated electronic information with a referring physician or specialist - this data flow is bi-directional. [redacted] |
| Secure Messaging [redacted] | The system must permit physicians to send structured and unstructured messages to and from other connected systems electronically and securely. [redacted] |
| Web Based Clinical Access Portal [redacted] | The clinical access portal permits physicians to access the central data using a web browser and a designated website for them to log into. [redacted] |
| Patient Identity Resolution [redacted] | The system must ensure that information entered into the system is associated with the correct patient. [redacted] |
| Administrative Tools [redacted] | Customer must have administrator level abilities to perform essential administrative functions such as adding and removing users, setting passwords, resolving conflicts with data feeds, etc. [redacted] |
| Auditing [redacted] | The system must permit production of an audit trail for purposes of maintaining HIPAA compliance. [redacted] |
| Results Viewing [redacted] | Physicians must be able to view patient data and results from ancillary service providers such as lab, radiology and from hospitals. [redacted] |
| | |
| Intelligent Message Routing | The system must route electronic messages to the correct recipients based on pre-defined business rules and identities. |

| | |
|---|---|
| [redacted] | [redacted] |
| Alerts<br>[redacted] | The system must permit notification of the appropriate physician of an occurrence based on a pre-defined set of business rules or clinical criteria.<br>[redacted] |
| | |
| **Reporting & Analysis** | |
| Ability to access and use clinical data for reporting, graphing, and clinical decision support<br>[redacted] | **Health**vision system provides reporting for clinical decision support including a longitudinal view of all labs with graphing capabilities. It also includes reporting on usage and activities including break the glass and clinical auditing.<br>[redacted]. The first set of reports will focus on the most common guidelines being tracked by "pay-for-performance" (P4P) programs, Bridges to Excellence, NCQA and IHA. These reports will use data collected from the system and report on treatment based on guidelines. |
| Application Usage and Activity<br>[redacted] | Customer administrators must be able to monitor who is using the system and what they are doing on or with the system. Healthvision provides a standard set of monthly activity and usage based reports that are available on-line by the 5th business day of the next month. |
| | |
| **System Interoperability** | |
| Electronic Medical Record | **Health**vision supports the [redacted] standard to move data from EMR vendors into the exchange and from the exchange back out to the EMR vendors. We are working with several EMR vendors on the exchange and will support all vendors that adhere to the standard and are certified by **Health**vision. In regards to the movement of clinical guidelines from Customer to a variety of EMRs, **Health**vision is committed to working with Customer, the EMR vendor and [redacted] to find the most cost effective solution with each EMR vendor. [redacted] |
| Lab Information Systems | **Health**vision will accept and process data via a real-time interface between the source system and **Health**vision's data center. Availability of data is dependent on frequency of transmissions from source system(s) and the time necessary to complete the translation of data for processing and filing within the central data store. Format and data components will be defined as part of the interface implementation process and will be in accordance to the **Health**vision [redacted] specifications.<br><br>**Health**vision will also provide a copy of each Lab transaction to a database maintained by Customer. The format and data components will mirror what has been agreed to during the interface implementation process. **Health**vision will route a copy, following receipt and processing, of each transaction to Customer for further processing within the Customer data center. All translations of this data once received by Customer are the responsibility of Customer. |
| Hospital Registration Systems | **Health**vision will make available within the central data store all data that is received that meets the interface requirements defined during interface implementation and in accordance with the **Health**vision [redacted] standards. Available data includes patient demographic, registration and visit information (ADT), laboratory results (discrete and textual results), radiology reports, and transcribed reports as defined within the **Health**vision [redacted] specifications. Availability of data is dependent on frequency of transmissions from source system(s) and the time necessary to complete the translation of data for processing and filing within the central data store. |

| | |
|---|---|
| | In addition to the items listed above, **Healthvision** will provide information pertaining to inpatient status (as defined within the Customer source system [redacted] transactions) and enable the ability to link (pointers) to images stored on Customer source systems servers for display. |
| Insurance Claims Systems | The **Healthvision** solution is focused on the clinical side of office workflow and is currently working on connectivity with payor systems. [redacted] We are also working with payers to exchange demographic data. Within the **Healthvision** eRx application, we are able to check prescriptions benefits eligibility using a specified standard electronic transaction [redacted] through [redacted], a third party that provides connectivity between various entities involved in electronic prescriptions. Within the Referral Management application, we are able to work with payors or clearing house vendors to do an electronic referral authorization and certification using a different standard electronic transaction [redacted] |
| Imaging Systems | Imaging diagnostic reports are sent to **Healthvision** via [redacted]. Reference pointers are optionally embedded in the reports **Healthvision** receives [redacted]. The imaging report source system can include a Uniform Resource Locator (URL) address referencing the location of the image in the observation (OBX) segment of the transaction data. If present, the report will render the URL as a link, which can be clicked on to launch a new browser window back to the image. Single sign-on and reference pointers can be combined so that when the image URL is clicked, the user is automatically logged into the imaging system and the image is displayed with no further user interaction. The ability to implement single sign-on depends on the capabilities and cooperation of the imaging system vendor. |
| | |
| **Messaging Standards Supported** | |
| HL7 | "HL7" refers to "Health Level 7," which is a standard format for healthcare-specific data exchange between computer applications. |
| CCR | "CCR" refers to the Standard Specification for the Continuity of Care Record developed by ASTM (formerly the American Society for Testing and Materials). |
| ADT | "ADT" refers to the a standard component of hospital information management systems which applies to admission, discharge and transfer data. |
| X.12 | "X.12" refers to standards promulgated by the ANSI Accredited Standards Committee X.12, and refers to components of health care payor information systems. [redacted] |
| XML | "XML" refers to "extensible markup language," which is a language that allows for storage of structured data in a messaging format. |
| Requirement. | The system will recognize and be compatible with the above messaging standards. The system will continue to be adaptable to future developments of standardized code sets in accordance with the state of the art of the health care industry with limitations to the clinical messaging types including HL7, CCR, ADT and XML. [redacted] |
| | |
| **Codification Libraries** | |
| LOINC | The **Healthvision** system can support the "LOINC" coding standard. "LOINC" refers to "Logical Observation Identifiers Names and Codes" which (like SNOMED) is a logical system for ensuring that particular entries in an electronic medical record are recognized as such when read by another computer system. For example, a physician's entry regarding an allergy must be recognizable by another physician's electronic medical record system as an entry regarding an allergy. |

| | |
|---|---|
| | [redacted] |
| CPT-4 | "CPT-4" refers to "Current Procedural Terminology" codes and means a system of codes developed and maintained by the American Medical Association for describing medical procedures. The system must recognize the CPT codes and be able to manage data created using such codes or linked to such codes in a data set. |
| ICD-9 | "ICD-9-CM" refers to codes under the International Statistical Classification of Diseases and Related Health Problems (Clinical Modification) published by the U.S. National Center for Health Statistics, and is the predominant system for assigning codes diagnoses and procedures associated with hospital utilization. The system must recognize ICD-9-CM codes and be able to manage data created using such codes or linked to such codes in a data set. |
| Requirement. | The system must recognize and be compatible with the above standards and must be adaptable to future developments of standardized code sets in accordance with the common standards in the health care industry. |
| | |
| **Security** | |
| Single Sign-On | Healthvision has a robust set of technologies that supports single sign-on in many different ways. [redacted] Each application that participates in the single sign-on domain needs to provide a means to enable single sign-on into the application. Healthvision will work with the vendors of any systems to which Customer wishes to enable single sign-on to implement the most effective approach. Each SSO effort will require a separate scoping effort and associated Statement of Work. |
| Based on Roles and Rules | Healthvision has a comprehensive roles, rules, and relationships-based security system that can be customized to model most common security requirements. Specific rules are assigned to roles and can require relationships to patients or clinicians in order to provide clinical data access. These roles can be assigned to individuals as appropriate to their job title or work function. |
| | |
| **Reliability & Performance** | |
| Scalable | The product must be scalable. Scalable means able to accommodate a significantly increased number of users without significant changes in the structure of the product. For example, a product that will allow between 1 and 1000 physicians to regularly use the central data is "scalable." A product that would require significantly different hardware or a system redesign if more than 500 physicians are regularly using the information is not "scalable." |
| High Reliability and Uptime | [redacted] |
| | |

***Services***

| **Support & Maintenance** | |
|---|---|
| Maintenance of System Interfaces | Healthvision will provide monitoring of all interface processing and connectivity to ensure the availability of clinical information is maintained and connectivity is established. **Health**vision is also responsible for the monitoring of all hardware within its environments to ensure their availability. **Health**vision will perform all necessary system maintenance.<br><br>Customer is responsible (through data exchange agreements with each source systems) for ensuring that all system codes and user information is up to date. Customer will notify **Health**vision of any upgrades or changes to sending/receiving systems. Customer is further responsible for coordinating source system resources to address data exchange requirements and system support as appropriate, including escalation |

| | |
|---|---|
| | process for addressing data exchange issues. |
| Client and User Support | **Health**vision will work with Customer to define the rollout and deployment process, including ongoing user monitoring and utilization trends. **Health**vision will work with Customer to implement best practices to ensure a high acceptance by end users. **Health**vision's Service Management Center will be available to address system issues or questions 24/7.<br><br>Customer is responsible for executing these plans and approaches. |
| | |
| **Implementation** | |
| Hardware/Software/Networking Assessment | **Health**vision will provide and jointly develop with Customer an end user assessment and evaluation to identify workflow and hardware requirements.<br><br>Customer will work with **Health**vision in executing these workflow and hardware assessments to ensure success of the program. |
| Client Testing | **Health**vision will make available a test environment for system testing and customer acceptance. **Health**vision will work with Customer in developing test plans and scenarios to adequately test the system and make available resources to assist with this function.<br><br>Customer will make available appropriate resources for test plan development and execution. The test plan will include target dates and key milestones related to testing and customer acceptance. |
| Training & Documentation | **Health**vision will provide training prior to system testing and customer acceptance. Further, **Health**vision will jointly develop a training strategy and approach with Customer and conduct appropriate training with Customer staff to ensure successful execution of the training strategy. |
| | |

**Timeline**

Timing is of the essence with the implementation of this product. It is critically essential that network physicians begin productive use of the features and services facilitating clinical integration within nine (9) months of signing of the Agreement. [redacted]

The "product" as described above is stated in Exhibit A [redacted] of the Master Service Agreement as the "Clinical Data Exchange (CDE)", "Basic Application" and "Support Package" Services. The Basic Application includes the *Clinician Desktop with e-Results and Secure Messaging*. The implementation and deployment of the "product" begins on the date the Master Service Agreement is executed by both parties. As additional "product" functionality add-ons are purchased [redacted] both parties will work together to accommodate implementation and deployment timelines.

It is envisioned that both parties will use their best efforts to ensure that the timeframes outlined in the Agreement are met except in unavoidable circumstances.

{Space Intentionally Left Blank-Signature Page to Follow}

**Healthvision, Inc.**

By: _____

Date: _____

Printed: _____

Title: _____

Greater Rochester Independent Practice Association, Inc.

By: _____

Date: _____

Printed: _____

Title: _____

Bill to: _____

# GRIPA Membership as a Percentage of Total

| Specialty | Total Physicians in Area | Total GRIPA physicians | GRIPA % of Total | Total physicians in Monroe | GRIPA physicians in Monroe | GRIPA % of Monroe | Total physicians in Wayne | GRIPA physicians in Wayne | GRIPA % of Wayne | Total physicians in Ontario | GRIPA physicians in Ontario | GRIPA % of Ontario |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adolescent Medicine | 12 | 1 | 8.3% | 12 | 1 | 8.3% | 0 | 0 | 0.0% | 0 | 0 | 0.0% |
| Allergy and Immunology | 22 | 10 | 45.5% | 20 | 10 | 50.0% | 1 | 0 | 0.0% | 1 | 0 | 0.0% |
| Anesthesiology | 162 | 36 | 22.2% | 155 | 36 | 23.2% | 4* | 4* (1 practice) | 100.0% | 47* | 0 | 0.0% |
| Cardiology | 87 | 40 | 46.0% | 85 | 37 | 43.5% | 14* | 14* (3 practices) | 100.0% | 18* | 12* (4 practices) | 66.7% |
| Child & Adolescent Psychiatry | 22 | 2 | 9.1% | 20 | 2 | 10.0% | 1 | 0 | 0.0% | 1 | 0 | 0.0% |
| Colon & Rectal Surgery | 11 | 7 | 63.6% | 11 | 7 | 63.6% | 0 | 0 | 0.0% | 0 | 0 | 0.0% |
| Critical Care Medicine# | 21 | 1 | 4.8% | 21 | 1 | 4.8% | 0 | 0 | 0.0% | 1* | 0 | 0.0% |
| Dermatology | 37 | 21 | 56.8% | 37 | 21 | 56.8% | 0 | 0 | 0.0% | 4* | 4* (2 practices) | 100.0% |
| Endocrinology | 19 | 6 | 31.6% | 18 | 6 | 33.3% | 0 | 0 | 0.0% | 1 | 0 | 0.0% |
| Gastroenterology | 40 | 15 | 37.5% | 33 | 15 | 45.5% | 1 | 0 | 0.0% | 6 | 0 | 0.0% |
| General Surgery | 75 | 22 | 29.3% | 65 | 21 | 32.3% | 1 | 1 | 100.0% | 10* | 1 | 10.0% |
| Gynecologic Oncology | 3 | 3 | 100.0% | 3 | 3 | 100.0% | 0 | 0 | 0.0% | 0 | 0 | 0.0% |
| Hematology/Oncology | 40 | 14 | 35.0% | 38 | 12 | 31.6% | 1* | 1* | 100.0% | 7* | 6* (2 practices) | 85.7% |
| Infectious Disease | 28 | 5 | 17.9% | 27 | 4 | 14.8% | 1 | 1 | 100% | 0 | 0 | 0% |
| Maternal & Fetal Medicine | 11 | 5 | 45.5% | 11 | 5 | 45.5% | 0 | 0 | 0% | 0 | 0 | 0% |
| Medical Genetics | 4 | 1 | 25.0% | 4 | 1 | 25.0% | 0 | 0 | 0% | 0 | 0 | 0% |
| Neonatal / Perinatal Medicine | 12 | 2 | 16.7% | 12 | 1 | 8.3% | 0 | 0 | 0% | 0 | 0 | 0% |
| Nephrology | 29 | 7 | 24.1% | 27 | 7 | 25.9% | 0 | 0 | 0% | 2 | 0 | 0.00% |
| Neurological Surgery | 13 | 4 | 30.8% | 13 | 4 | 30.8% | 0 | 0 | 0% | 0 | 0 | 0% |
| Neurology | 75 | 14 | 18.7% | 72 | 10 | 13.9% | 1 | 1 | 100% | 4 | 1 | 25% |

# GRIPA Membership as a Percentage of Total

| Specialty | Total Physicians in Area | Total GRIPA physicians | GRIPA % of Total | Total physicians in Monroe | GRIPA physicians in Monroe | GRIPA % of Monroe | Total physicians in Wayne | GRIPA physicians in Wayne | GRIPA % of Wayne | Total physicians in Ontario | GRIPA physicians in Ontario | GRIPA % of Ontario |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ophthalmology | 88 | 25 | 28.4% | 60 | 23 | 38.3% | 2 | 2 | 100% | 11* | 4 | 36% |
| Oral Surgery | 17 | 4 | 23.5% | 9 | 3 | 33.3% | 2* | 1 | 50% | 1 | 0 | 0.00% |
| Orthopedics | 90 | 20 | 22.2% | 74 | 16 | 21.6% | 4 | 4 | 0% | 12 | 0 | 0% |
| Otolaryngology | 44 | 14 | 31.8% | 24 | 9 | 37.5% | 4 | 4 | 100% | 8 | 7 | 88% |
| Pain Management | 23 | 4 | 17.4% | 17 | 4 | 23.5% | 0 | 0 | 0.00% | 4 | 0 | 0.00% |
| Physical Medicine & Rehabilitation | 20 | 2 | 10.0% | 16 | 2 | 12.5% | 0 | 0 | 0.0% | 4* (1 practice) | 0 | 0% |
| Plastic Surgery | 20 | 9 | 45.0% | 19 | 9 | 47.4% | 0 | 0 | 0.0% | 1 | 0 | 0% |
| Psychiatry | 137 | 22 | 16.1% | 109 | 22 | 20.2% | 4 | 0 | 0.0% | 7*(1 practice) | 0 | 0% |
| Pulmonary | 40 | 10 | 25.0% | 40 | 10 | 25.0% | 0 | 0 | 0.0% | 4 | 1* | 25% |
| Radiology | 169 | 50 | 29.6% | 114 | 48 | 42.1% | 10* | 10* | 100.0% | 34 | 10* | 29% |
| Radiation Oncology | 30 | 6 | 20.0% | 17 | 3 | 17.6% | 0 | 0 | 0.0% | 9 | 3 | 33% |
| Reproductive Endocrinology | 6 | 2 | 33.3% | 6 | 2 | 33.3% | 0 | 0 | 0.0% | 0 | 0 | 0.00% |
| Rheumatology | 19 | 5 | 26.3% | 17 | 5 | 29.4% | 0 | 0 | 0.0% | 1 | 0 | 0.00% |
| Thoracic Surgery | 11 | 5 | 45.5% | 10 | 5 | 50.0% | 0 | 0 | 0.0% | 0 | 0 | 0.00% |
| Urology | 38 | 16 | 42.1% | 28 | 15 | 53.6% | 1 | 1 | 100.0% | 2 | 0 | 0.00% |
| Vascular Surgery | 17 | 6 | 35.3% | 13 | 6 | 46.2% | 1* | 1 | 100.0% | 2 | 0 | 0.00% |
| Geriatric Medicine | 49 | 16 | 32.7% | 43 | 14 | 32.6% | 1 | 2 | 100.0% | 6 | 0 | 0 |
| Internal Medicine | 433 | 134 | 30.9% | 382 | 119 | 31.2% | 20* | 14 | 70.0% | 37* | 1 | 2.7% |
| Family Practice | 179 | 20 | 11.2% | 146 | 15 | 10.3% | 13* | 5 | 38.5% | 26* | 0 | 0 |
| Pediatrics | 230 | 100 | 43.5% | 203 | 89 | 43.8% | 12 | 11 | 91.7% | 15 | 0 | 0 |
| TOTAL PCP | 845 | 257 | 30.4% | 732 | 225 | 30.7% | 47 | 32 | 68.1% | 79 | 1 | 1.3% |
| Gynecology | 10 | 4 | 40.0% | 9 | 4 | 44.4% | 1 | 1 | 100% | 0 | 0 | 0% |
| OB/GYN | 140 | 46 | 32.9% | 119 | 41 | 34.5% | 9 | 2 | 22.20% | 19* | 4* | 21.1% |
| TOTAL Women's Care | 177 | 50 | 28.2% | 130 | 44 | 33.8% | 10 | 3 | 30.0% | 19* | 4* | 21.1% |

## GRIPA Membership as a Percentage of Total

* Physicians practice in more than one county.
# Only 2 Critical Care Specialists practice in only that field; 16 also practice in Pulmonary disease;
2 also practice in anesthesiology; 1 also practices in Pediatrics.
## All Geriatric Medicine specialists also specialize in Internal Medicine or Family Practice.

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January 29, 2007

**VIA COURIER**

David M. Narrow, Esquire
Federal Trade Commission
Mail Drop 7264
601 New Jersey Avenue, N.W.
Washington, D.C. 20001
Phone: (202) 326-2744

**Re:** Greater Rochester Independent Practice Association, Inc.
Advisory Opinion Request

Dear David,

The Greater Rochester Independent Practice Association, Inc. ("GRIPA"), is responding to your request for additional information, dated September 21, 2006, on a rolling basis. This is the second installment and answers the questions in the first two sections of your request. For clarity, we have broken down your questions into smaller parts, which we list below with GRIPA's responses.

GRIPA requests that you treat this information and the exhibits confidentially under Federal Trade Commission Procedure Rule 4.10, 16 C.F.R. § 4.10(a)(2) (2006), and § 6(f) of the Federal Trade Commission Act, 15 U.S.C. § 46(f) (2000). If GRIPA should determine that the confidentiality designation is unnecessary, I will notify you of that change.

## Program Description

Q1 How did you arrive at the estimated participation rates for physicians in GRIPA (i.e., 90% of primary care (family practice, internal medicine, general practitioner, and pediatrics) physicians and 75% of specialists and women's care physicians participating under GRIPA's risk contracts)?

Based on information provided by Mr. Miles regarding the experience of MedSouth, Inc., GRIPA initially estimated that significantly less than all current GRIPA physicians would

participate in its clinical integration program. Based on feedback from its members after meetings to discuss the program, GRIPA estimated that 90% of its current primary care physicians ("PCPs") and 75% of its current specialty care providers ("SCPs"), the numbers it submitted to the FTC, would participate.

In July 2006, GRIPA sent clinical integration participation contracts to all its current members with the promise that those who signed up first would be set up earliest on the GRIPA Connect Web Portal (the "Portal"). At present, 181 independently practicing GRIPA physicians (78 PCPs and 103 SCPs) have signed participation contracts, and ViaHealth has signed a contract for the participation of its 150 employed physicians, adding 86 PCPs and 64 SCPs. Other physicians have indicated their intent to participate in the program, and GRIPA anticipates that as the Portal's advanced applications (e-prescribing, lab order entry, referral management, etc.) are brought online over the next year, more physicians will sign up. At this time, it believes that a realistic estimate of participation is 450 physicians (45% PCPs and 55% SCPs).

Q2 **Please provide copies of all materials regarding the proposed program that have been presented, provided, or distributed to any potential physician participants in the program, or to any potential customers for the program.**

Sent 11/13/06.

**Integration and Efficiencies**

Q1 **What financial investment, if any, will be required of physicians participating in GRIPA's proposed program? Is this the same for all physicians?**

To finance its contract with Healthvision for the Portal and advanced applications, GRIPA is using withhold funds from its physicians' payments under its risk contracts that otherwise would have been returned to members. GRIPA estimates that the value of this contribution is approximately per physician. In addition, all physicians and their office staffs will be required to attend in-office training regarding use of the Portal, the advanced web-based software applications, and the clinical integration program in general. GRIPA will present four half-day training sessions over the course of the next year. Estimating the wages of the staffs for the training periods and the average lost patient revenue from closing the office for training, GRIPA estimates that these training sessions will cost each physician approximately $3200 for the four sessions. Additional physician investment includes the cost of the Internet connection, which is approximately $70 per office per month. The greatest long-term cost to the physicians will be the significant time investment each will need to make—contributing data, collaborating in patient care, complying with the guidelines, and participating on GRIPA committees and SAGs. As noted in the initial submission, GRIPA believes the average physician will spend an additional two hours per month, at an average cost to the physician of $100 per hour, or $2400 per year. Although participation in the program will

cost the physicians time, the marginal benefit from the efficiencies of the program should more than offset the marginal cost of the time investment.

GRIPA predicts that each office will need to invest in at least three computers and two to three printers—at least one for printing prescriptions and one for copies of records, handouts, and referrals—an estimated investment of $6000-$7000 per three-provider office. Those physicians and offices that have already invested in computer hardware and EMR systems will have lower implementation costs because they will already have some of the necessary hardware.

**Q2 GRIPA's proposed program would involve approximately 600 physicians, in about 200 separate medical practices. Please explain why and how GRIPA believes that it will be able to achieve a "high degree of interdependence and integration among the physicians to control costs and ensure quality" with participation in the program by this number of physicians and medical practices, many of whom presumably will have little, if any, practice interaction with most of the other physicians participating in the program.**

GRIPA disagrees to some extent with the presumption that many of its participating physicians will have little or no practice interaction with other participating physicians. In the past, that, admittedly, has been true of interaction among GRIPA's PCPs, but it has not been true of the degree of interaction between the PCPs and SCPs, which has been substantial, and among the hospital-based specialists themselves, which has been significant, if not substantial. The CI program will increase the degree of interaction among both the PCPs and the SCPs through the work of GRIPA's committees. For example, a SAG, composed of physicians practicing in all the specialties affected by the disease-state, has developed each of GRIPA's guidelines through a process requiring substantial interaction among different specialists.

GRIPA believes that it will be able to achieve a "high degree of interdependence and integration among the physicians to control costs and ensure quality" because of its historical success with integrative activities through its risk-contracting program, the collaborative activities built into its clinical integration program, the policies it will establish and implement for its program, and the technology that it is establishing to facilitate the integration of its members' practices.

GRIPA physicians already have a history of working collaboratively, through GRIPA's risk contracts, to achieve the efficiencies necessary to successfully share financial risk. Although the clinical integration program will not involve financial risk sharing (assuming GRIPA is unable to enter a pay-for-performance contract—*See* Response to Q8), the physicians must work together in a similar manner to achieve the desired efficiencies of their quality improvement and cost containment activities.

Through the Specialty Advisory Groups ("SAGs") and the Clinical Integration Committee ("CIC"), which are integral parts of the clinical integration program, GRIPA physicians are collaborating to create the guidelines and corresponding measures embodying the

quality standards to which the physicians will be held. To successfully achieve the organization-level benchmarks that the CIC sets for the guideline measures, the physicians will need to monitor their own guideline compliance and that of their peers. All physicians will be required, if selected by lot, to serve on the Quality Assurance Council (the "Council"), which will review and evaluate their peers' guideline compliance and then make and implement the decisions regarding discipline and sanctions. The group's ability to achieve its efficiency goals depends entirely on the physicians' working together in their treatment of GRIPA patients and using their committees to ensure that all GRIPA physicians continue to improve the quality of care they provide.

GRIPA's policies are designed to integrate the physician practices. The in-network referral policy increases collaboration among GRIPA physicians in the care of GRIPA patients. Keeping patients within the GRIPA network will improve the overall continuity and quality of care GRIPA patients receive. GRIPA's policy of posting the performance scores of the physicians will also encourage physicians to work together to improve compliance by all participants and will also challenge physicians to become one of GRIPA's top ten performers, whose names will be published with their scores. The Council will review the performance of the lowest performers and may require their peers to educate or mentor them.

The Portal also should be instrumental in integrating GRIPA's physicians. They are collaborating in the Portal design to ensure that it is user friendly and that it will facilitate the necessary exchange of patient information. The ease of confidential communication and sharing of patient information through the Portal should result in more frequent communication and greater collaboration among GRIPA physicians. Distance between practices will no longer be a barrier to physician communication, and the Portal will open up new consultation opportunities. Because the Portal will identify all in-network treating physicians in a patient's record, the physicians will have greater opportunity to coordinate treatments, reduce duplication of services, and ensure continuity of care.

**Are there any examples or studies of other clinical integration programs involving comparable numbers of physicians, and any evaluation of their mechanisms of operation or effectiveness in integrating the physician practices?**

Although GRIPA has contacted and discussed clinical integration programs with MedSouth, Brown & Toland, and Waukesha Elmbrook Health Care, it has no studies or evaluations of these programs.

Q3 **Please describe GRIPA's experience and results in monitoring performance and implementing corrective action regarding physician performance under its risk contracts. Please provide any official analyses or reports concerning the effectiveness of these activities.**

Under its risk products, GRIPA has historically monitored, and will continue to monitor, the performance of internal medicine, family practitioners, pediatricians, obstetrician/gynecologists, cardiologists, and orthopedic surgeons. GRIPA provides each of

these physicians a performance report (a type of report card) that shows the physician, (1) his or her compliance rate for each performance measure, (2) a comparison of each compliance rate to the last quarter's results, (3) his or her cumulative compliance "score" for all performance measures, and (4) the average score for all physicians to whom each measure applies. GRIPA then uses a weighting system to compare scores for all measured physicians and specialties. The results of these performance reports determine the percentage of withhold return for which each physician is eligible, assuming satisfactory aggregate network results. GRIPA penalizes poorly performing physicians financially. Historically, GRIPA has not needed to take any action against physicians who failed to meet performance targets, other than penalizing them financially or eliminating the amount of withhold returned.

To improve or correct physician performance under its risk contracts, GRIPA distributes clinical services reports ("CSRs"), which inform physicians of patients for whom they have not complied with performance measures. The physicians review the CSR information and provide feedback (or "defenses") to GRIPA such as "Not my patient," "Not diabetic (asthmatic, congestive heart failure patient, etc.)," or "Mammogram (or other screening test) was done" with date. GRIPA sends the CSRs to the physicians in sufficient time for them to provide feedback before their next biannual performance report. When a physician provides feedback, GRIPA enters the information into a "correction file." Then, GRIPA checks the physician's "defense," if any, to determine if it is reasonable and verifiable. If it is, GRIPA uses the correction file information for that physician's next performance report. Information remains in the correction file for a one-year period.

In monitoring the performance of its physicians, GRIPA has learned that physicians who provide feedback on their CSRs improve their performance reports more than those who do not. GRIPA also has learned that its reviewing the CSRs and corresponding patient data results in physicians' paying closer attention to their compliance with the performance measures. Over the past three years, the number of physicians providing feedback on the CSRs has increased and so have performance report scores. *See* Exhibit A. Once the Portal is operational, GRIPA will provide CSRs on the Portal in "real time" and thus post performance-measure compliance failures as soon as they occur (e.g., a missed annual diabetic eye exam).

**Has GRIPA ever found it necessary to terminate any physicians from participation in its risk programs? If so, how frequently?**

GRIPA has not terminated any physicians from its network based on performance. Its financial incentives and corrective-action programs under its risk-contracting program have sustained acceptable physician performance.

Q4 **Please explain whether and how having non-exclusive participation in GRIPA, which potentially subjects GRIPA physicians to different practice and utilization standards from various payers, is likely to affect GRIPA's ability to achieve its efficiency goals for the physicians, and GRIPA physicians' ability to effectively incorporate and implement GRIPA's operational requirements in their practices.**

GRIPA's policy of non-exclusivity should not affect its ability to achieve its efficiency goals or its physicians' ability to effectively incorporate and implement GRIPA's operational requirements in their practices. Rochester-area payors have not instituted any practice or utilization standards applicable to GRIPA physicians. GRIPA is the only remaining Rochester-area physician network that requires member compliance with practice and utilization standards. When its members contract individually or through other organizations, GRIPA's practice and utilization standards will be the only ones with which the physicians must comply. And even when its members contract individually, GRIPA anticipates entering payor contracts covering a sufficient number of subscribers to affect a significant portion of its member physicians' patient populations, thus generating significant efficiencies. GRIPA's requirement that all GRIPA physicians participate in all GRIPA contracts should magnify this effect.

**In your proposal, you assert that it is burdensome for physicians to consult referral lists for different contracts in order to see which providers are in-network. Isn't this what physicians currently do, insofar as they participate in, and see patients covered by, multiple programs?**

Yes, and it is burdensome. GRIPA physicians currently must consult referral lists for each patient to determine which providers are in-network for the patient's insurance. For its risk contracts, GRIPA generated product-specific lists by specialty and distributed these lists to its PCPs. These likely were infrequently used, just as lists created by payors are generally not used. GRIPA seeks to obviate this problem for GRIPA-contracted payor products through readily available drop-down lists of preferred specialists on the Referral Management application. This electronic application will allow physicians to generate referrals quickly to GRIPA providers and should increase the in-network referral percentage.

**Won't this continue to be the case for GRIPA physicians insofar as their participation in GRIPA is non-exclusive?**

To some extent. For non-GRIPA products in which GRIPA physicians participate, its physicians will still need to consult payors' referral lists. For GRIPA-contracted products, however, there will be only one panel because all GRIPA members must participate in every GRIPA contract. With a single, uniform panel, the Referral Management application will make in-network referrals for all GRIPA-contracted products fast and efficient for the GRIPA physicians.

**Could the proposed program's computerized systems be used to simplify/address the problem of identifying participating physicians, when GRIPA physicians need to make a referral?**

Yes, the computerized systems could alleviate, but not obviate, the burden of GRIPA's identifying participating physicians on a contract-by-contract basis and that of its physicians' identifying participating physicians to whom they may refer GRIPA patients.

We assume this question arises from the concern GRIPA expressed in its June 28, 2006 letter that if all GRIPA physicians were not included in all GRIPA contracts, confusion would result from GRIPA and its participating physicians having to differentiate between GRIPA physicians who are "in" particular GRIPA contracts and those who chose not to participate in particular contracts and thus were "out."

GRIPA's computerized system should ease the task of its physicians identifying the "in" and "out" physicians easier, but the identification would still be necessary, creating some burden and possible confusion and mistakes in referrals, since there could be multiple contracts, each with different "in" and "out" groups. The problem, however, is not in just identifying the "ins" and "outs." In addition, for example, once that task is complete, GRIPA would still have to create some mechanism for distinguishing between the two groups in collecting data and including it in its database and then ensuring that it included only the appropriate data in its monitoring, data analysis, and corrective-action functions. Having "ins" and "outs" and having to distinguish between them in implementing and operating the program simply complicates, unnecessarily, the various tasks the program requires.

We say "unnecessarily" because the requirement that all GRIPA physicians participate in all GRIPA contracts would seem to benefit both GRIPA customers and GRIPA, while not raising the specter of any anticompetitive effects. The requirement eases GRIPA's administrative burdens and also guarantees payors GRIPA's full panel of physicians. If that's not what a payor wants, then it can simply not contract with GRIPA.

**Q5 Will all contracts with payers require that covered individuals stay within the GRIPA network of providers for services to be covered under the contracts? If not, under what circumstances will covered individuals be allowed to obtain services outside the network?**

GRIPA will attempt to keep covered individuals in-network, but some out-of-network leakage will occur. The easiest way to ensure that individuals stay in-network would be for GRIPA to participate in only closed-panel products. Indeed, GRIPA would prefer to offer its clinical integration program only as a closed-panel product and believes it could be successful in doing so because its providers have participated in at least one close-panel product each year since 1997. If the payors, however, are not interested in such a product (because of consumers' preference for full-access products), that would probably require GRIPA to contract for open-access products in which its members will be a sub-panel. Even then, GRIPA would attempt to limit the degree of open access by encouraging its members to keep referrals in the GRIPA

network when medically appropriate. Thus, the open-access-product GRIPA patients obtaining treatment outside GRIPA's network will generally do so by self-referral.

**How will such instances be treated for purposes of GRIPA's monitoring and evaluating use of services under its proposed program?**

GRIPA will monitor its physicians—not the patients—so instances in which patients obtain services out of network will not affect GRIPA's evaluation of services under its program. Unlike a risk product, GRIPA's compliance with its cost benchmarks will be judged only by what the GRIPA physicians do, or fail to do. Even if GRIPA contracts with sub-specialists as part of a closed-panel product (see answer below), it believes that its cost-improvement goals will not be significantly affected because such instances, though sometimes high-cost, are low-volume.

For the purpose of ensuring continuity of care, GRIPA will collect as much patient data as possible from non-GRIPA physicians when its patients go out of network, but it expects to lose some treatment information.

**Will there be some specialty physician services that GRIPA must arrange for from non-GRIPA physicians? If so, how will this affect GRIPA's operation and achievement of efficiencies?**

Although the GRIPA CI panel will have a broad range of specialties, it is likely that some patients will be referred out of the GRIPA network, regardless of whether the product is closed- or open-panel. For example, pediatric subspecialty and inpatient care is available only at the University of Rochester system. GRIPA physicians also do not provide neonatal care, extracorporeal shockwave lithotripsy (ESWL), some endovascular procedures, stereotactic radiation treatment, or transplants. For closed-panel products, GRIPA will probably contract with non-GRIPA physicians to provide those services its members do not provide. This sub-contracting will facilitate collection of treatment information for those patients to ensure that GRIPA physicians have more-complete records for use in further treatment of those patients. Because GRIPA will monitor its physicians and not the patients, non-GRIPA physicians' treatment of GRIPA patients will not affect GRIPA's operation and achievement of efficiencies.

**To the extent that physicians participating in GRIPA may have referral relationships with non-GRIPA physicians, either through prior established relationships, or because of the GRIPA physicians' participation in other networks (due to GRIPA's non-exclusivity), how realistic is it for GRIPA to expect that physicians participating in multiple network arrangements will be willing and able, from a practical standpoint, to effectively operate within the in-network referral constraint?**

Very realistic. First, if the plan is closed-panel, GRIPA will require in-network referrals unless the needed service is not available from GRIPA physicians. Second, GRIPA physicians have experience participating in closed-panel products and have done very well at keeping referrals in-network for those products. For example, in 2005, 93 percent of GRIPA physicians' referrals for ViaHealth Plan patients were within the GRIPA network. The Council will monitor physicians' compliance with this policy and failure to comply, without medical justification, will result in corrective action.

If GRIPA participates in open-panel products, it will still require its physicians to keep referrals in-network to the maximum extent possible, but it will have no control over patient self-referrals.

**Q6 What is the anticipated timetable for GRIPA implementing its program components, and for achieving its anticipated efficiencies?**

GRIPA has already begun implementing some of its preliminary program components and believes it will fully implement the program not later than the end of 2007. Based on the experience of other networks and GRIPA's own experience with its risk-contracting programs, GRIPA estimates that the program will begin generating efficiencies approximately six months after full implementation but that because of data-lag times, measurements may not be available until six- or nine-months later.

The CIC has been meeting since April 2006, making policy determinations and working on guideline development. At present, the CIC has approved 14 guidelines, 11 of which the CMO presented to, and were approved by, the GRIPA Board. The CIC is currently reviewing two additional guidelines. SAGs met and developed each of these 16 guidelines, and a SAG will meet next week regarding one more guideline. At the request of the CIC, GRIPA staff members are collecting literature supporting two additional guidelines. GRIPA anticipates organizing SAGs to develop two to four additional guidelines per month during 2007.

The Council will begin meeting after GRIPA begins receiving data from its physicians, the hospitals, and ancillary providers. The Council will monitor GRIPA physicians' risk contract data to assess the quality performance of the network and advise the CIC regarding the setting of performance benchmarks for the newly established guidelines.

To have the Portal and electronic applications in place by the time of full-program implementation, GRIPA will establish the electronic applications for its risk contract physicians and patients. The Portal base, lab and radiological image results viewing features, secure messaging, and clinical guidelines text will be brought online during the first half of 2007. Once these features are in place, the Referral Management application will be rolled out approximately two to three months later. GRIPA will next bring lab-order entry online, one to three months after Referral Management. GRIPA will roll out e-prescribing, which will initially be an

optional feature for physicians, at a rate of 20 to 30 physicians per month, beginning this quarter. Interactive clinical guidelines should become operational by the end of 2007.

**Will overall efficiency outcomes (as opposed to the establishment of structural or process measures) be measured? How? For example, will GRIPA be able to determine, on a macro level, whether its interventions and monitoring actually are improving health outcomes or lowering total costs for a payer's covered population?**

Yes. GRIPA has developed a model for forecasting savings attributable to each clinical guideline, which the CIC is using to identify those guidelines that should produce the greatest return on investment in efficiencies and cost savings for both GRIPA and its contracted payors. After the guidelines are implemented, GRIPA will measure the utilization impact of its guidelines, from which it will be able to estimate cost savings. GRIPA's performance-monitoring software will also allow it to calculate cost savings, in the form of costs avoided, through primary care intervention and disease management. If payors provide historic claims data so that past expenses can be accurately determined, GRIPA will be able to measure actual cost savings attributable to its program. Although GRIPA is aware that guideline compliance may result in higher primary care and prescription costs (as numerous studies predict), the total patient costs for payors should decrease, consistent with the evidence-based guidelines. *See* Exhibit B, which shows GRIPA's experience with prescription drug monitoring and compliance.

Using available data, GRIPA will track changes in the health of its physicians' population of patients. The lab data will show whether certain health outcomes are improving, such as lowered cholesterol and hemoglobin A1c levels. The prescription data will reflect physicians' prescription, and patients' use, of maintenance medications for chronic conditions. In addition, GRIPA will track whether its physicians are providing screening procedures mandated by its guidelines, such as mammograms and colonoscopies, thus improving the likelihood of early detection and treatment. Although not all of GRIPA's guidelines lend themselves to measurement of health outcomes, the medical literature suggests that physician compliance with evidence-based guidelines results in better health and a lower incidence of admissions to emergency departments and hospitals. *See* Exhibit C.

**Is there a minimum number of covered lives under GRIPA's proposed program that is necessary for the program to achieve those efficiencies?**

Efficiencies can be achieved regardless of the number of covered lives under the program. GRIPA's monitoring features and interactive guidelines can be "turned on" for any product, group of physicians, or group of covered lives. A minimum number of cover lives is, however, necessary to measure statistically significant quality improvements and cost reductions. At present, GRIPA is not sure what that number is. It depends in part on the degree of statistical significance chosen.

**What performance and outcome benchmarks (including regional or national ones) or standards for measuring group (as opposed to individual) performance are anticipated to be used by the program?**

GRIPA will be able to compare its physicians' aggregate performance to national, regional and local benchmarks. The comparative benchmark scores will be derived from selected indicators from a plethora of sources such as federal government agencies (e.g., AHRQ, CMS, and CDC), national organizations focused on quality (e.g., NCQA and The Institute Clinical Systems Improvement), national organizations focused on specific disease states (e.g., American Diabetes Association and the American Heart Association), national specialty societies (e.g., American College of Obstetricians and Gynecologists, American Academy of Family Physicians, and American Academy of Pediatrics) and the New York State Department of Health. If payors provide claims data, GRIPA will also use risk-adjusted cost measures, such as per member per month plan liability and total annual plan liability for PCP care, SCP care and pharmacy care comparisons.

**Q7 Have potential customers expressed any interest in the potential transactions costs efficiencies of joint contracting with physicians through GRIPA?**

Yes and no. GRIPA has not discussed potential transaction-cost savings with payors. WellCare, however, in contracting with GRIPA for 2006 financial risk-sharing business, expressed interest in single-signature contracting as one reason for the agreement. It wanted a ready-made physician panel and found it in GRIPA. Payors will have to decide the extent to which single-signature contracting benefits them.

**You state that Excellus, which covers approximately 70% of the privately insured lives in the Rochester area, already has individual contracts with a majority of Rochester-area physicians. Many Blue Shield plans apparently have a policy of only contracting with individual medical practices for their networks. What is Excellus's view of GRIPA's potential transactions costs efficiencies, and what position, if any, has it taken with regard to possibly contracting jointly with physicians through GRIPA?**

GRIPA does not know Excellus's view of GRIPA's potential transaction costs efficiencies. Unlike many Blue Cross Blue Shield companies, however, Excellus does not have a history of contracting directly with physicians. Excellus began direct contracting only last year, and its contracts did not go into effect until January 1, 2007. The contract Excellus offered, and many of the Rochester-area physicians signed, is unusual in that it includes a specific provision permitting any IPA contract to supercede individual contracts. *See* Exhibit D. In addition, the contract allows Excellus to exclude the physician from any health benefit program serviced by physicians through an exclusive arrangement between Excellus and an IPA in which the physician is not a member. As a result, it appears that Excellus is not opposed to entering

contracts with IPAs in the future, depending on its needs and the terms and conditions it can obtain from the IPA.

Because GRIPA has not yet implemented its clinical integration program, it has not discussed contracts with any payor, including Excellus. Therefore, Excellus has not specifically stated whether or not it will contract with GRIPA. In discussions of its clinical integration program with payors, GRIPA has provided them information and requested their input regarding the Portal and electronic applications, guideline development, quality monitoring, and the general concepts of its program.

**Has GRIPA, or anyone else, attempted to quantify the transactions costs efficiencies from joint contracting through the network? What were the findings?**

No. Given the number of variables involved in such a calculation and their subjective nature, GRIPA is not even sure such a calculation is possible.

**Q8 Will GRIPA's proposed program involve any financial incentives for superior performance, such as pay-for-performance arrangements with payors?**

There are no financial incentives built into the GRIPA clinical integration program itself. But, GRIPA intends to pursue pay-for-performance or gain-sharing arrangements with payors willing to consider such arrangements. Indeed, GRIPA will welcome payor suggestions for improvement of all aspects of its program.

**GRIPA has attempted to respond to your requests in as complete a manner as possible. If you have any questions regarding any of the above responses, please let us know. In addition to the exhibits to the questions above, we are enclosing copies of the revised physician participation agreements and the correspondence to GRIPA members that accompanied these contracts. We appreciate your consideration.**

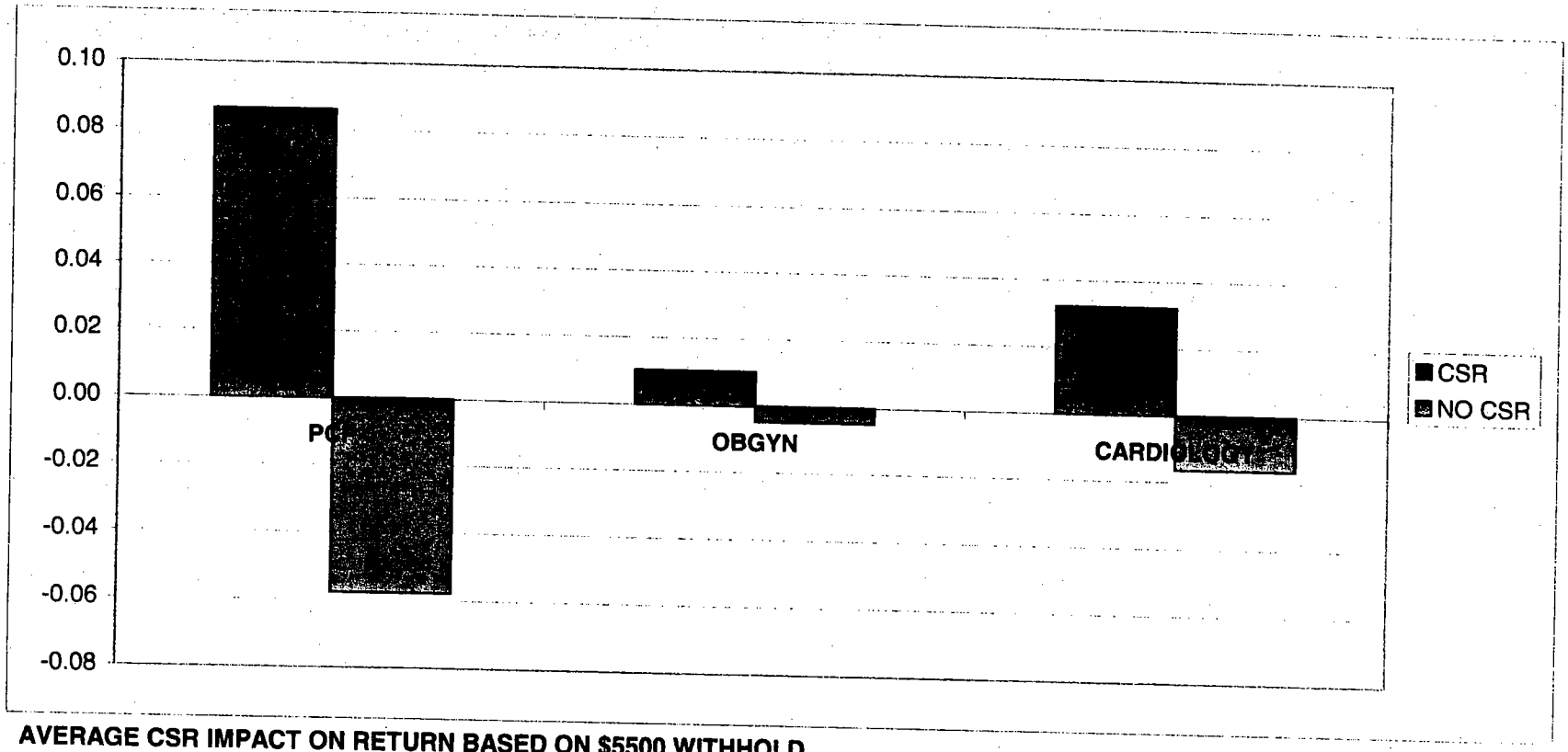
Best regards,

Christi J. Braun

Enclosures

GREATER ROCHESTER
GRIPA
INDEPENDENT PRACTICE ASSOCIATION

# Impact of Clincal Services Report on P4P scores 3 Qtr 2005

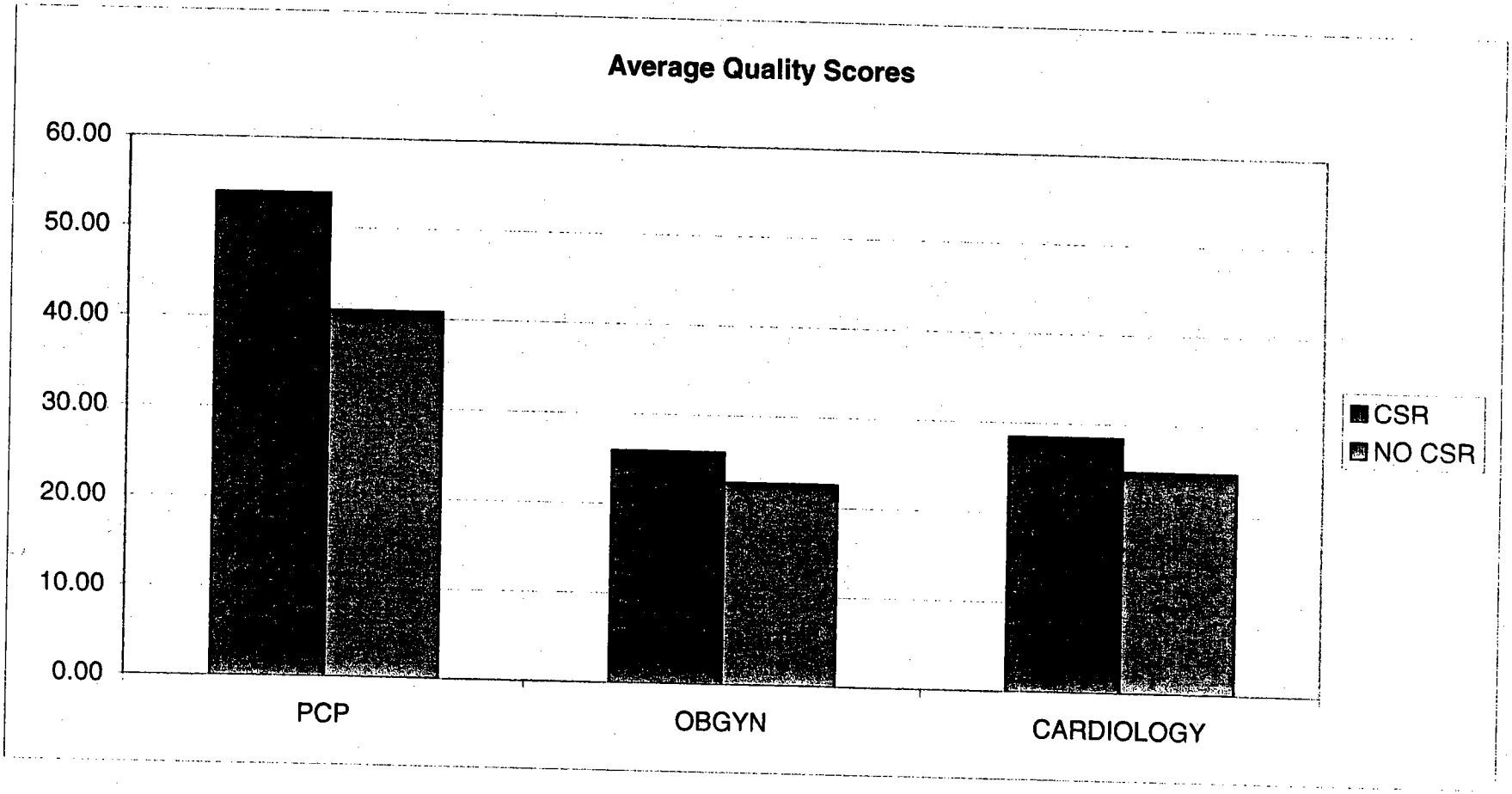


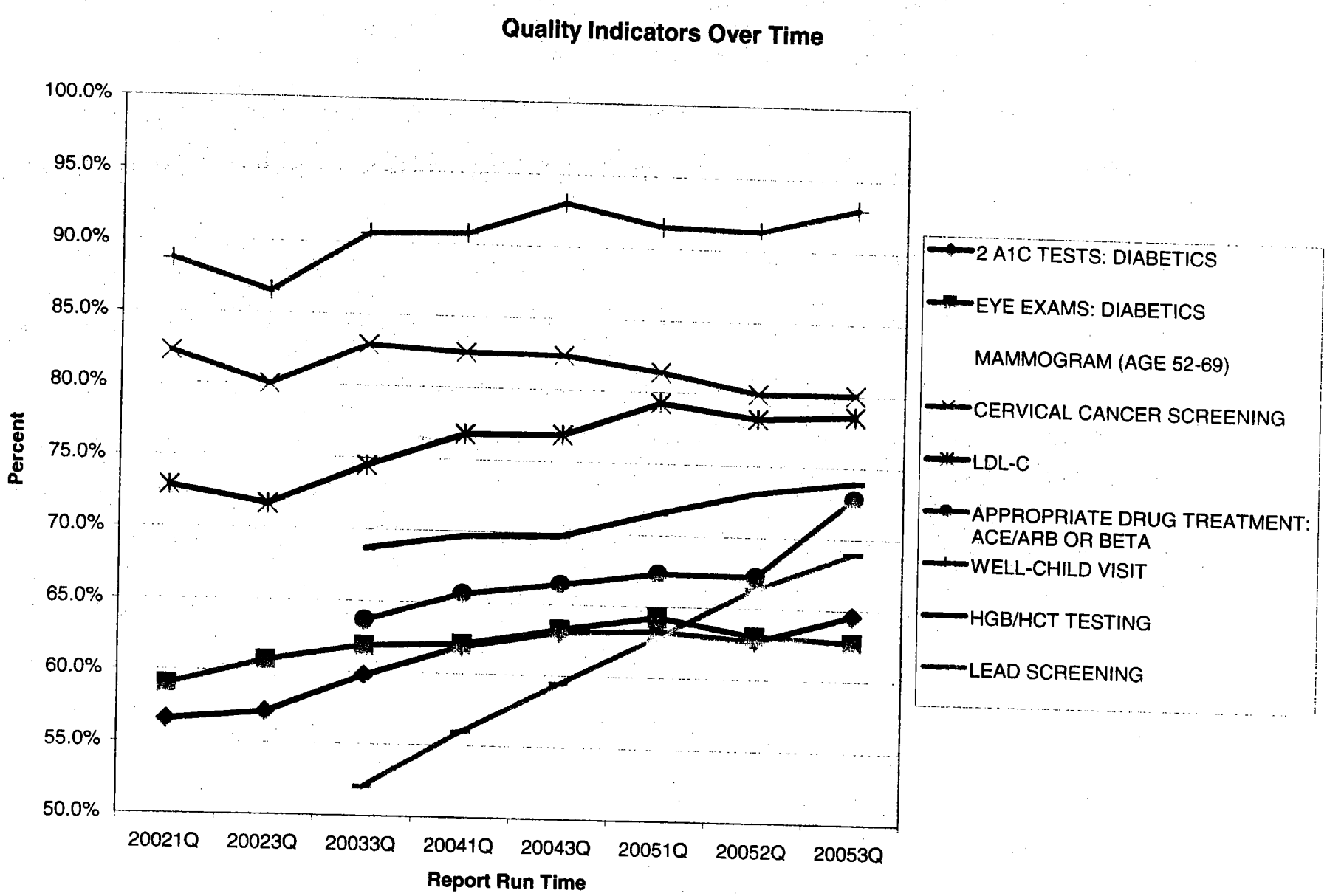

**AVERAGE CSR IMPACT ON RETURN BASED ON $5500 WITHHOLD**

| | CSR | NO CSR |
|---|---|---|
| PCP | $ 474.49 | -$318.08 |
| OBGYN | $ 47.69 | -$21.48 |
| CARDIOLOGY | $ 240.71 | -$123.21 |

GREATER ROCHESTER
GRIPA
INDEPENDENT PRACTICE
ASSOCIATION

# Average Quality Scores
# Only measures included in the Clinical Services Report
# 3 Qtr 2005




Quality Indicators Over Time
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Percent
20021Q
20023Q
20033Q
20041Q
20043Q
20051Q
20052Q
20053Q
Report Run Time
2 A1C TESTS: DIABETICS
EYE EXAMS: DIABETICS
MAMMOGRAM (AGE 52-69)
CERVICAL CANCER SCREENING
LDL-C
APPROPRIATE DRUG TREATMENT: ACE/ARB OR BETA
WELL-CHILD VISIT
HGB/HCT TESTING
LEAD SCREENING

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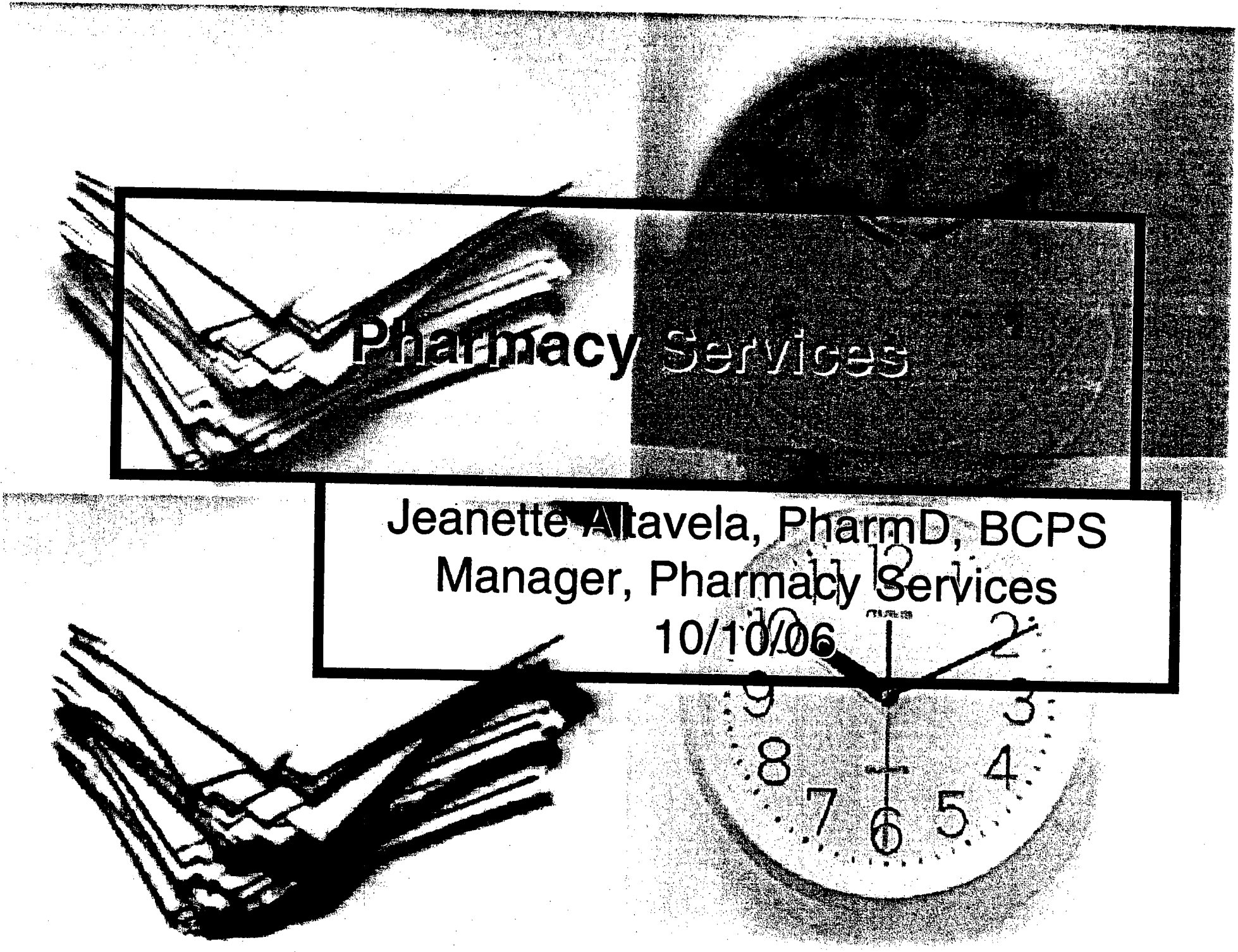
GRIPA

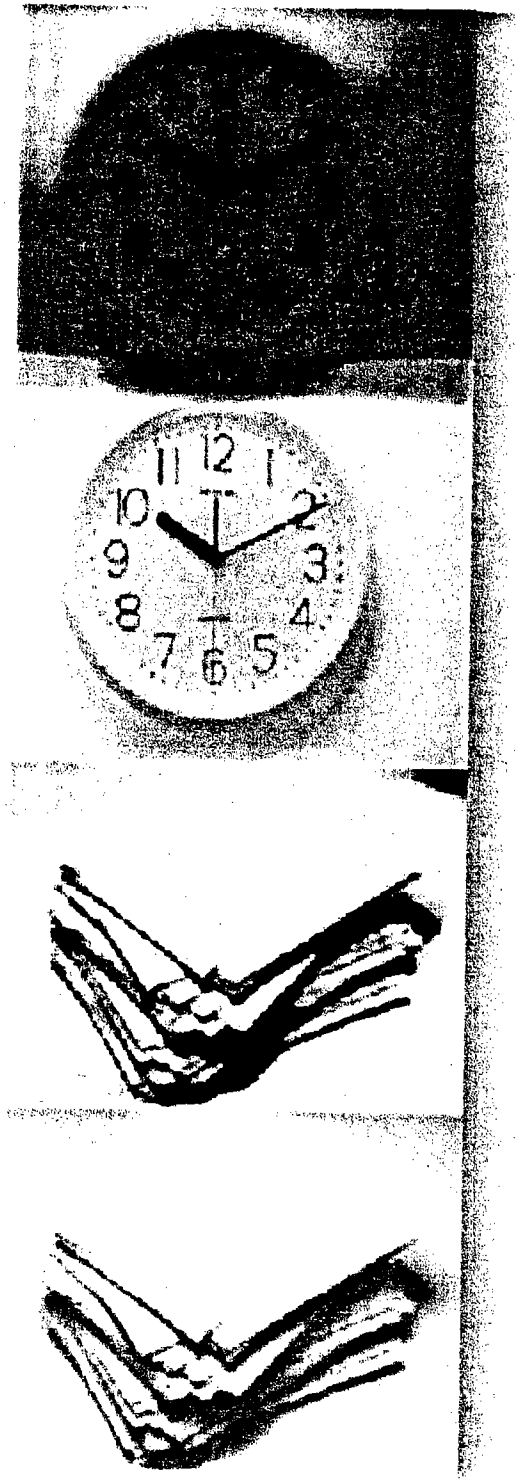
INDEPENDENT PRACTICE ASSOCIATION

| MEASURES | 20021Q | 20023Q | 20033Q | 20041Q | 20043Q | 20051Q | 20052Q | 20053Q |
|---|---|---|---|---|---|---|---|---|
| 2 A1C TESTS: DIABETICS | 56.6% | 57.1% | 59.8% | 61.9% | 63.0% | 63.2% | 62.7% | 64.6% |
| EYE EXAMS: DIABETICS | 59.0% | 60.7% | 61.9% | 62.1% | 63.2% | 64.2% | 63.0% | 62.7% |
| MAMMOGRAM (AGE 52-69) | 76.0% | 75.3% | 76.9% | 75.9% | 76.5% | 77.0% | 76.9% | 77.8% |
| CERVICAL CANCER SCREENING | 82.2% | 80.0% | 82.9% | 82.4% | 82.4% | 81.4% | 80.0% | 80.0% |
| LDL-C | 72.8% | 71.6% | 74.4% | 76.8% | 76.9% | 79.2% | 78.3% | 78.5% |
| APPROPRIATE DRUG TREATMENT: ACE/ARB OR BETA | | | 63.6% | 65.6% | 66.4% | 67.3% | 67.2% | 72.8% |
| WELL-CHILD VISIT | 88.7% | 86.5% | 90.6% | 90.8% | 93.0% | 91.5% | 91.3% | 92.9% |
| HGB/HCT TESTING | | | 68.7% | 69.6% | 69.8% | 71.5% | 73.1% | 73.9% |
| LEAD SCREENING | | | 52.0% | 55.9% | 59.4% | 62.8% | 66.3% | 68.9% |



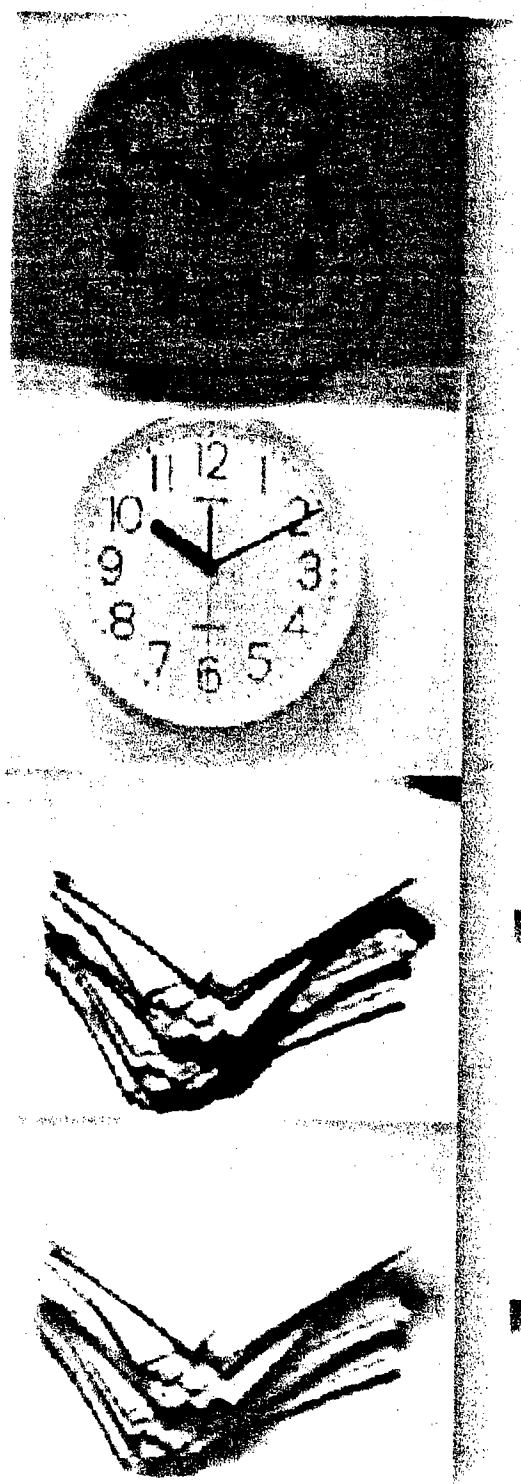
# Pharmacy Services

Jeanette Atavela, PharmD, BCPS
Manager, Pharmacy Services
10/10/06



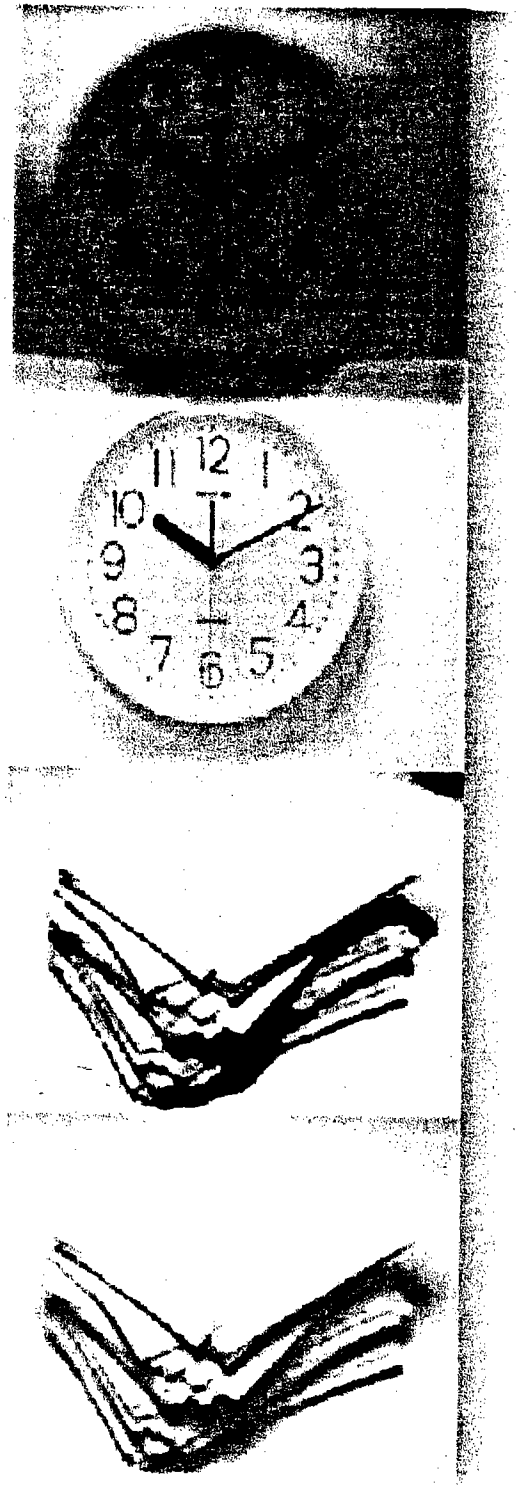
# Clinical Pharmacy Services (3 clinical pharmacists)

- Purpose
  - To optimize medication therapy in the community
  - To decrease overall health care costs
  - To provide education to patients about medications
  - To provide education to prescribers about medications



# Pharmacy Services

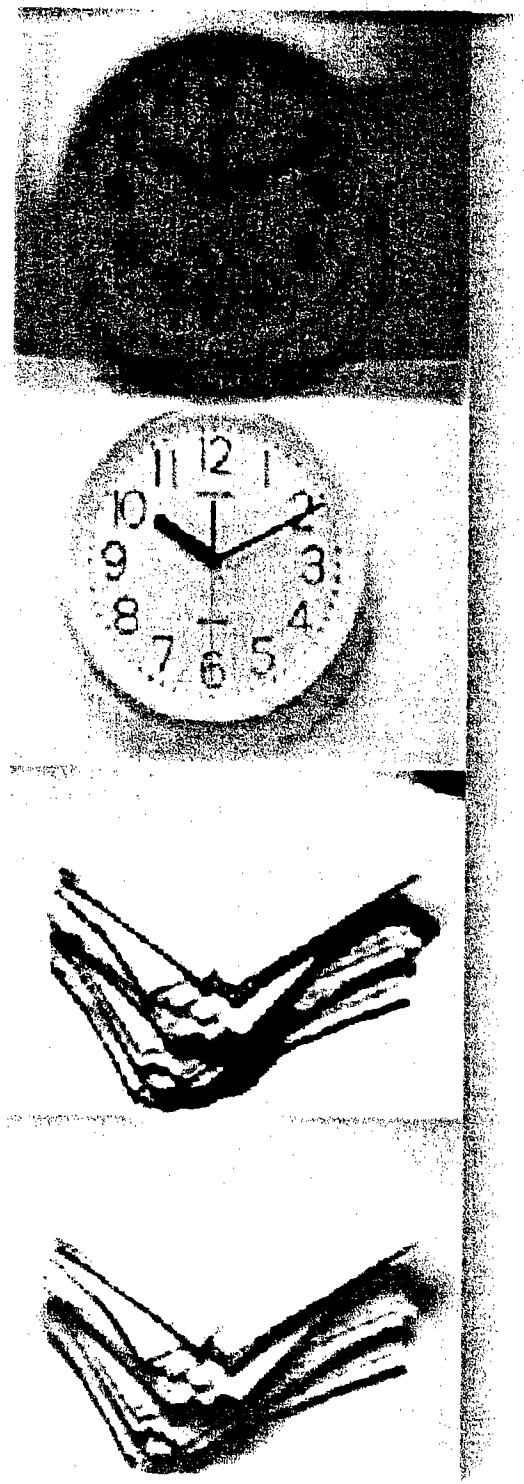
- **Proactive Pharmacy services**
  - GRIPA Primary Care Offices
    - Proactive Medication Reviews
    - Diabetes Group Visits
  - Independent Living for Seniors (ILS)
    - Proactive Medication Reviews
    - Provide Education to ILS staff
- **Pharmacy Consults**
  - Requested patient consults
    - Any GRIPA physician
    - Family member or GRIPA staff driven
- **Education**



# Criteria for proactive reviews

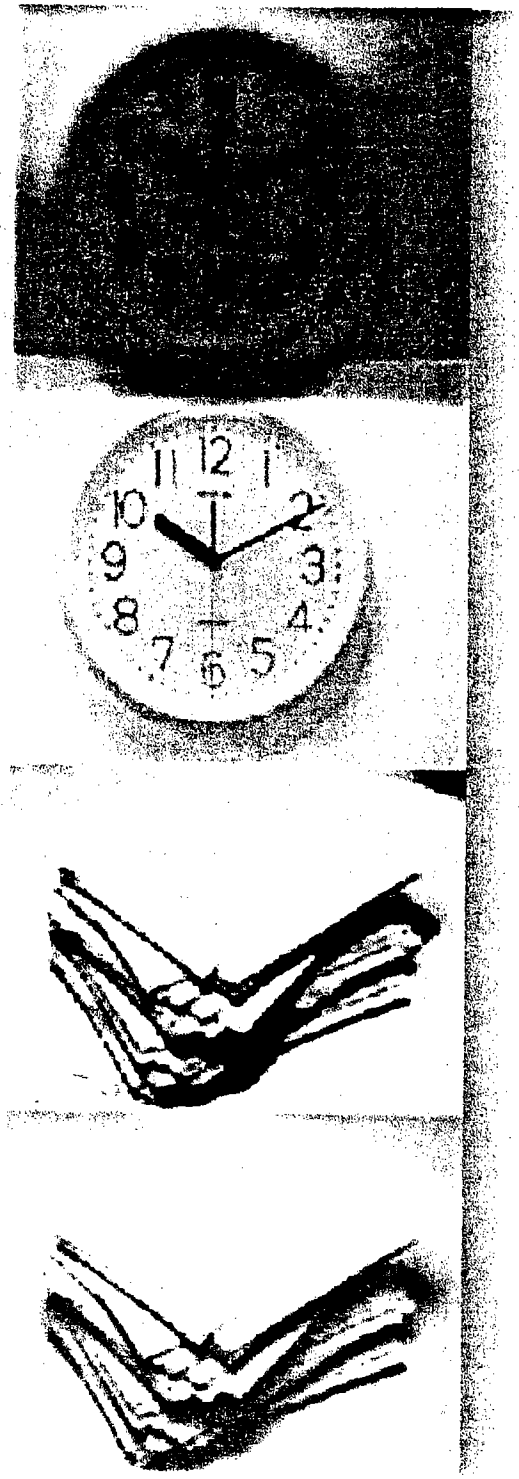
- Diabetes
- CHF
- COPD
- CAD
- Asthma
- Risk Score > 2.6
- > 80 years old
- Morbidity without any follow up
- Patients attending DM group visits

Not ILS criteria



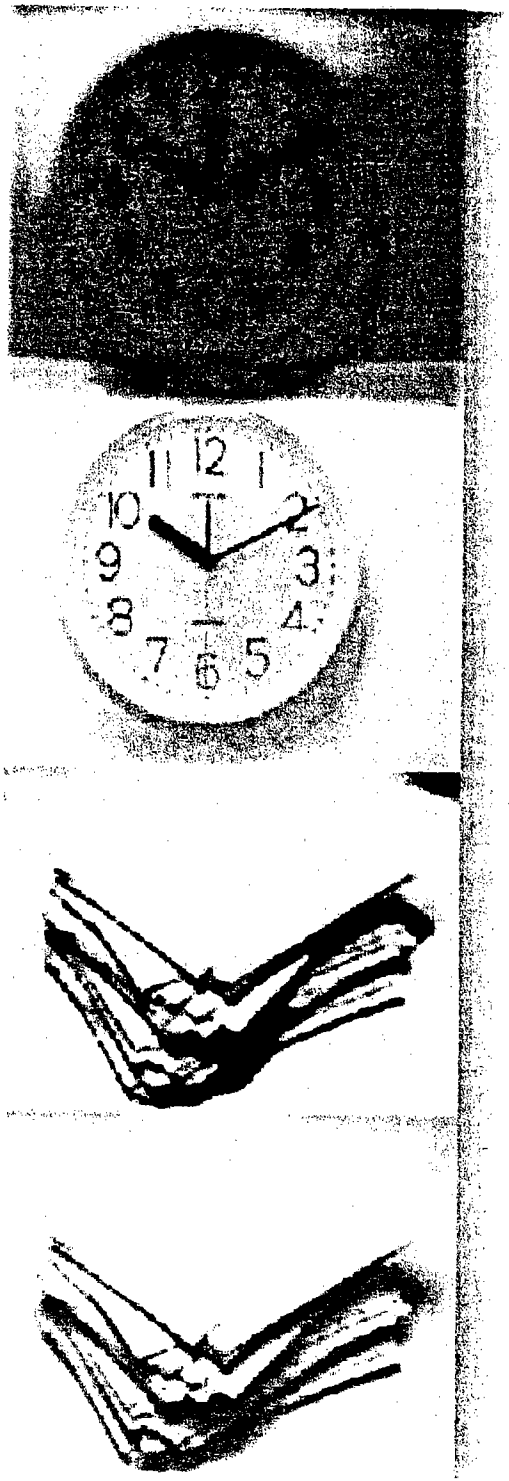
# Physicians receiving consults from clinical pharmacists Jan-June 2006 (n=46)

- **Proactive Pharmacy Services:**
  - 29 physicians + 3 ILS providers
    - Majority are Via-employed physicians
    - Generally 20 -100 patients over 6 months
- **Pharmacy Consults:**
  - 14 physicians (1 specialist)
    - Each had less than 10 patient consults

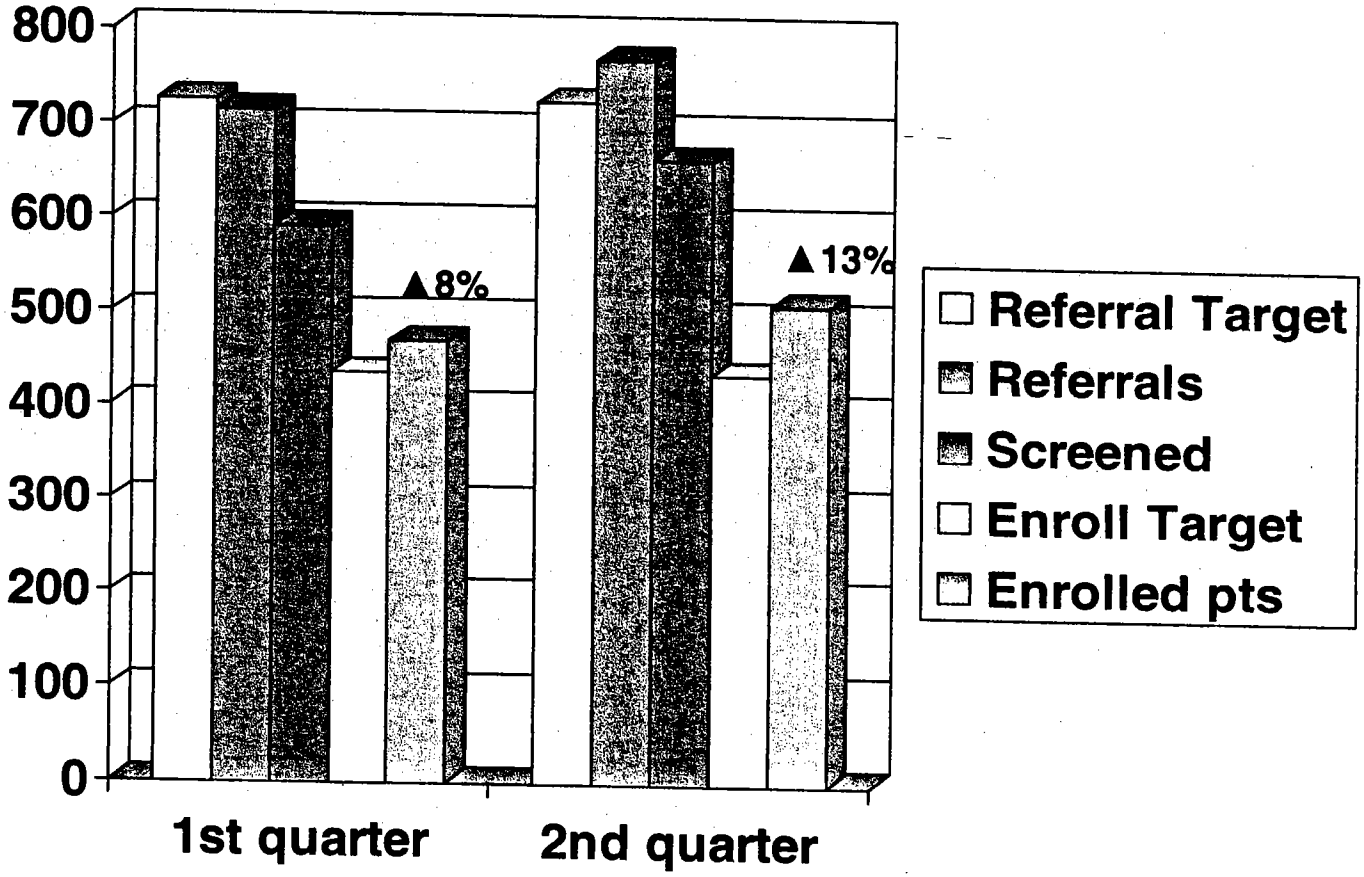


# Physicians receiving consults from clinical pharmacists Jan-June 2006 (n=46)

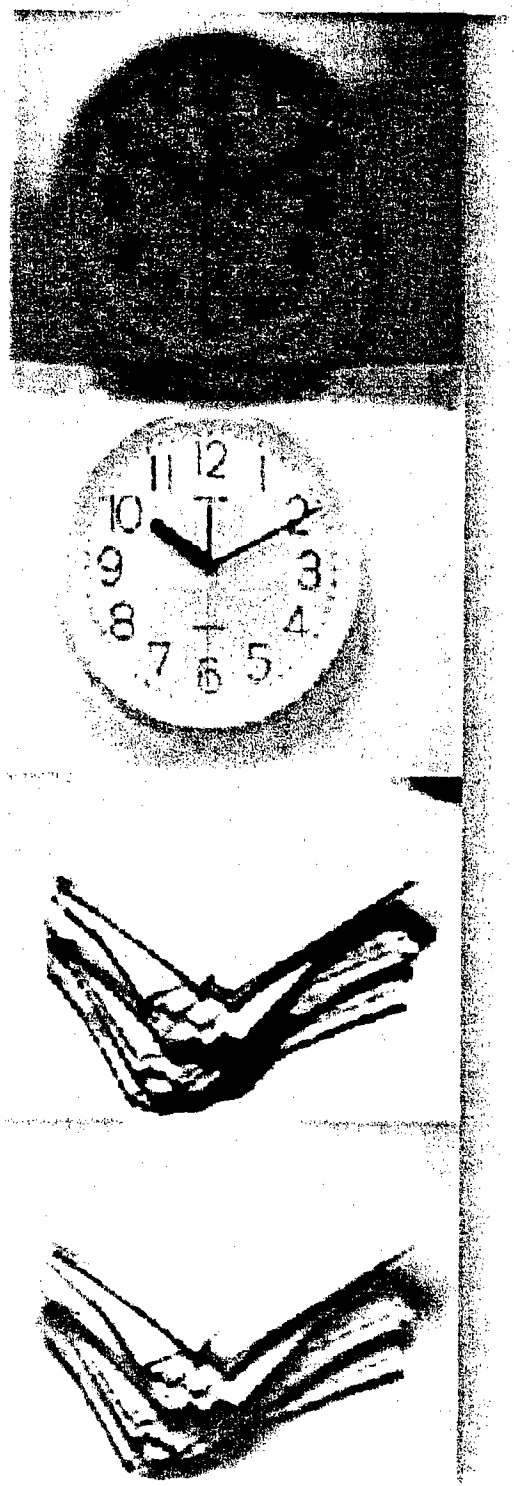
- 20 % of GRIPA primary care physicians
- 21% of these physicians signed up for Clinical Integration; will increase to 84% when ViaHealth signs



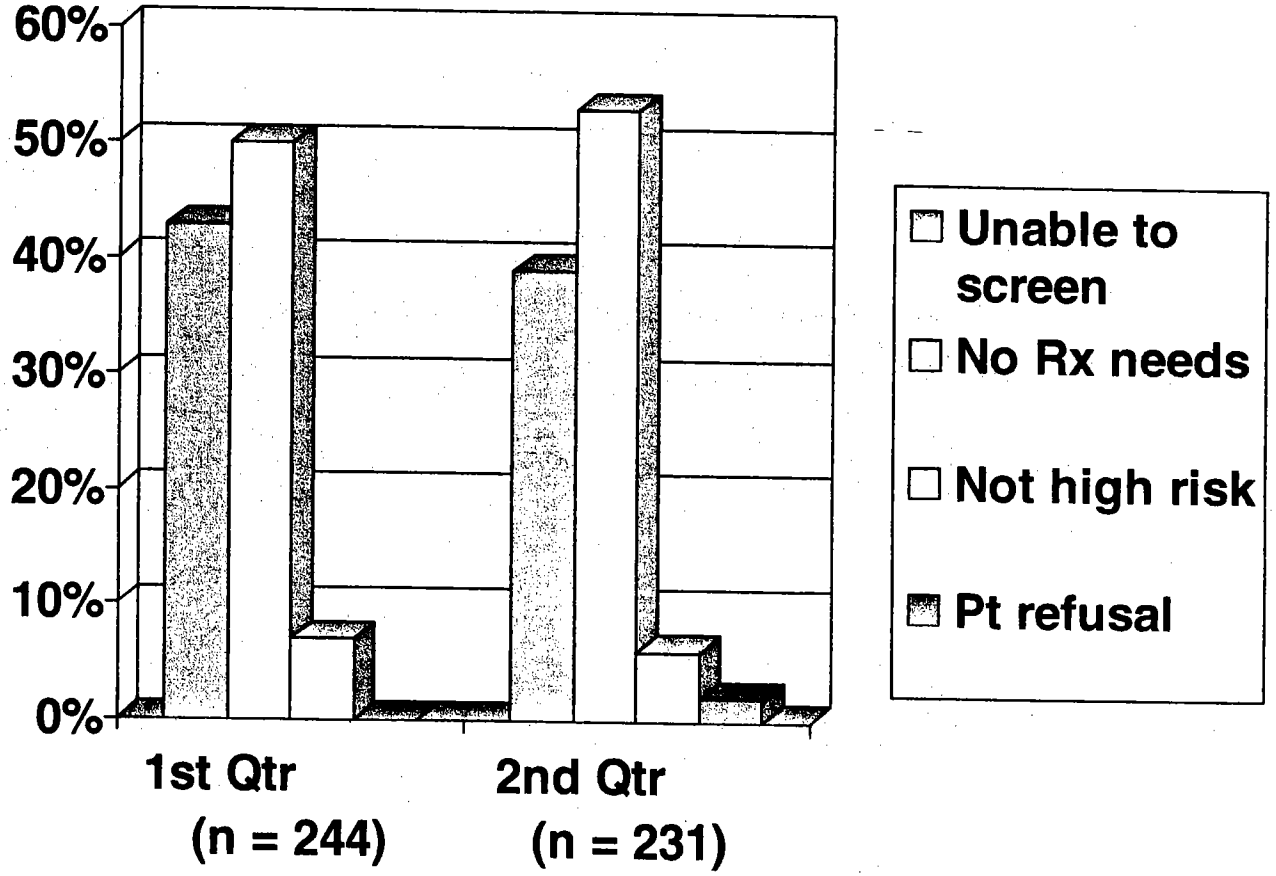
# Enrollment exceeded Targets

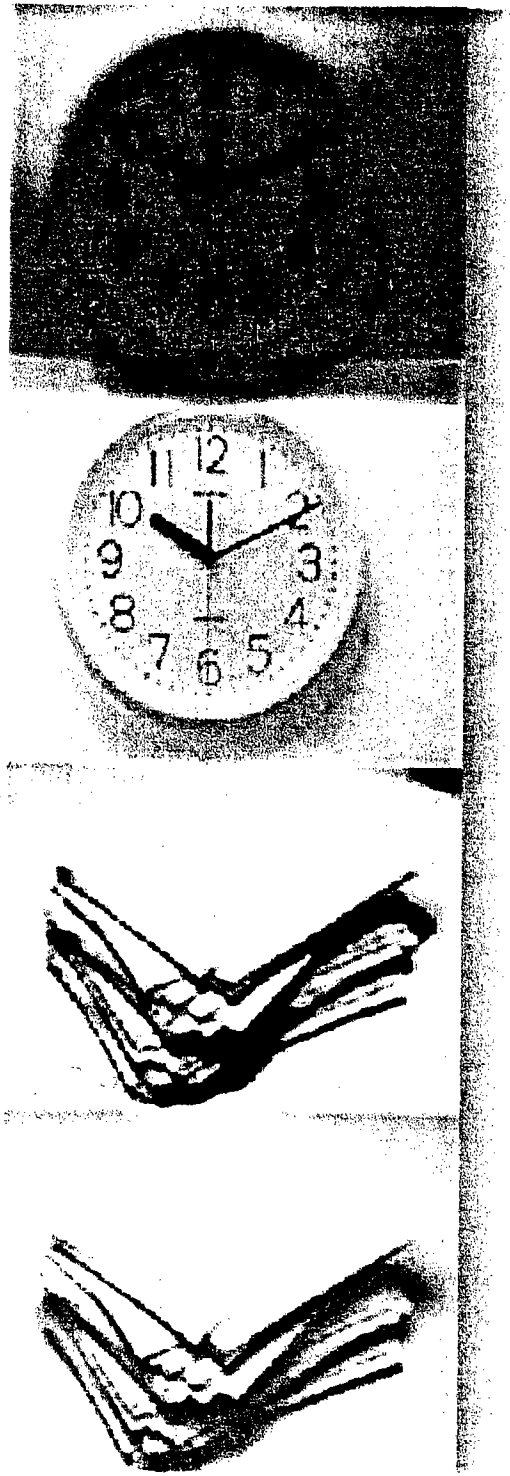



75% of patients that were screened were enrolled

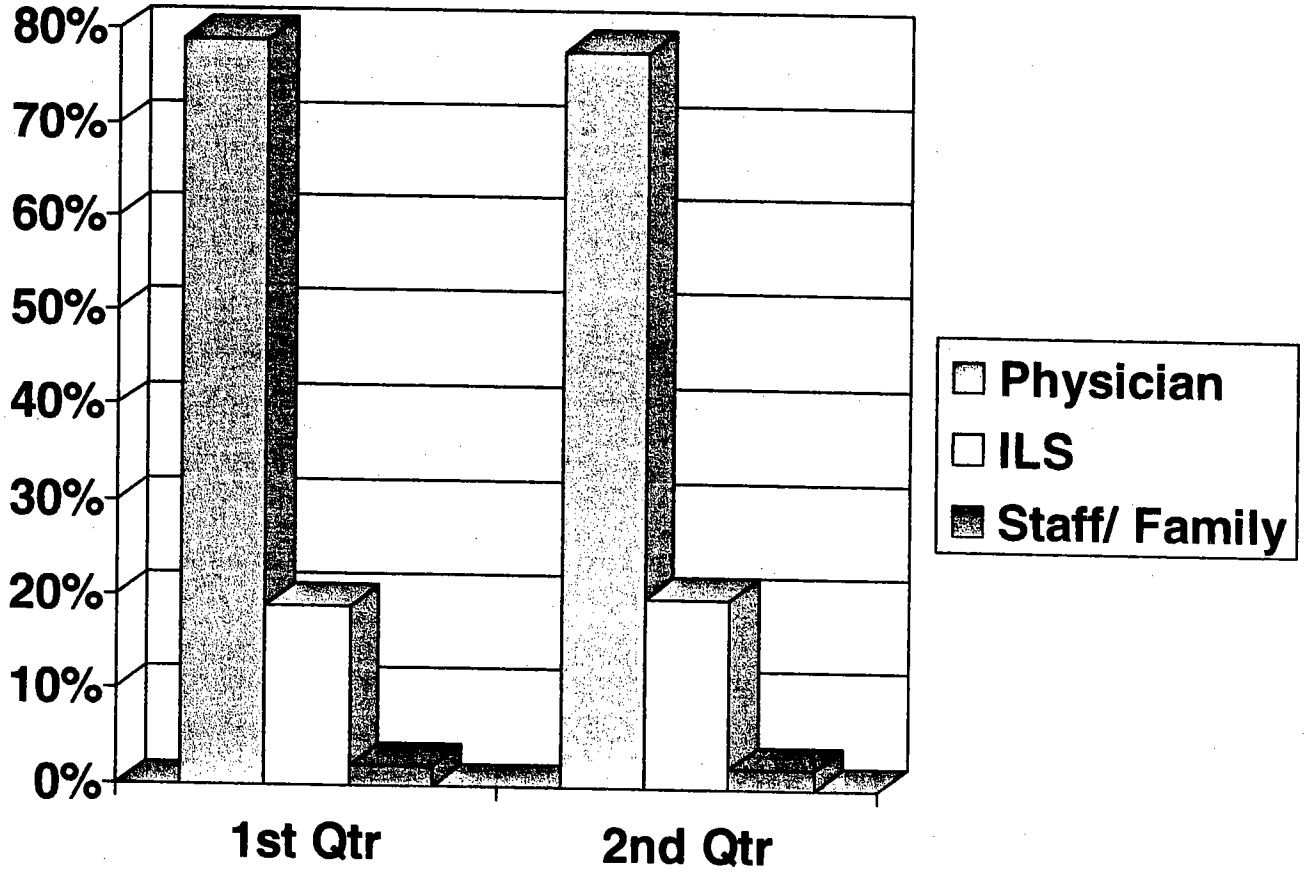


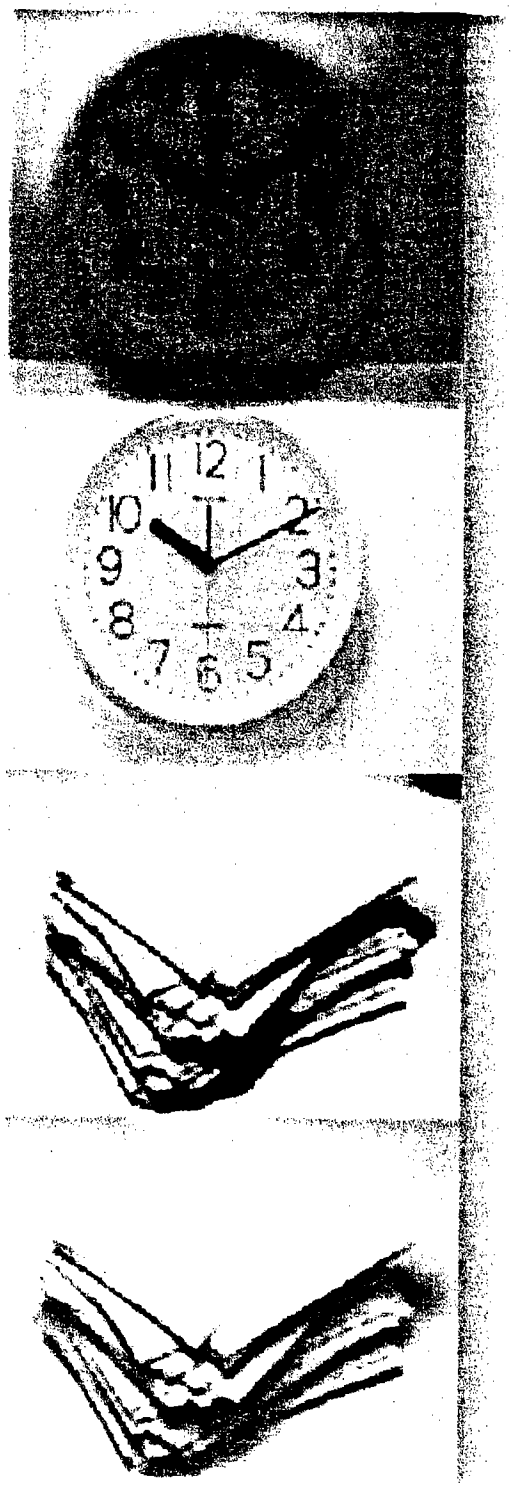
# For the 25% not enrolled; The reasons....



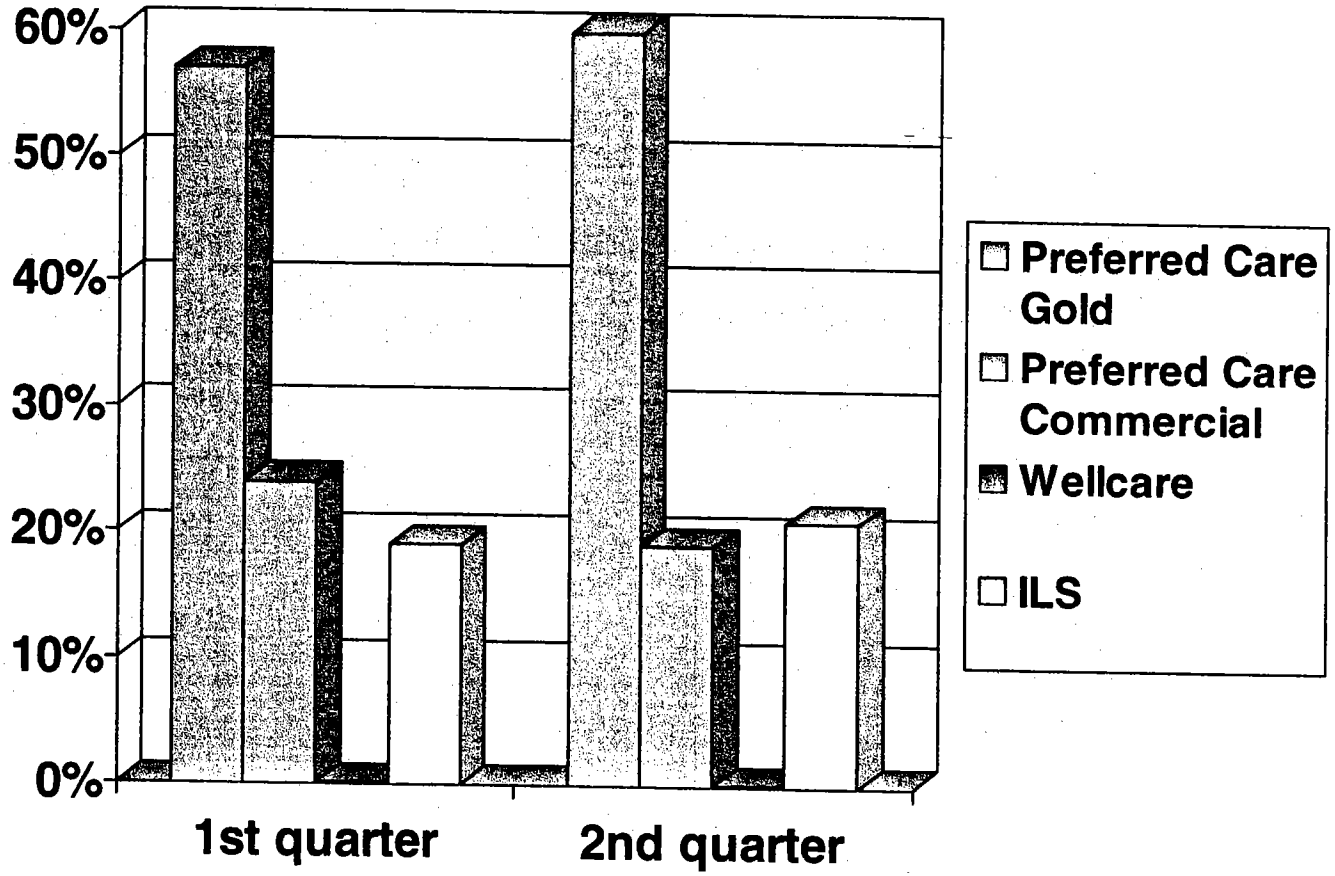


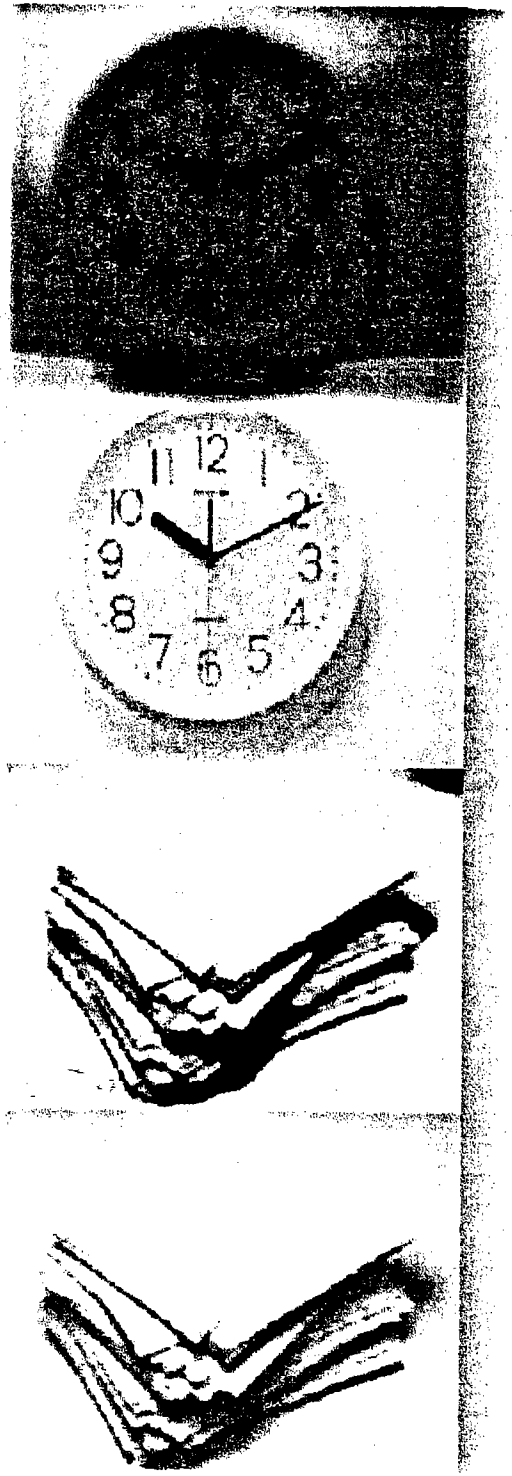
# Where did referrals come from?



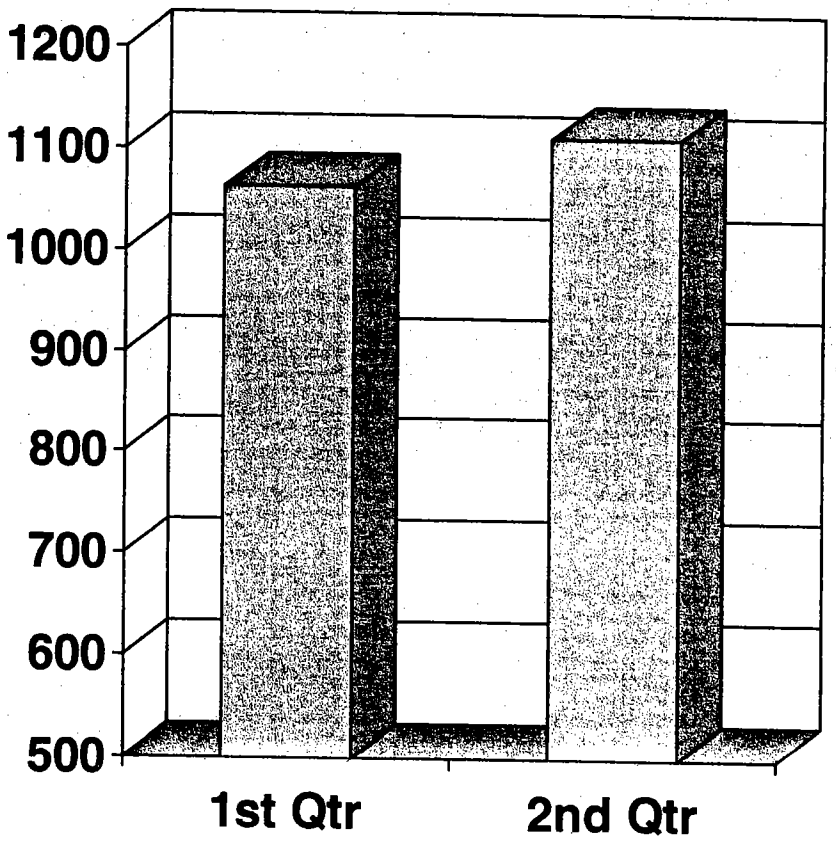


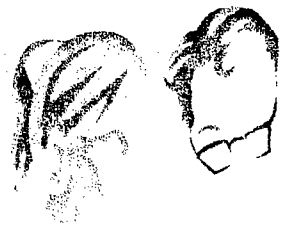
# Which patients?

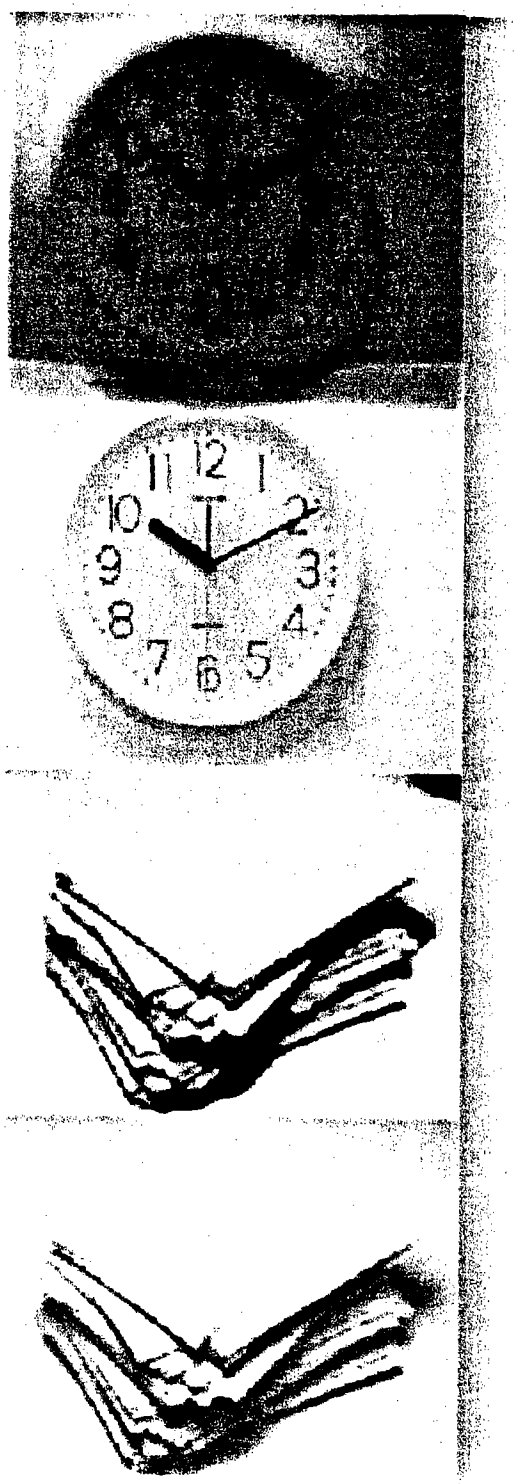




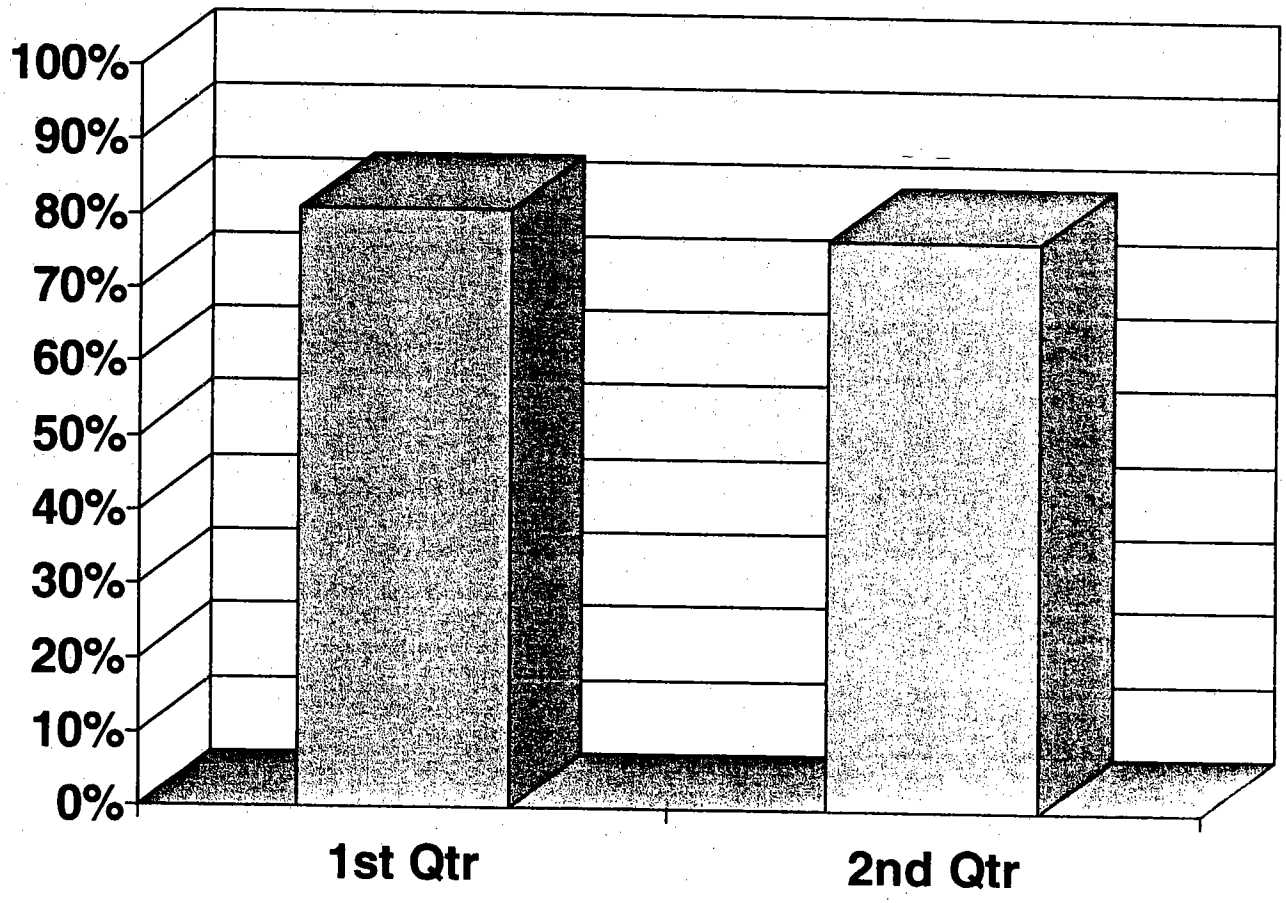
# How many recommendations were made to physicians?

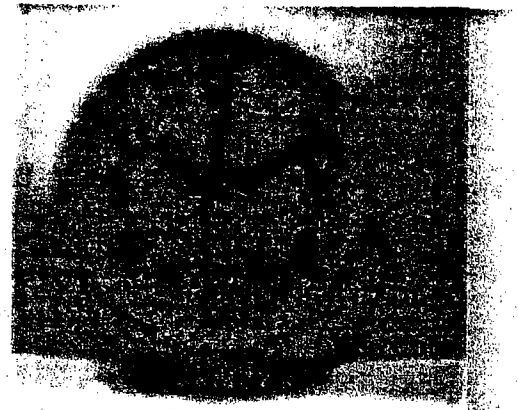


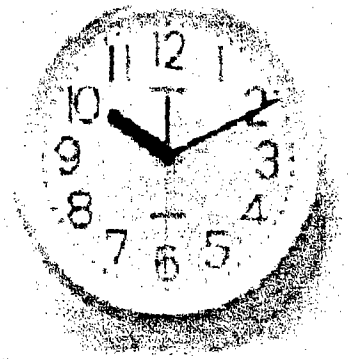





# Acceptance Rate:

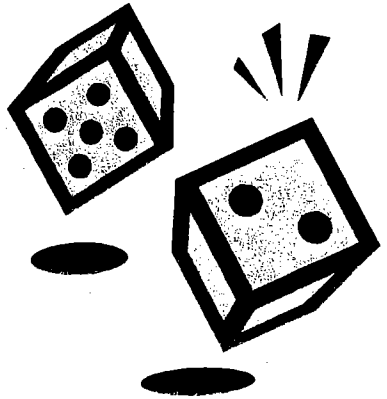




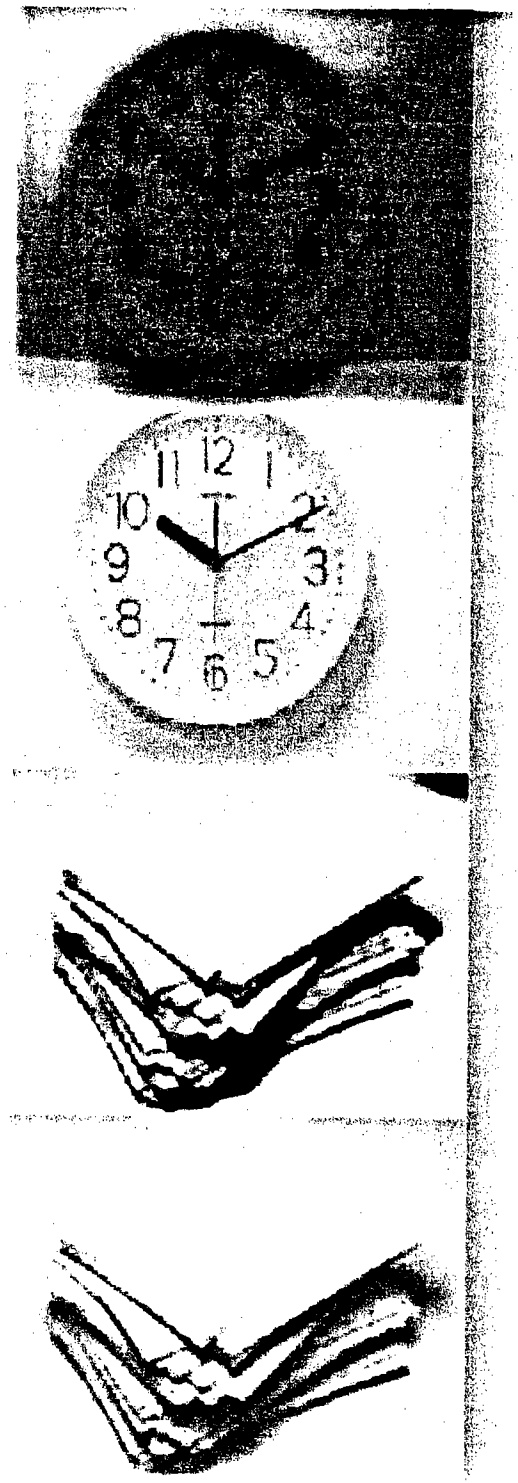


How much more likely is a medication issue recognized and addressed when a clinical pharmacist reviewed chart?

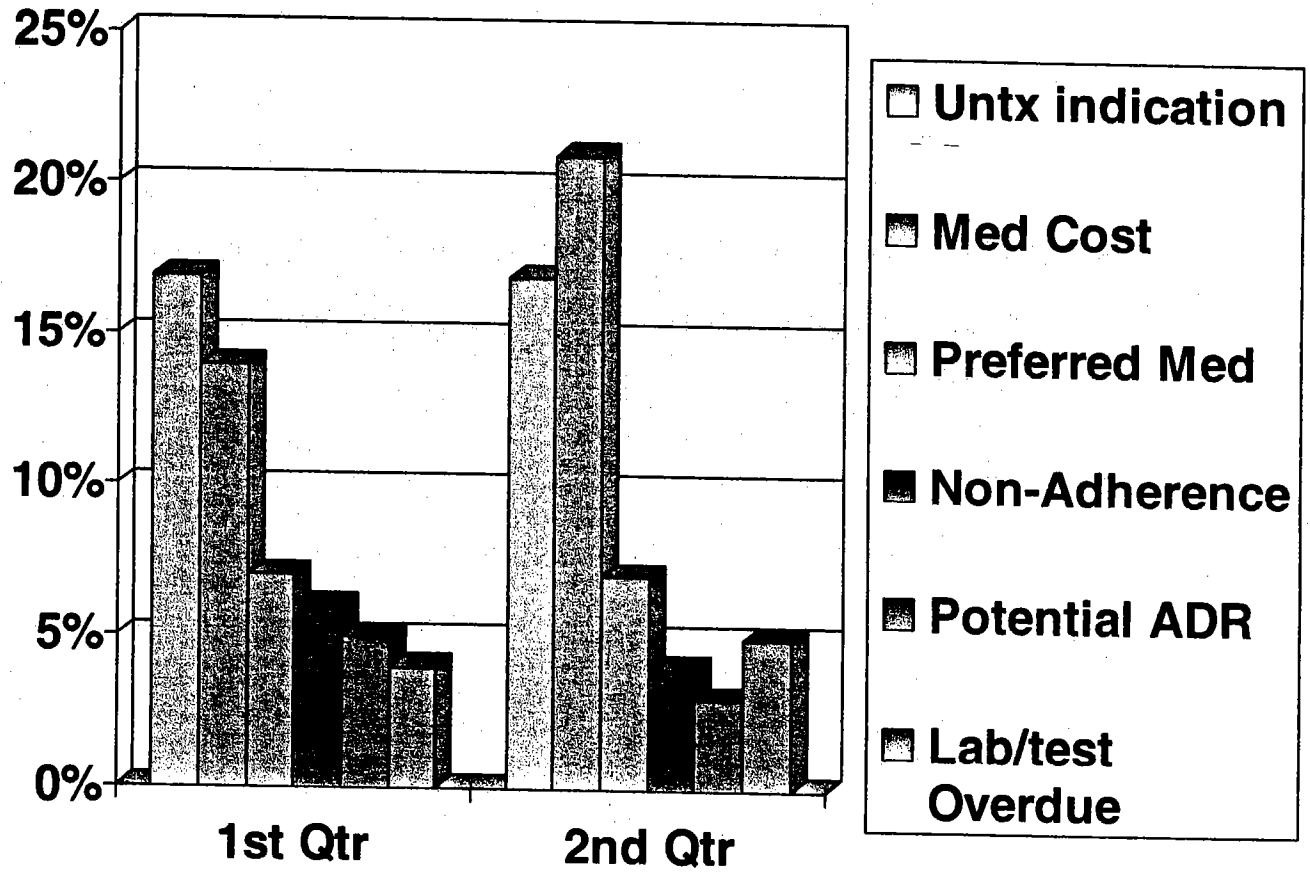
- Untreated Indication – 6 x's
- Medication Cost Reduction – 12 x's
- Preferred Medication – 10 x's
- Medication Adherence > 2x's
- Drug interaction - > 3 x's



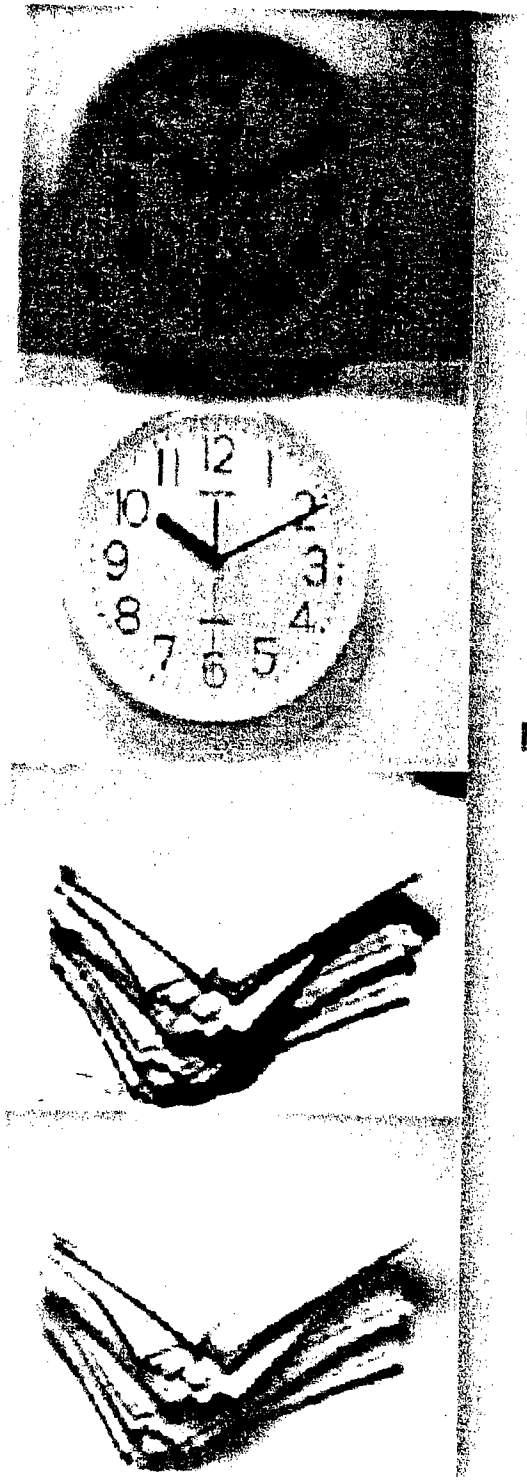
Data from Rochester, NY
Pharmacotherapy 2004;24 (10):1476.



# Top 5 Medication recommendations

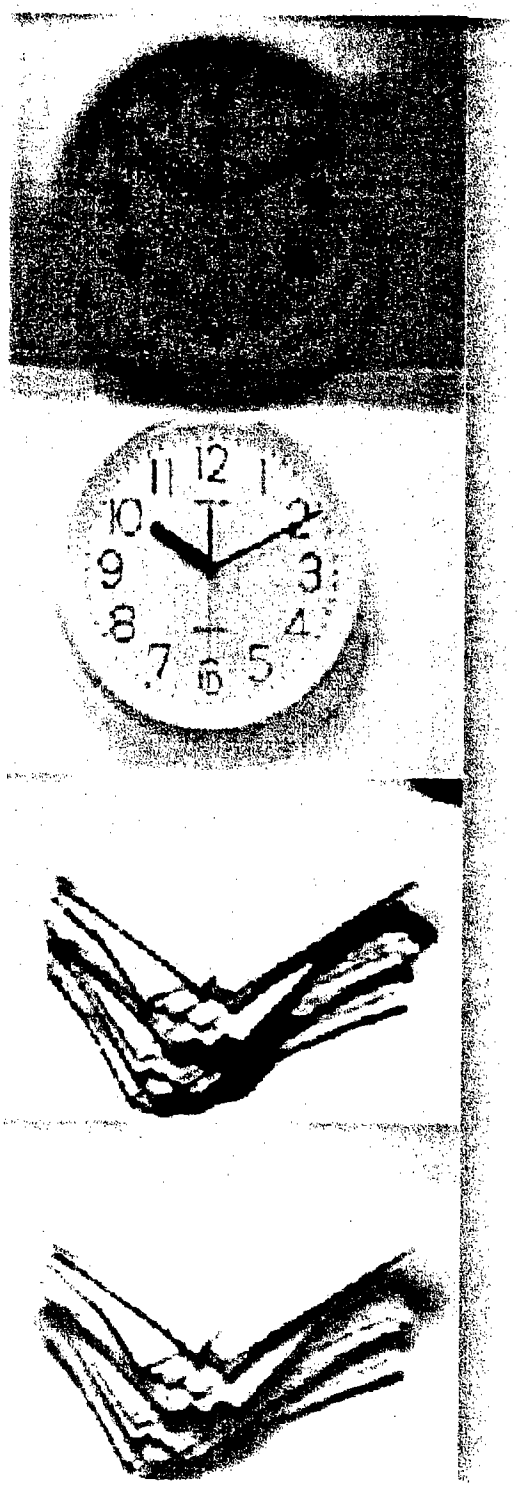



These were over 50% of the total recommendations



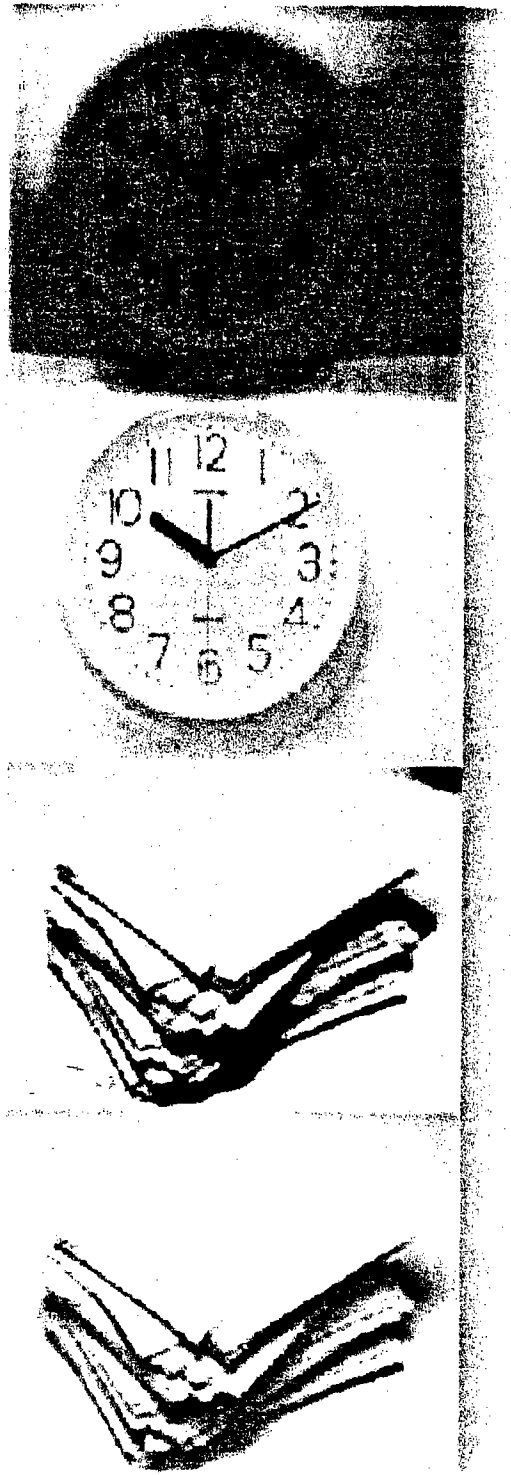
# Estimated Cost Savings

- Out of pocket cost savings for patients
  - > $18,000 in 6 months
- Cost Avoidance estimates are over $200,000



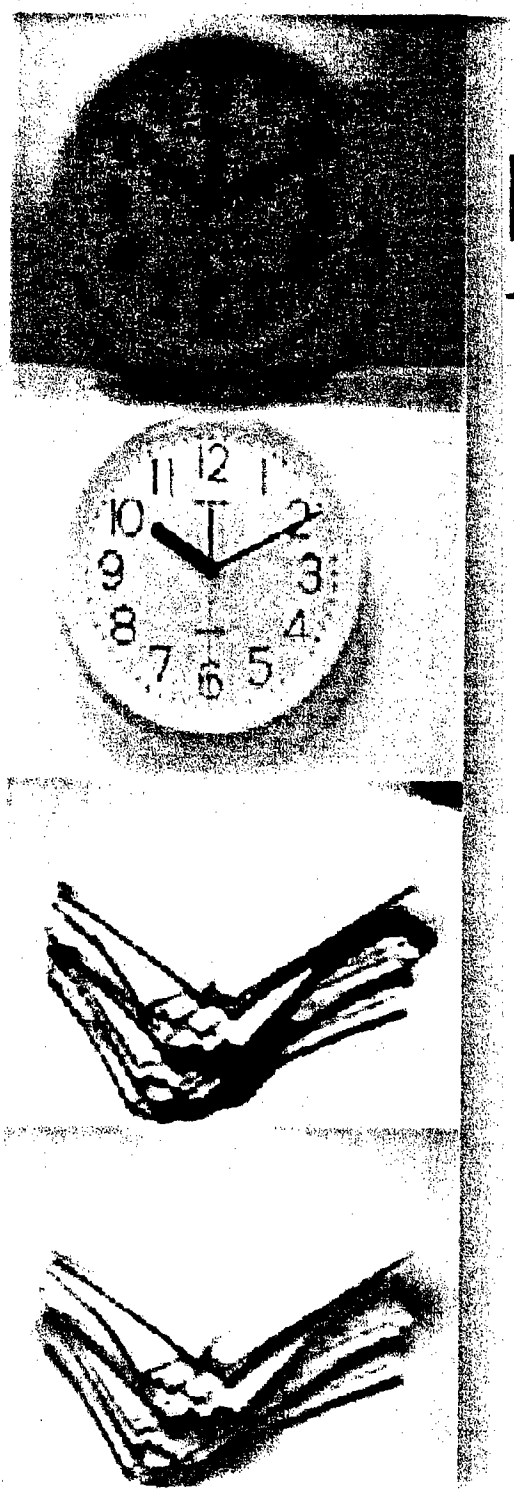
# Physician Time saved

- Pharmacists provide pertinent information at physicians fingertips proactively
- Pharmacists work with patients beyond their appointment
- Pharmacists provide on the spot answers or research answers to pertinent clinical questions
- Pharmacists provide physician and patient tools available “on line”



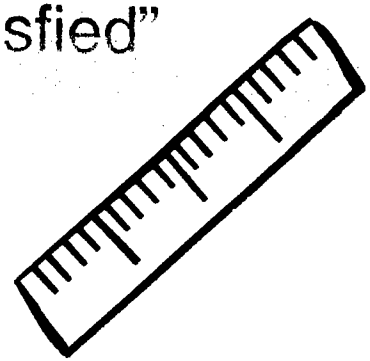
# Education:

- Pharmacy Tidbits Monthly
  - Insomnia Medication
    - New medications/costs
  - New Prescription Laws
    - Help facilitate / save physicians time
  - Diabetes Care and Group Visit
    - Common patient misunderstandings affecting adherence
  - Media Hype
    - Teach physicians resources to use
    - Show resulting effects on medication adherence

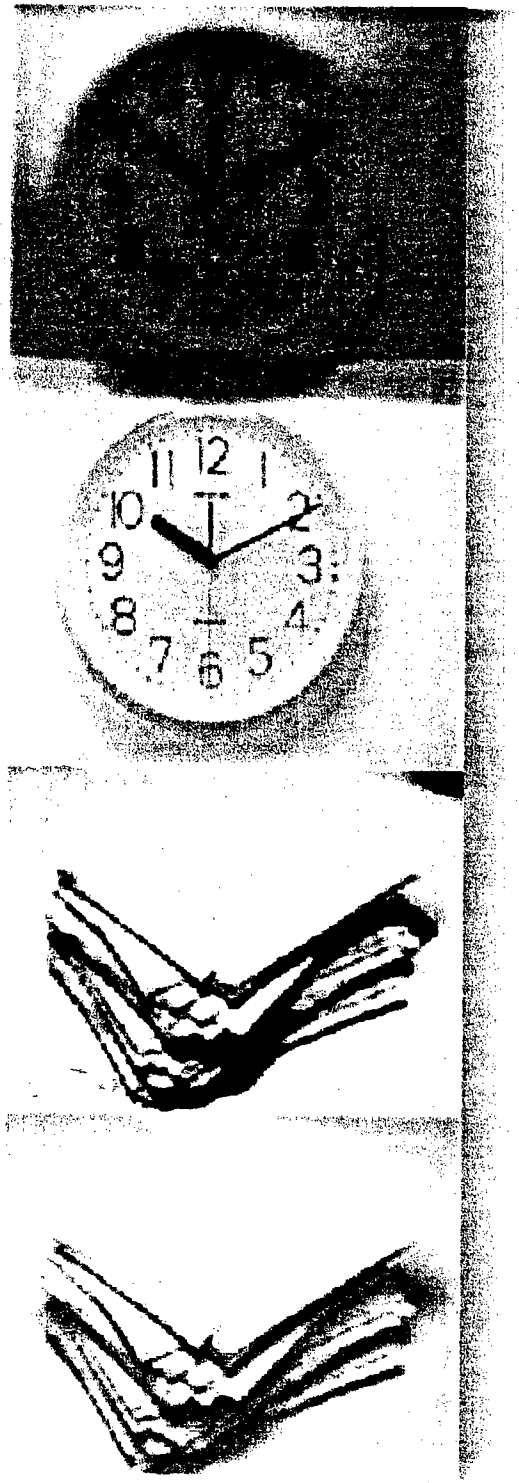


# Did they like what they got?

10 point scale, where 10 = "very satisfied"

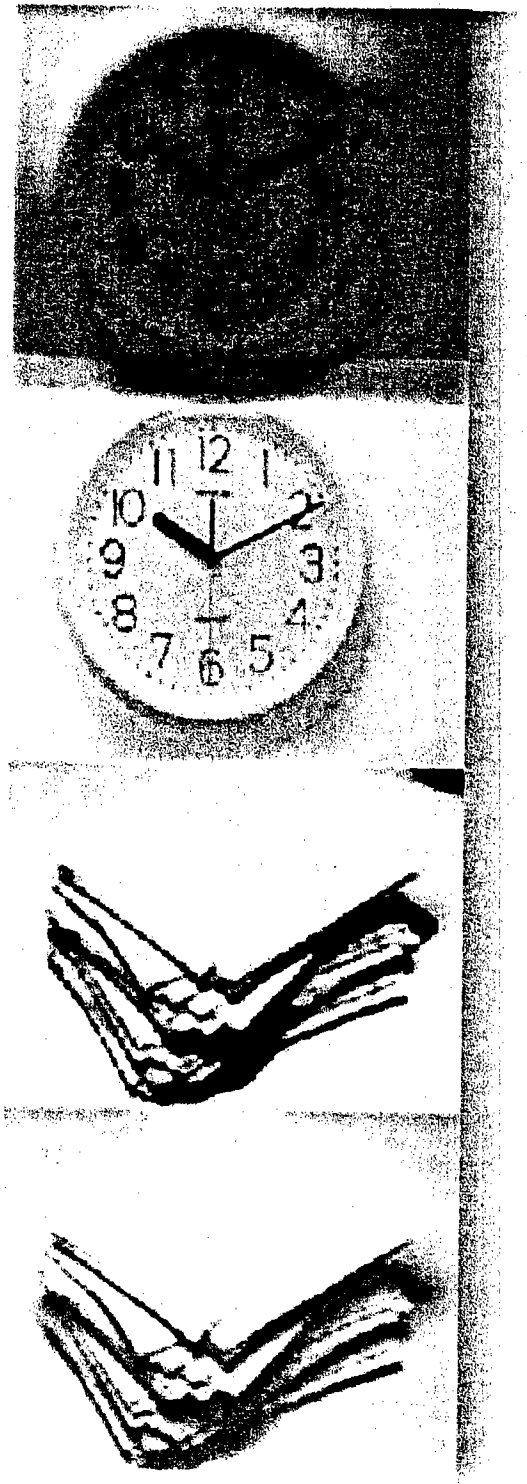


- Patient Satisfaction
  - 1st quarter: 10 out of 10
  - 2nd quarter: 9 out of 10
- Physician Satisfaction
  - 1st quarter: 8 out of 10
  - 2nd quarter: 10 out of 10



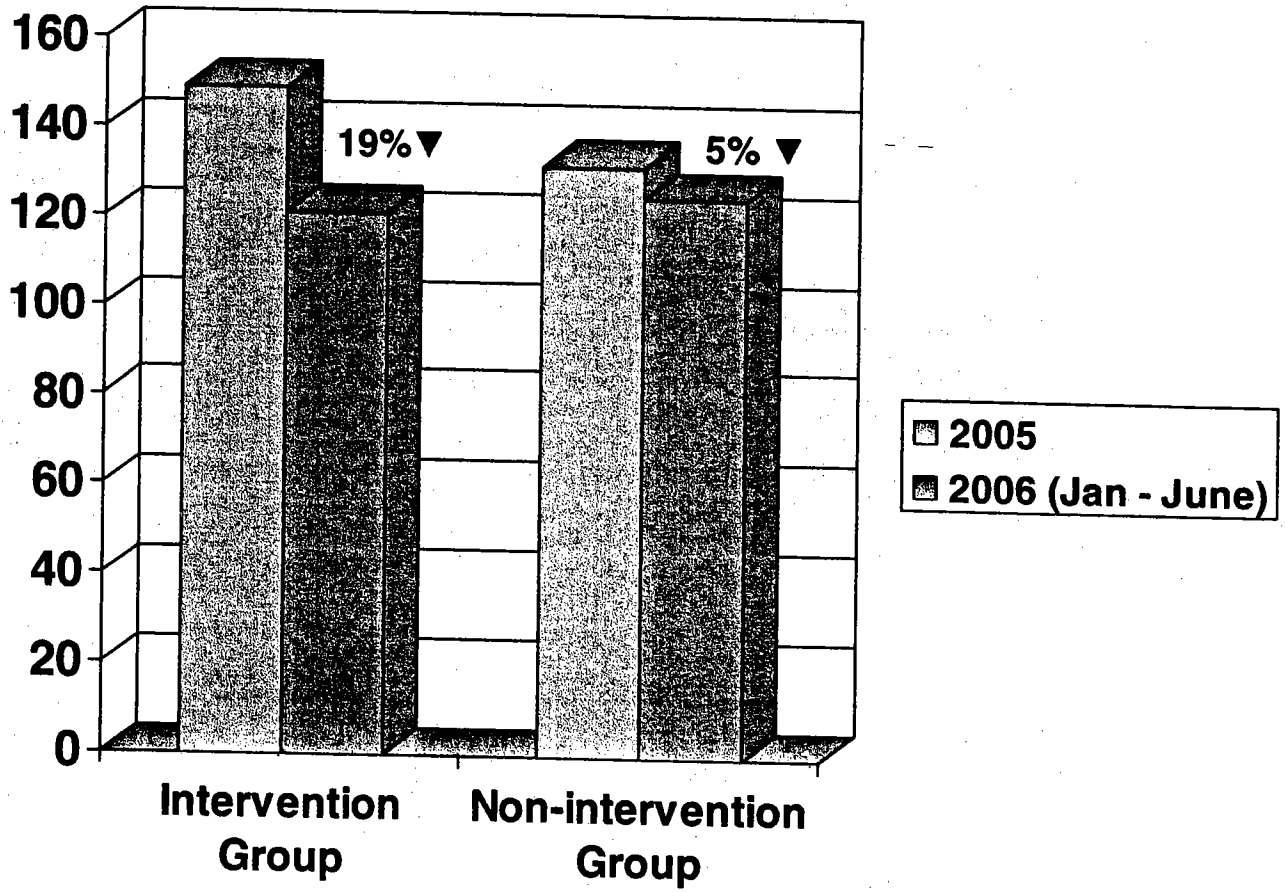
# Outcome data pearls:

- The "intervention" group has generally always been a higher cost/risk group of patients
- The following data looks at practices as a whole
  - not just the patients intervened with by the pharmacist
- The education we do reaches more than "intervention" practices

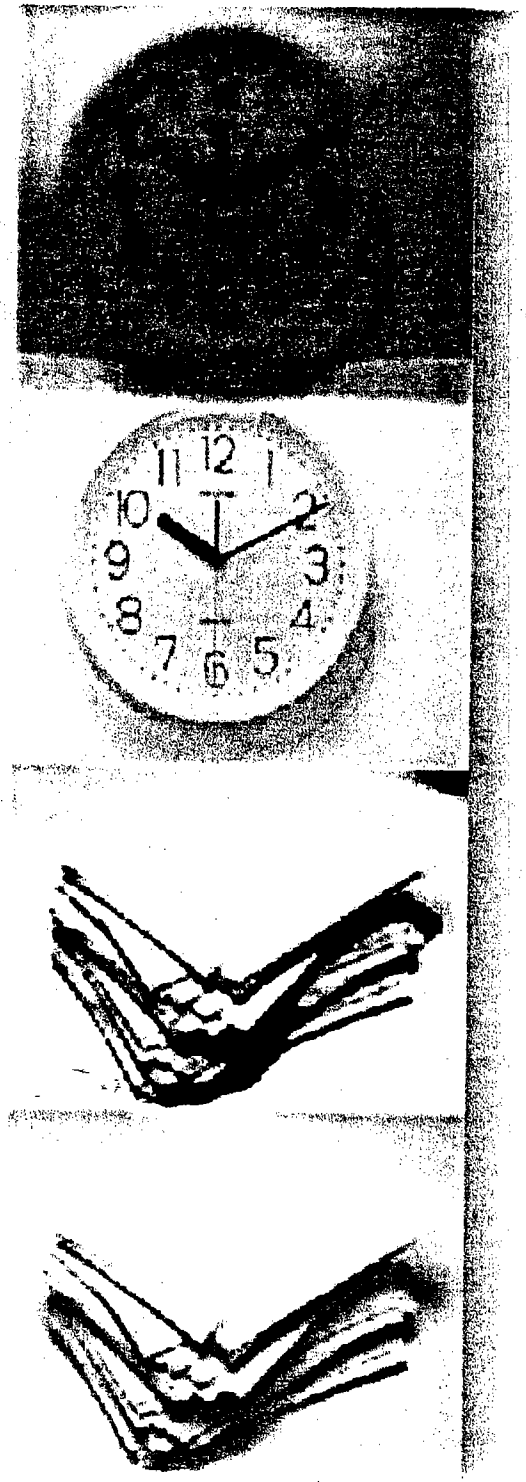


# ED admissions/1000

## Preferred Care Commercial

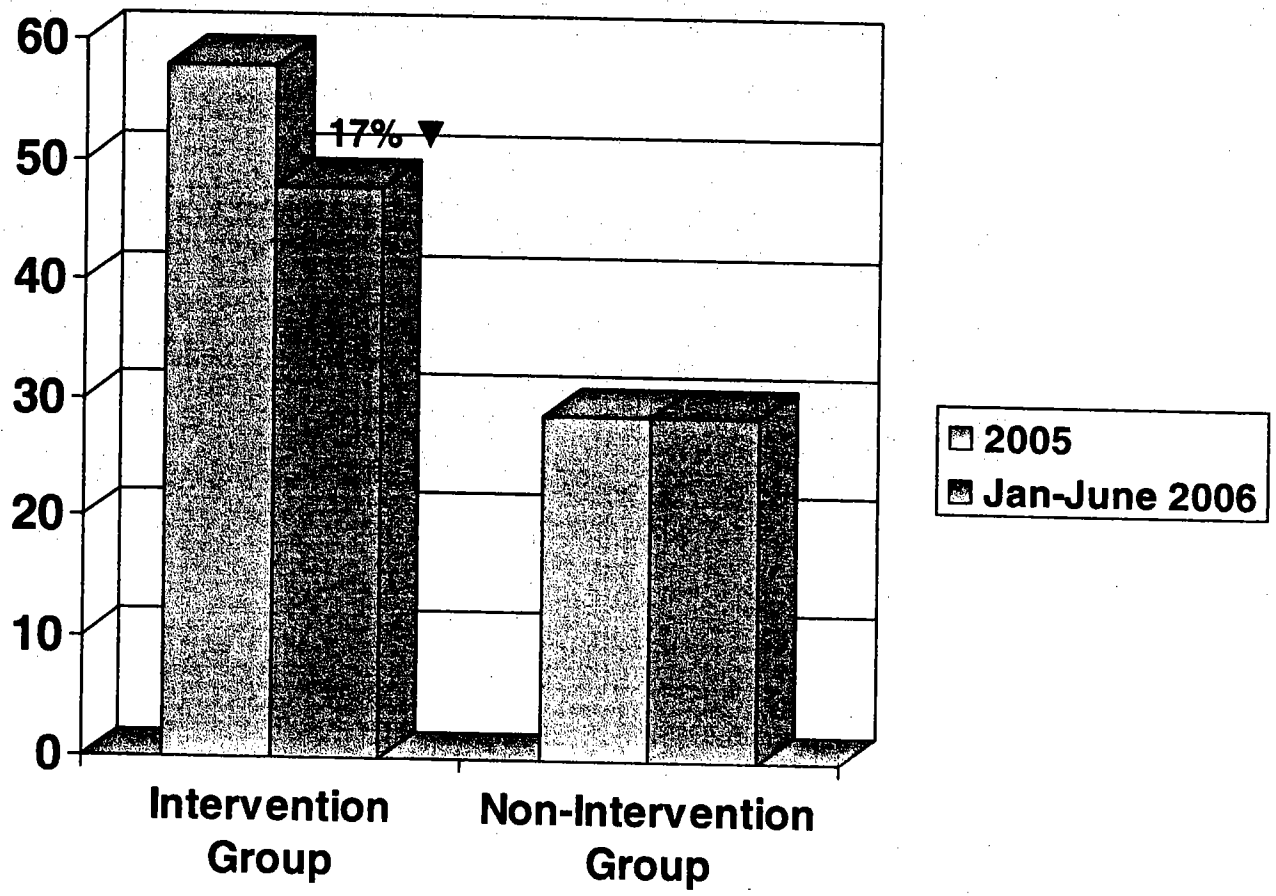


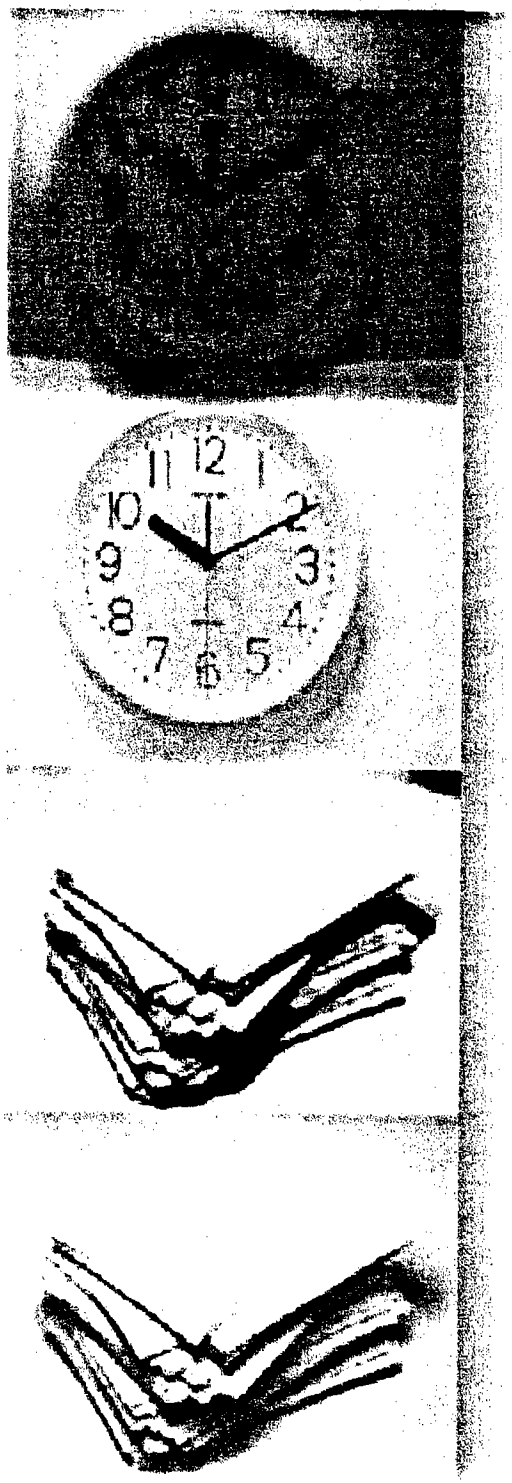

Intervention Group n ≈ 3,000
Non-intervention Group n ≈ 30,000



# Hospital Admissions/1000

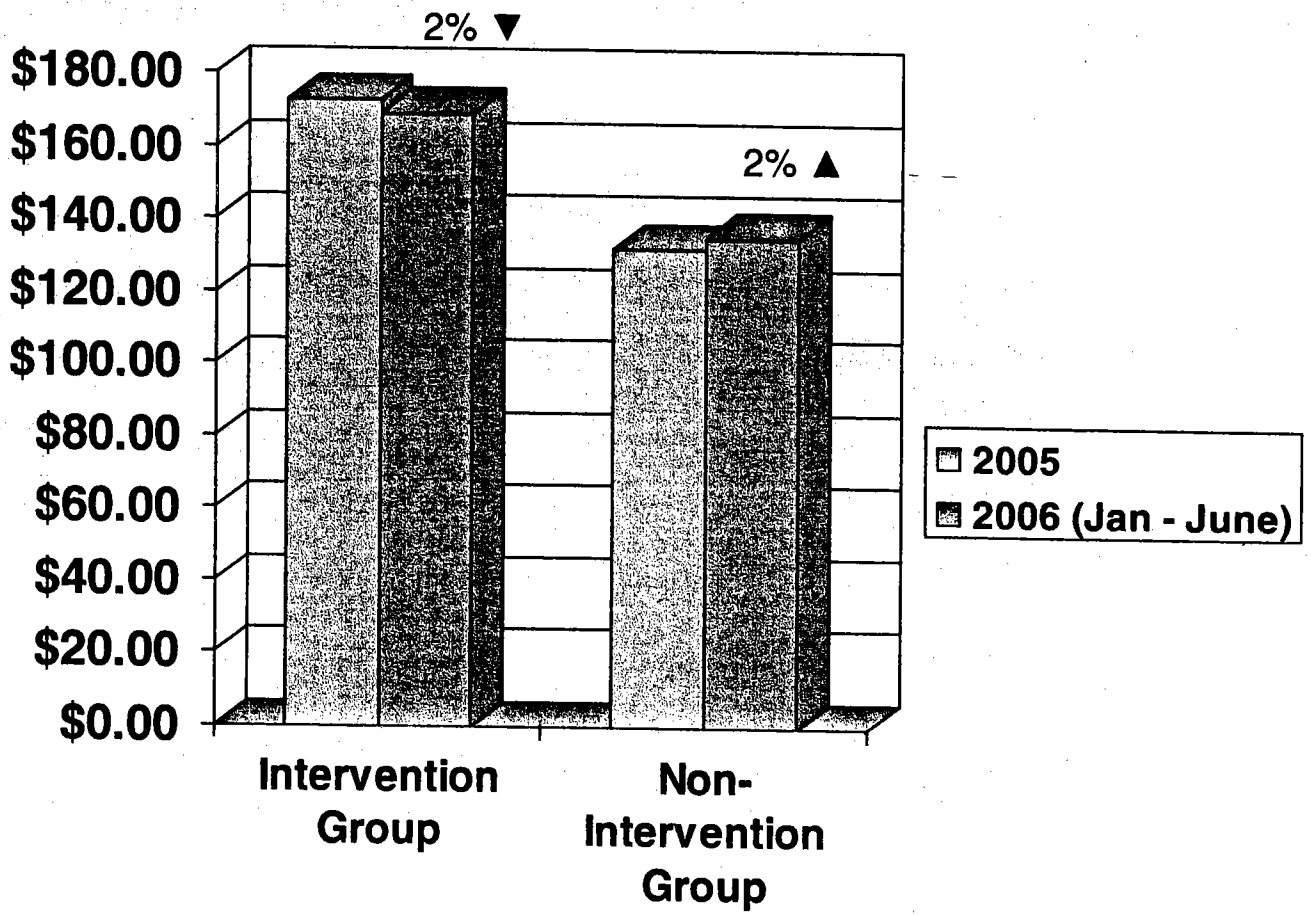
## Preferred Care Commercial

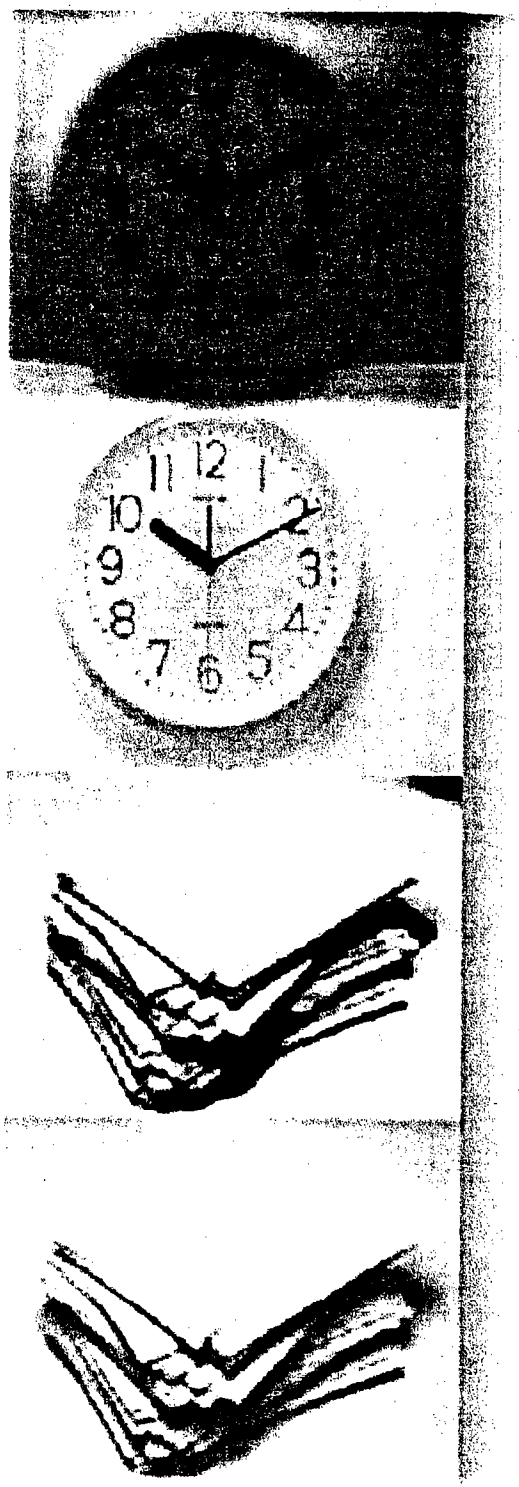




# Per Member Per Month

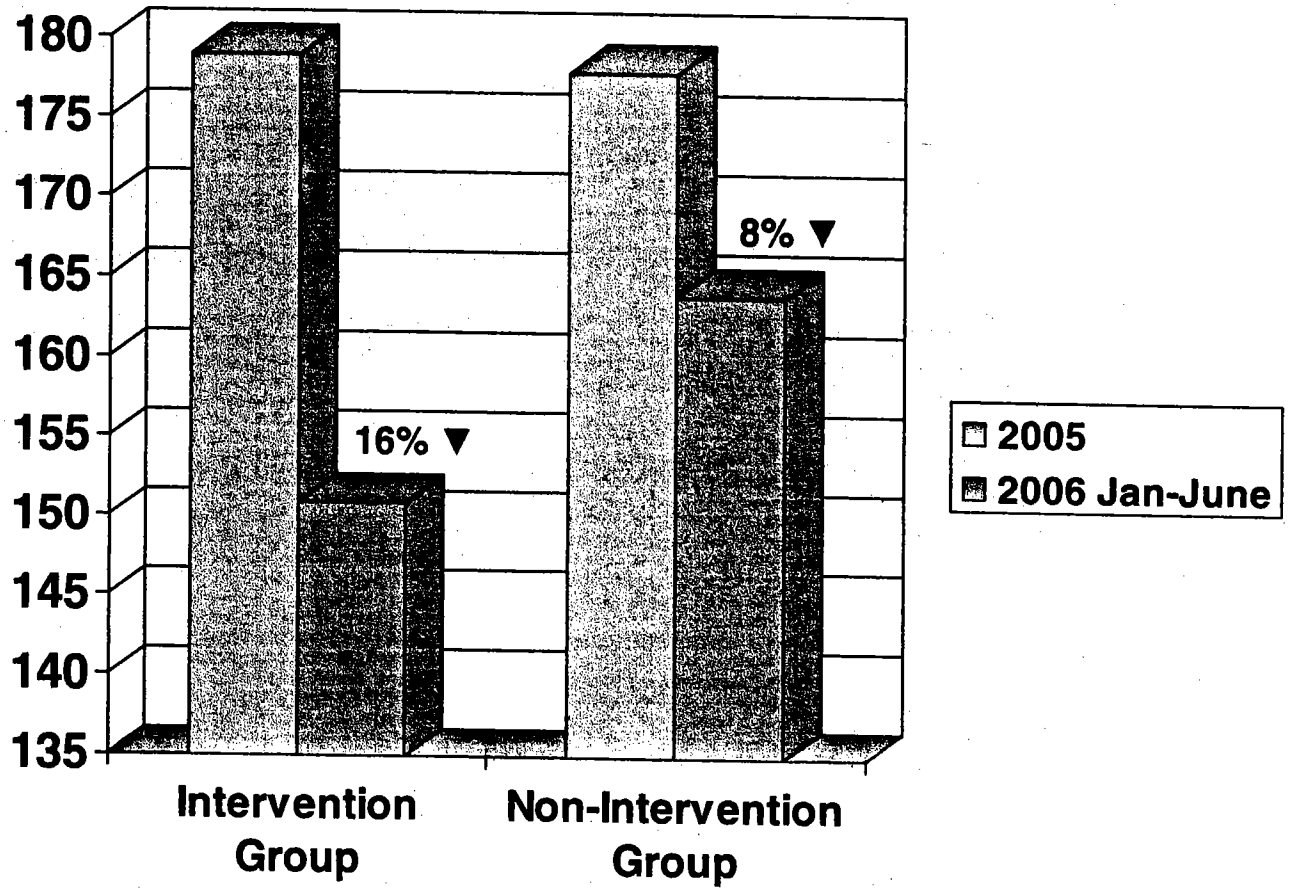
## Preferred Care Commercial





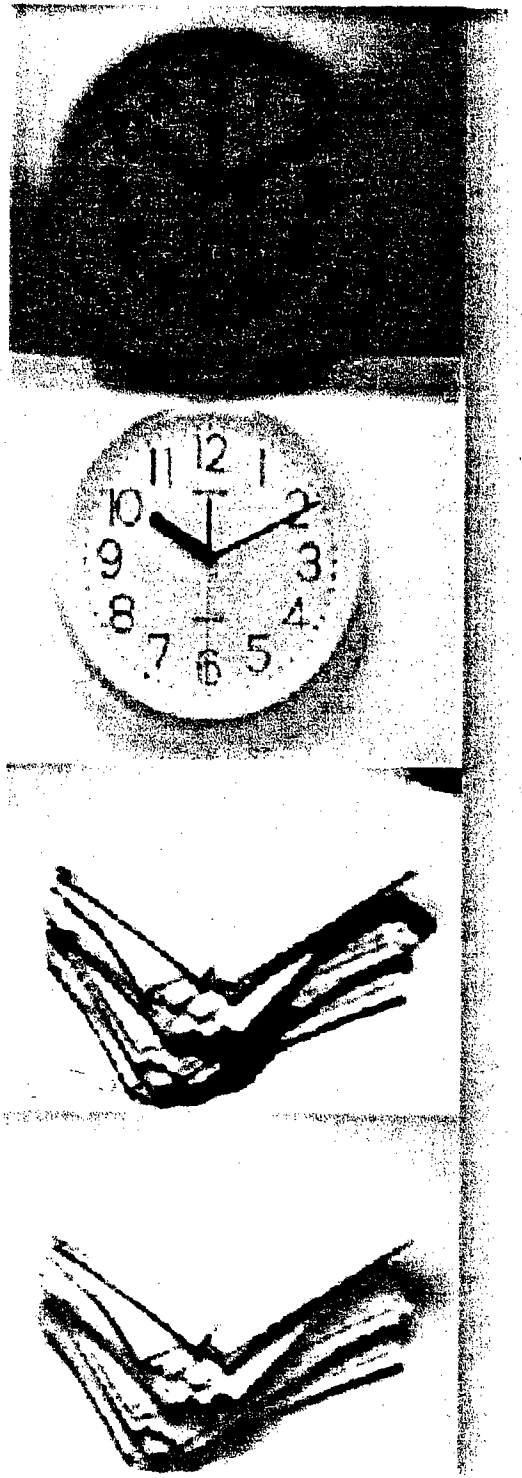
# ED visits/1000

## Preferred Care Gold



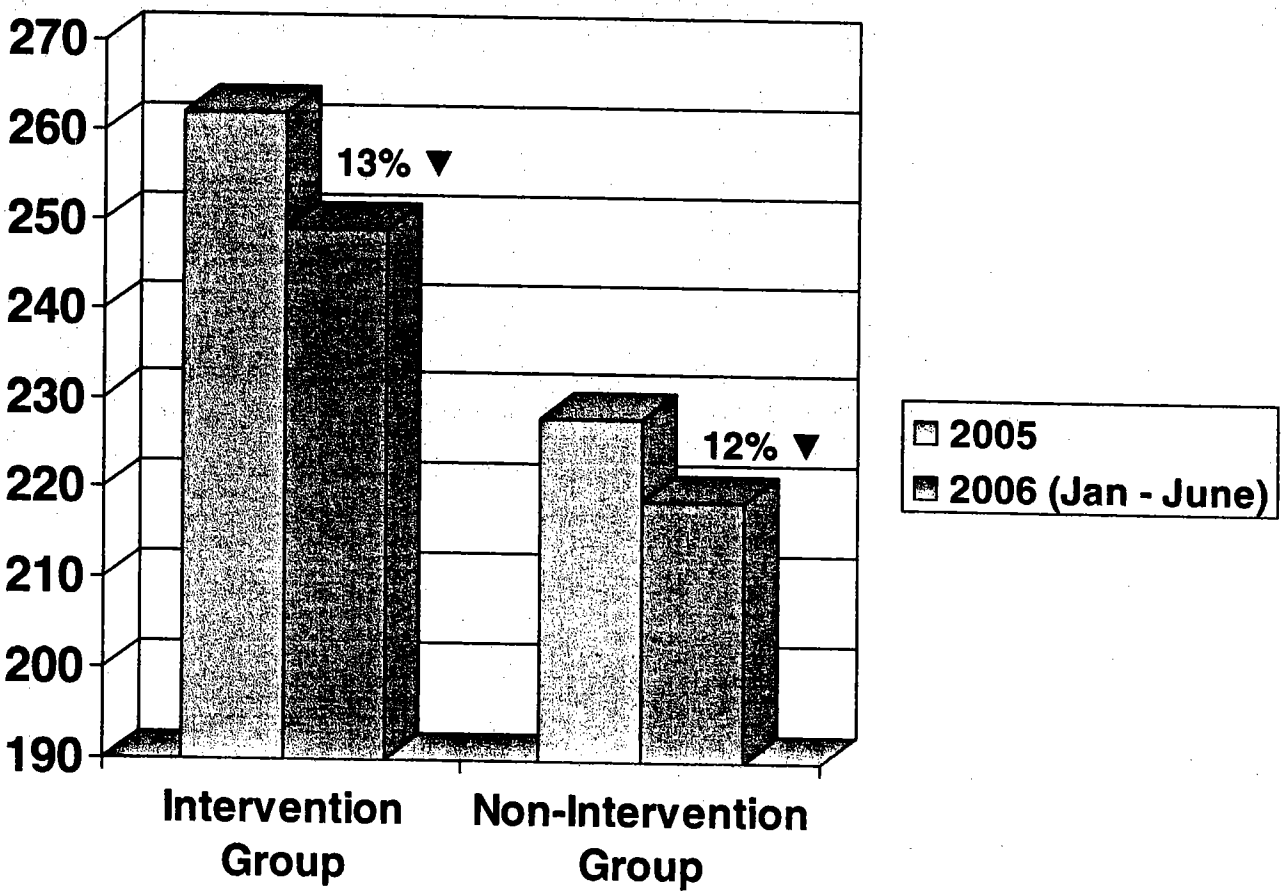

Intervention Group n ≈ 2,000

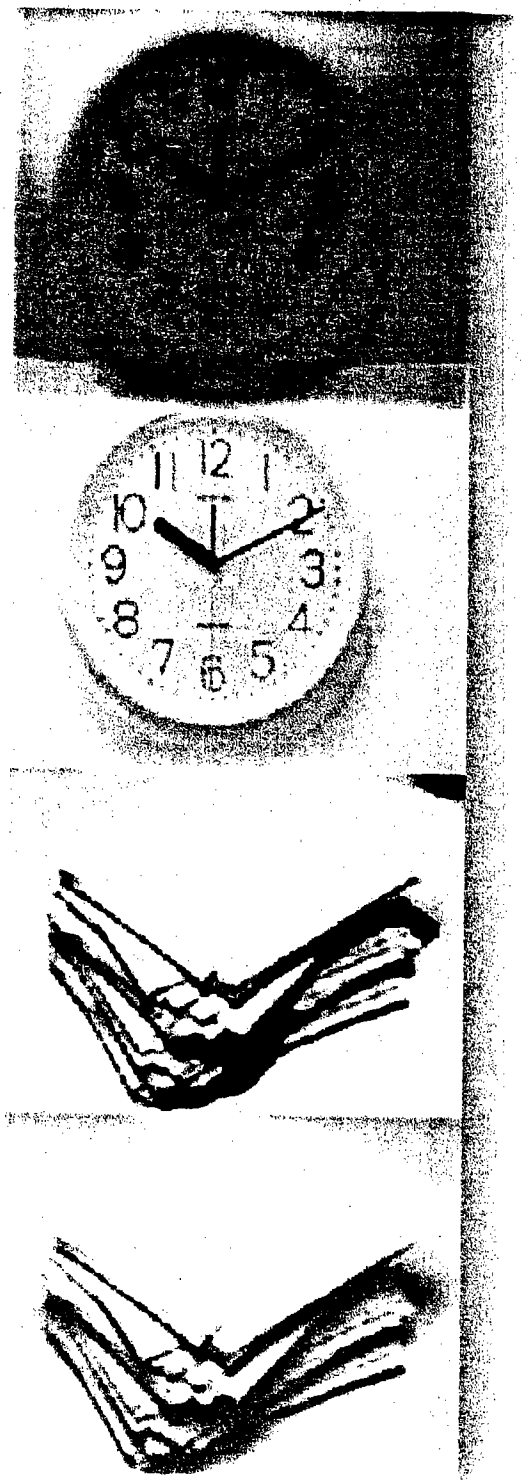
Non-intervention Group n ≈ 13,000



# Hospital Admissions/1000

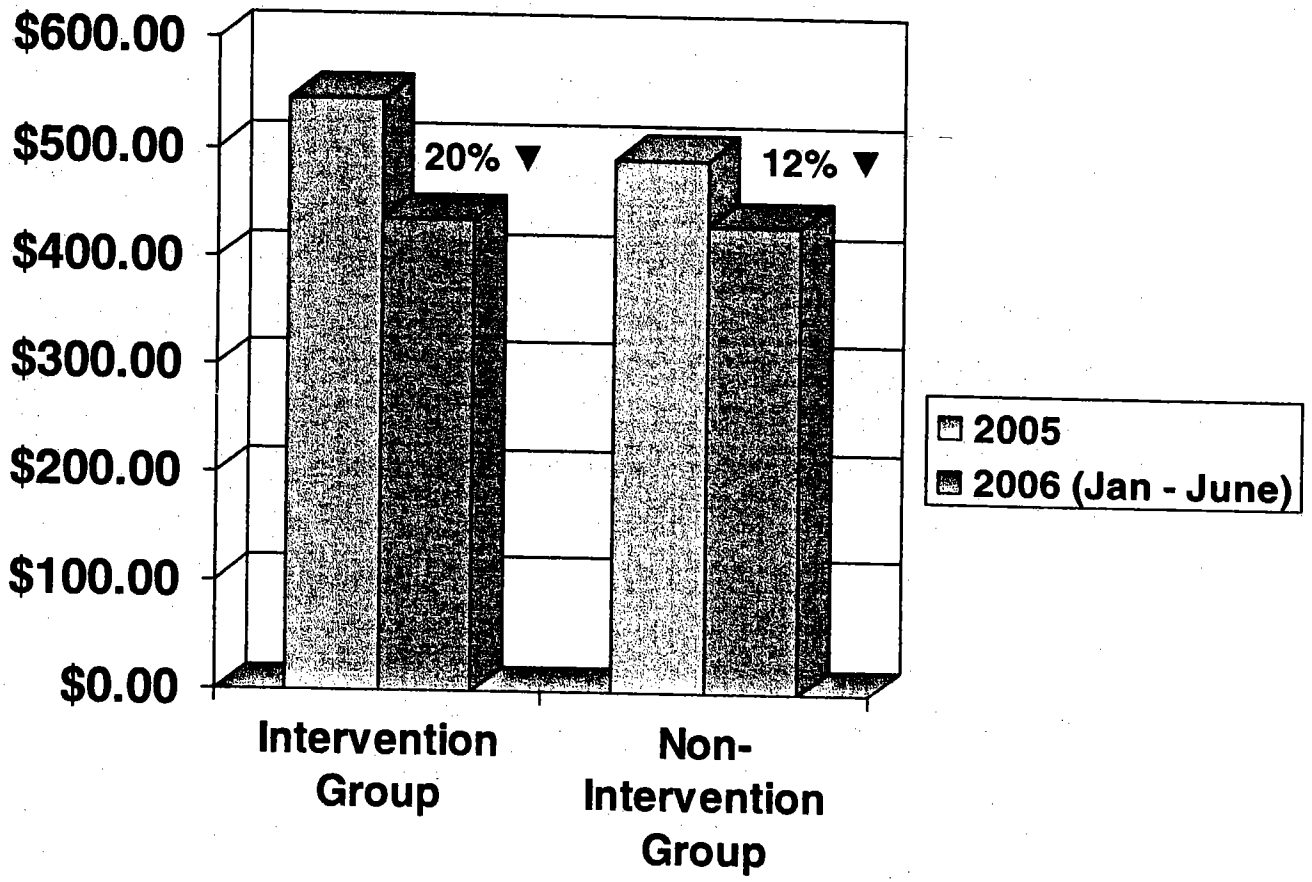
## Preferred Care Gold

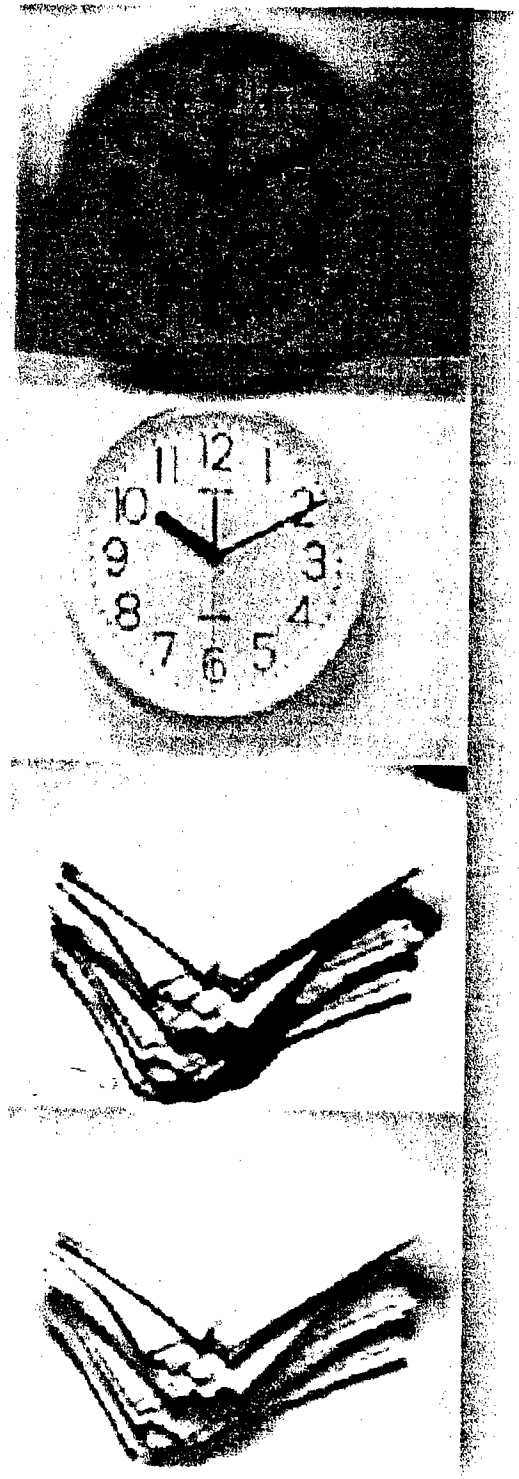




# PMPM

## Preferred Care Gold





# Goals:

- Continue to expand services to other physicians (non-employed, ?specialists)
- Continue to fine tune triggers to decrease to < 5% of referrals not meeting triggers)
- Increase WellCare enrollment (medication cost focus, referral upon signing up for Plan?)
- Roll out e-prescribing to physicians in Clinical integration
- Continue to support implementation of Clinical Guidelines and Measures
- Continue to expand peer review process

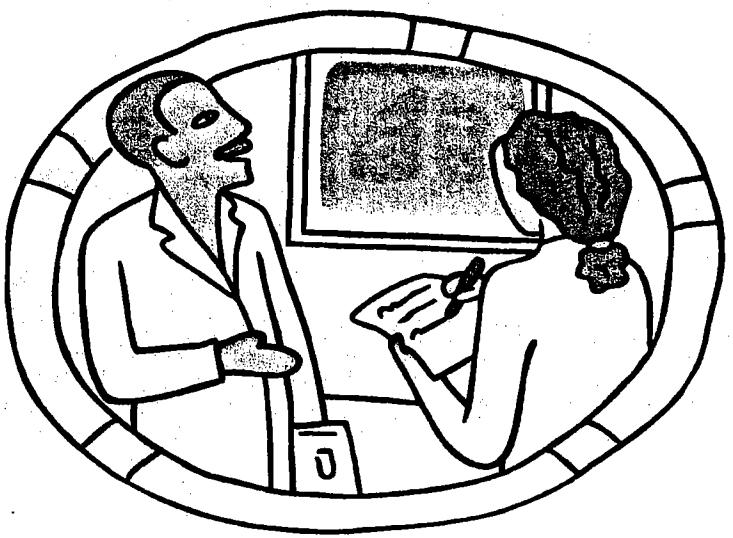
# Clinical Pharmacy Improves Outcomes in Primary Care Medicine - An Evolving Practice Paradigm

Jeanette Altavela, PharmD, BCPS
Consulting Clinical Pharmacist
Greater Rochester Independent Practice Association


GRIPA

# The Premise

Improvement in medication therapy likely improves overall care and decreases overall health care costs by reducing unnecessary hospitalization and emergency department visits



GRIPA

## Study Design

***Prospective***

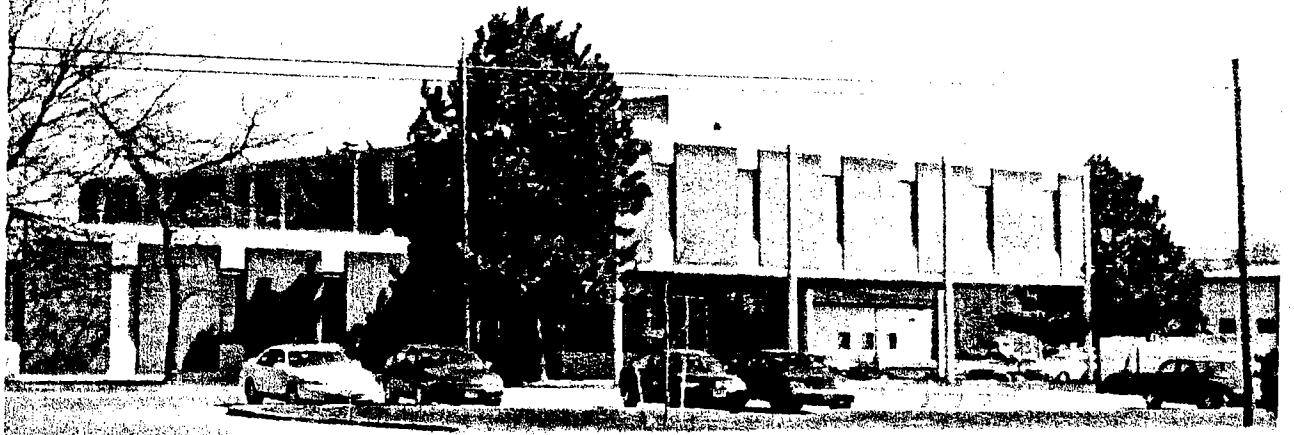
***Concurrent***

***Controlled***

***Intent to Treat***

**Active Site**

**Control Site**



# GRID4

# Pharmacist Services for "Active" Site

- Perform proactive chart review for high risk patients
- Provide recommendations to prescriber regarding medication therapy as well as standards of care
- Provide drug information as requested
- Provide medication counseling for patients as needed
- Provide general physician education
- Provide patient follow-up as needed

GRIPA

# Pharmacist Services at "Control" Site

- Perform proactive chart review for high risk patients
- Provide recommendations regarding medication therapy as well as standards of care to prescriber
- Provide drug information as requested
- Provide medication counseling for patients
- Provide general physician education
- Provide patient follow-up as needed

GRIPA

# Characteristics of Practices

| | "Active" Site | "Control" Site |
|---|---|---|
| Internal medicine physicians | 2 | 4 |
| Family Medicine physicians | 0 | 0 |
| Capitated patients in office in 2001 | 957 (12% Medicare) | 1272 (32% Medicare) |
| Capitated patients with 12 mo baseline data in 2001(# high risk) | 567 (59%) High risk = 249 (44% of pt with baseline data) | 748 (59%) High Risk = 485 (65% of pt with baseline data) |
| Capitated patients in 2002 | 705 | 745 |
| Private or owned practice | Private | ViaHealth owned |

GRIPA

# Characteristics of Practices

| | "Active" Site | "Control" Site |
|---|---|---|
| Specialty services | Endocrinologist, CDE once/month | Allergist once/week Social Worker once/week |
| Technical Services | Lab, orthopedics | Lab, X-ray |
| Other professionals | 1 Nurse Practitioner 2 certified medical assistants (CMA) | 1 Physician Assistant, 1 RN, 4 LPN |
| Secretaries | 2 | 3 |
| Technical staff | 1 | 2 |
| Computer based scheduling | No | No |
| Medication lists | Yes | Yes |
| Manual charts vs. computerized | Manual | Manual |

GRIPA

# Study Entry Criteria

- Patient must be a GRIPA patient (enrolled in insurance with a GRIPA primary care physician)
  - Preferred Care (Commercial product )

  OR
  - Preferred Care Gold (Medicare product)
- Patient must have been an active GRIPA patient for the entire twelve months prior to April 2001

GRIPA

# Study Entry Criteria

Patient must have met two of the four following entry criteria:

1) Patient had an appointment for office visit in the ensuing 2 weeks
2) Patient had one or more of the following 13 risk factors within the last 12 months

   *CAD, Diabetes, Congestive Heart Failure, Asthma, COPD, Hypercholesterolemia, Hypertension, Migraine, Tobacco abuse disorder, Atrial Fibrillation, Adverse Drug Reaction, Noncompliance with medical treatment, Any emergency department visit*
3) Patient without any of the above risk factors that is >50 years old
4) Patient not identified on scheduled visits, but had the diagnosis of Diabetes (a screening was done for this type of patient six months after start of study)

GRIPA

# Primary Outcome

- Total health care utilization costs
  - including hospitalizations, ED visits, x-rays, labs, PCP and SCP visits calculated as "Per Member Per Month"
- The difference in the median cost determined
  - 1 year before and 1 year after the clinical pharmacist worked with the practices

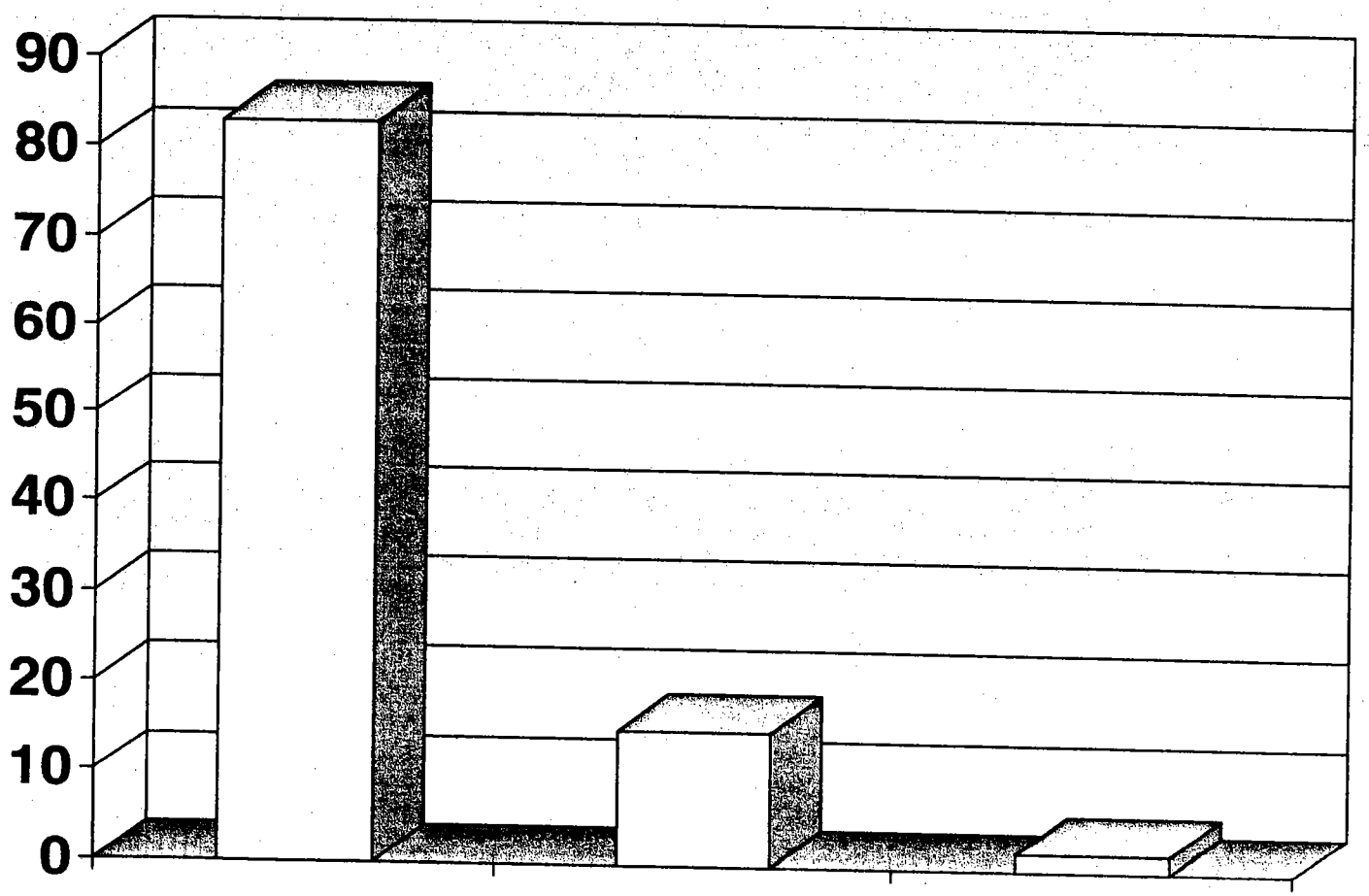
GRIPA

# Secondary Outcomes

- Primary Care Physician visits
- Specialist Care Physician visits
- Emergency Department (ED) visits
- Total Inpatient costs Per Member Per Month (PMPM)

GRIPA

# Study Entry Criteria Met by patients




GRIPA

# Patient characteristics

| | Active Site N= 127 | Control Site N= 216 | P-value |
|---|---|---|---|
| Average Age years (± SD) | 59.6 (11.6) | 68.2 (12.7) | 0.000 |
| Sex (Male - %) | 45 (35.4%) | 91 (42.1%) | 0.229 |
| **Ages by Groups** | **N (%)** | **N (%)** | |
| 20-50 year olds | 25 (20%) | 22 (10%) | 0.013 |
| 51-65 year olds | 58 (46%) | 48 (22%) | 0.000 |
| >65 year olds | 44 (34%) | 146 (68%) | 0.000 |

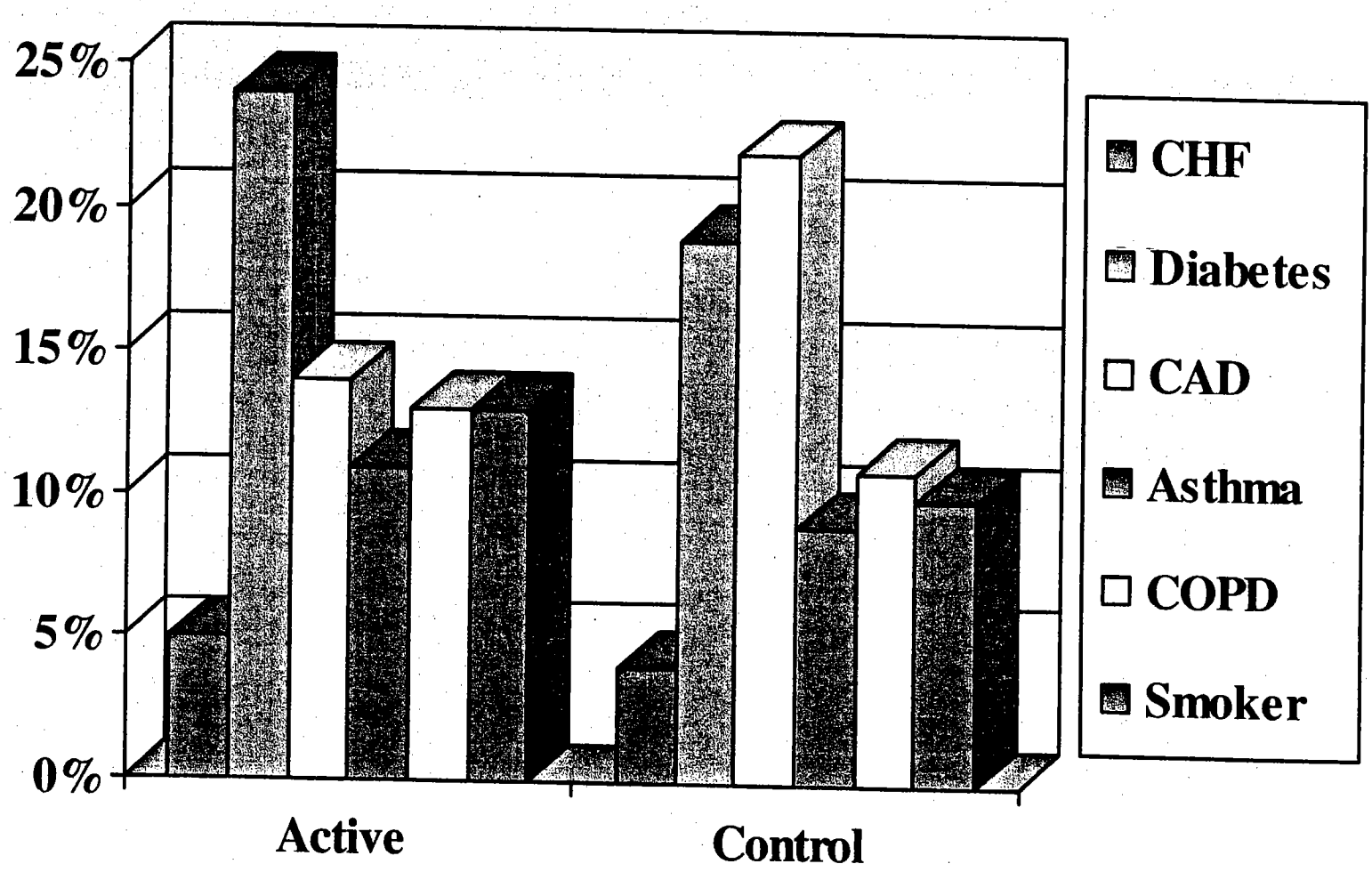
GRIPA

# Patient characteristics

| | Active Site N= 118 | Control Site N=210 | P-value |
|---|---|---|---|
| Average BMI (± SD) | 32.06 (7.51) | 28.45 (5.67) | 0.000 |
| Normal Weight | 16 (13%) | 59 (28%) | 0.003 |
| Overweight | 24 (20%) | 49 (23%) | 0.532 |
| Obese | 63 (54%) | 92 (44%) | 0.095 |
| Morbid Obesity | 15 (12%) | 10 (5%) | 0.009 |

GRIPA

## Characteristic of Patients




GRIPA

# Patient Characteristics

Prospective Risk: (Episode Treatment Groups or "ETG's"):

Identifies and quantifies an episode of care spanning inpatient, outpatient and all ancillary services and pharmaceuticals.

| | Active Site N= 127 | Control Site N= 216 | P-value |
|---|---|---|---|
| 20-50 year olds | 0.99 | 1.21 | 0.197 |
| 51-65 years olds | 1.76 | 1.78 | 0.454 |
| >65 year olds | 2.81 | 2.89 | 0.596 |

GRIPA

# Reasons Patients were Excluded

| REASON | # of Patients |
|---|---|
| Not a GRIPA member for full 12 months after study entry | 101 |
| Patient ID's with no GRIPA data | 2 |
| Switched Primary Care Physicians | 3 |
| TOTAL: | **106** |

**106 out of 343 excluded = 31%**

GRIPA

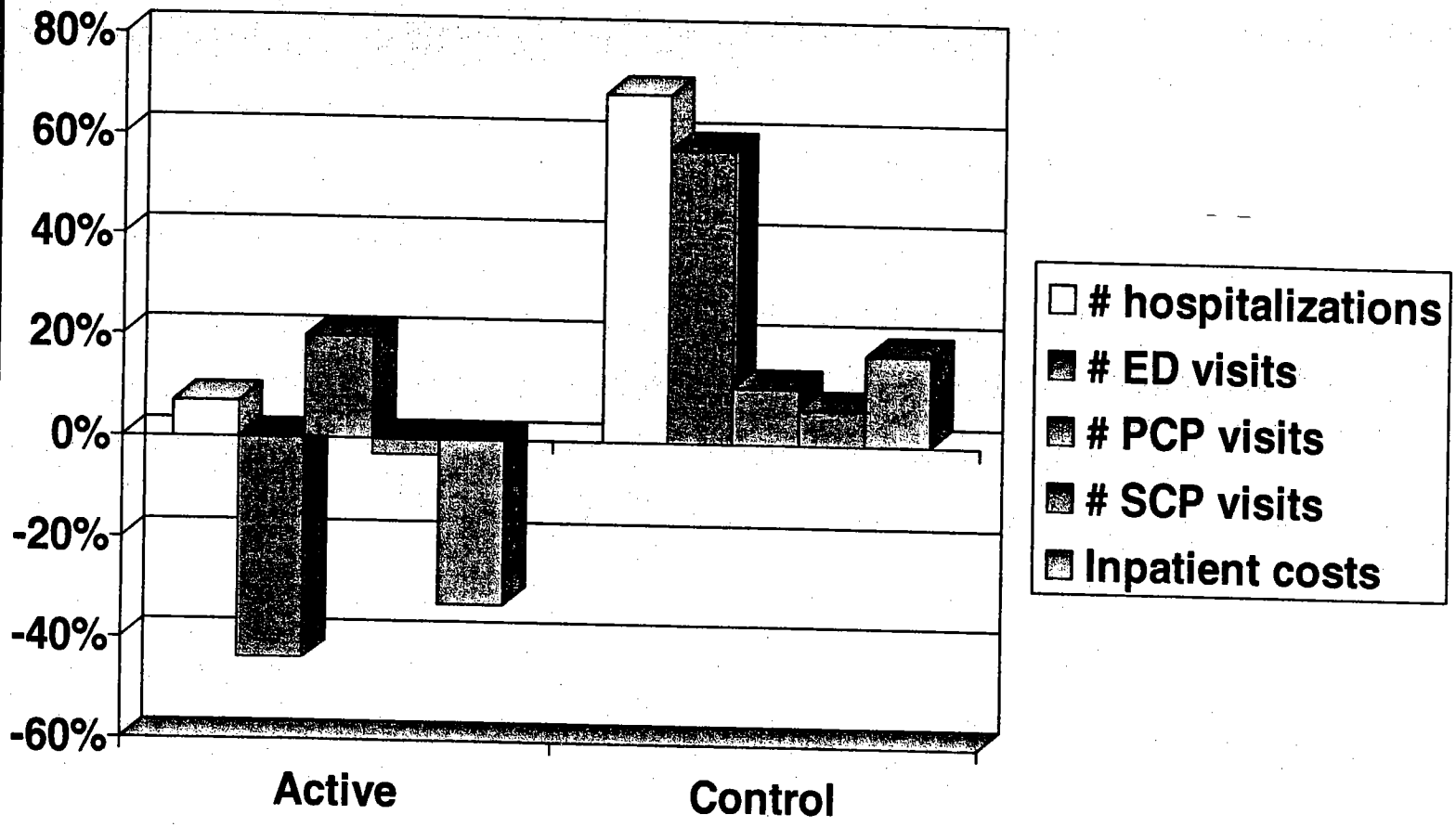
# Primary Outcome

| | # of patients | Avg. age (years) | Total PMPM | | Percentage Change |
|---|---|---|---|---|---|
| | | | Before | After | |
| Active | 127 | 59.6 | $418.99 | $353.36 | Decreased 16% |
| Control | 216 | 68.2 | $301.37 | $420.95 | Increased 40% |

**Active Site p = 0.000**
**Control Site p = 0.000**
**Difference between sites p = 0.711**

GRIPA

# Secondary Outcomes




GRIPA

# Statistical Analysis

- Due to a very significant difference in age group proportions between the two sites the analysis was broken down by age group
- 20-50 year olds
- 51-65 year olds
- 66 year old and up

GRIPA

# Characteristics of patients > 65 yo

| | Active (n= 44) | Control (n= 146) | P-value |
|---|---|---|---|
| Sex: % Male | 19 (43%) | 63 (43%) | 0.944 |
| Age years (± SD) | 72.3 (5.3) | 75.6 (6.4) | 0.001 |
| Age > 80 yo (%) | 3 (7%) | 34 (23%) | 0.008 |
| | Active (N= 40) | Control (N= 142) | |
| BMI (±SD) | 29.35 (5.3) | 27.7 (5.1) | 0.075 |
| Normal Weight | 8 (20%) | 45 (31%) | 0.151 |
| Overweight | 10 (25%) | 35 (25%) | 0.964 |
| Obese | 21 (53%) | 58 (41%) | 0.189 |
| Morbid Obesity | 1 (2%) | 4 (3%) | 0.914 |

**Weight was not known for all patients**

GRIPA

# Characteristics of patients > 65 yo

| | Active (n= 44) | Control (n= 146) | P-value |
|---|---|---|---|
| CHF | 5 (11.4%) | 6 (4.1%) | 0.071 |
| Diabetes | 9 (20.5%) | 22 (15%) | 0.397 |
| CAD | 12 (27.3%) | 42 (28.8%) | 0.847 |
| Asthma | 3 (6.8%) | 11 (7.5%) | 0.873 |
| COPD | 10 (22.7%) | 18 (12.3%) | 0.088 |
| Current Smokers | 4 (9.1%) | 10 (6.1%) | 0.618 |
| Prospective Risk (±SD) | 2.81 (1.47) | 2.89 (1.39) | 0.596 |

GRIPA

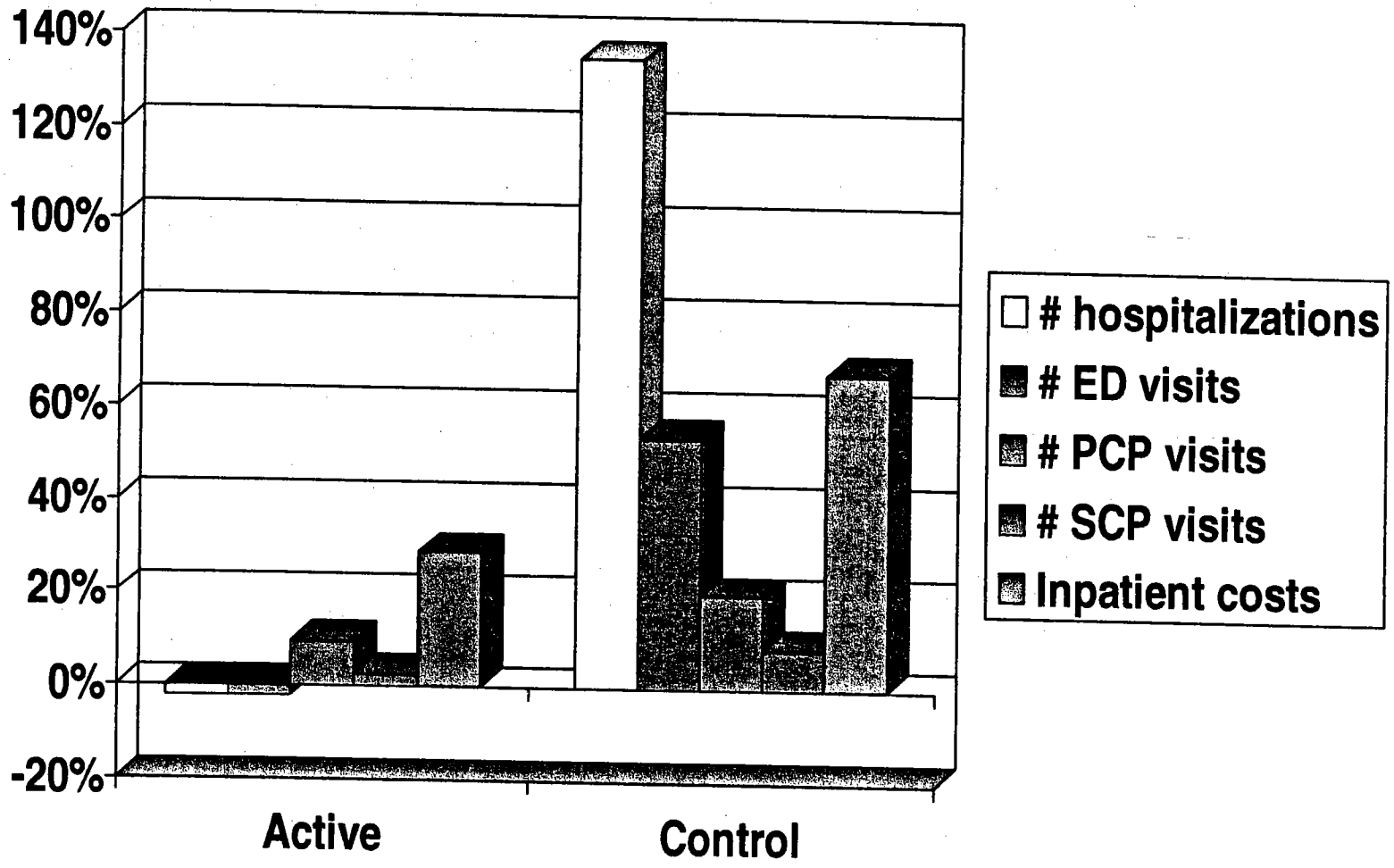
# Total PMPM > 65 years old

| | Number of Patients | Average Age (years) | Total PMPM | | Percent Change |
|---|---|---|---|---|---|
| | | | Before | After | |
| Active | 44 | 72.3 | $493.25 | $639.88 | ↑ 30% |
| Control | 146 | 75.6 | $310.81 | $ 515.29 | ↑ 66% |

**Active Site p = 0.005**
**Control Site p < 0.001**
**Difference between sites p = 0.793**

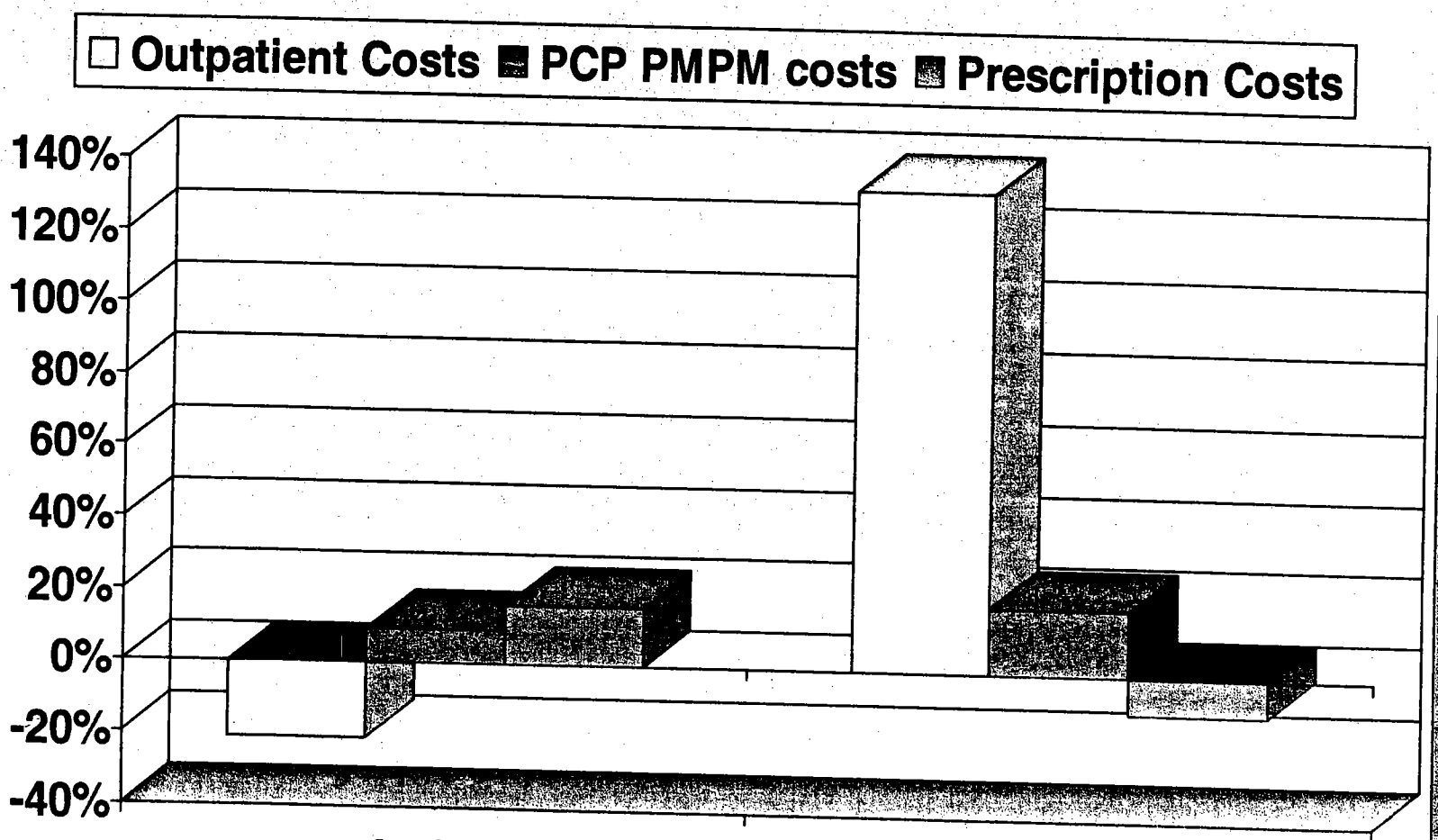
GRIPA

# Secondary Outcomes >65 year olds



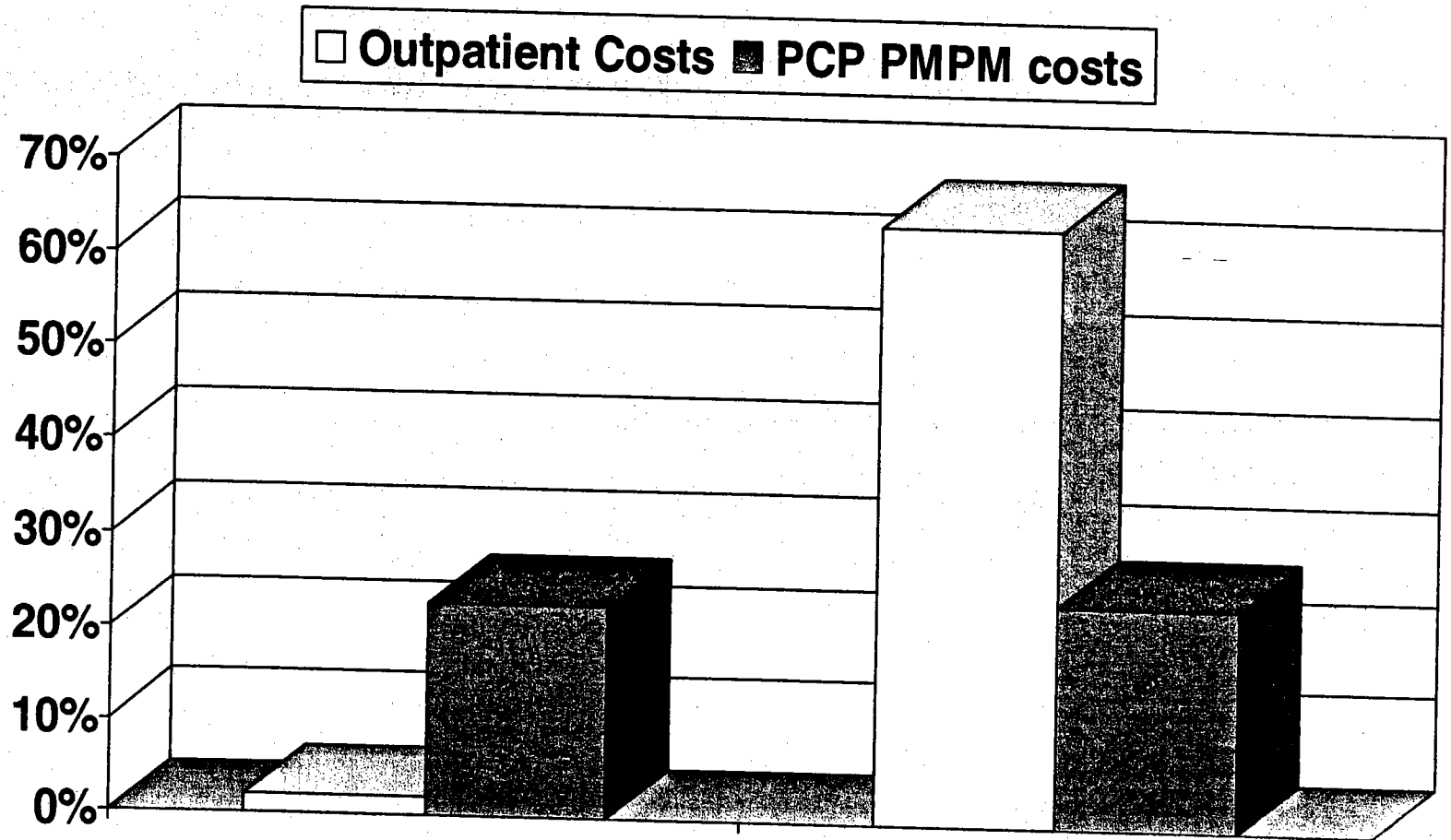

GRIPA

# Post Hoc Analysis Entire Population




GRIPA

# Post Hoc Analysis > 65 year olds




GRIPA

# High and Rising Health Care Costs. Part 4: Can Costs Be Controlled While Preserving Quality?

Thomas Bodenheimer, MD, and Alicia Fernandez, MD

Excellus

# PARTICIPATING PHYSICIAN AGREEMENT

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**Re:** Greater Rochester Independent Practice Association, Inc.
Advisory Opinion Request

Dear David,

The Greater Rochester Independent Practice Association, Inc. ("GRIPA"), is responding to your request for additional information, dated September 21, 2006, on a rolling basis. This letter is the third installment and answers the questions posed in the last three sections of your information request. For clarity, we separate your questions into smaller parts, which we state and then attempt to answer.

GRIPA requests that you treat the information and exhibits in this letter confidentially under Federal Trade Commission Procedure Rule 4.10, 16 C.F.R. § 4.10(a)(2) (2006), and section 6(f) of the Federal Trade Commission Act, 15 U.S.C. § 46(f) (2006). If GRIPA determines that confidentiality of any information is no longer necessary, we will notify you.

**Need for Joint Contracting/Price Agreements in Order to Obtain the Program's Potential Efficiencies**

Q1 Why doesn't the fact that GRIPA and its physicians will bill on a fee-for-service basis for each covered medical service provided to a patient covered under a GRIPA contract differentiate its proposed program from the "aggregating service" at a flat fee provided by the blanket license in *Broadcast Music,* and make any analogy to that arrangement inappropriate?

It is not clear to us why the fact that GRIPA physicians will bill their services on a fee-for-service basis distinguishes its clinically integrated product from the integrated blanket license in BMI. In BMI, as the Court recognized, the blanket license consisted of two parts—the individual compositions of the individual composers (which they were free to sell individually on a "fee-for-service" basis as here) and the so-called "aggregating service" of "sales, monitoring, and enforcement" (ironically, exactly what GRIPA intends to do, although its monitoring and enforcement is vis a vis its own members as opposed to ASCAP's customers as in BMI). See BMI, 441 U.S. at 21 ("The blanket license is composed of the individual compositions plus the aggregating service."). The GRIPA facts are similar. Its clinically integrated product is composed of the individual medical services of its members, together with the quality/cost-improvement program. The latter is analogous to the "aggregating service" in BMI because it integrates the sale of physician services with a program to increase the effectiveness of the sales in the sense of selling improved services. The aggregating service in BMI did the same thing but in a different way. It integrated the individual composers' compositions with a program that generated efficiencies for both customers (through the "single-signature" feature) and the composers (through the monitoring and enforcement mechanisms).

Just as ASCAP was "not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw materials," id. at 22, so will GRIPA be offering an integrated product of which the individual services of its physicians are a "raw material." And just as the "blanket license is quite different from anything any individual owner could issue," id. at 23, so too, none of GRIPA's individual physicians could offer the integrated product that it intends to offer.

The Court's decision that the composers' price-fixing agreement through ASCAP was not per se illegal was not premised on the fact that individual composers were not billing individually for individual compositions. There is no reason to believe that the Court's decision would have been any different if the composers had billed individually for their compositions, as long as there were only one contract for all the compositions and ASCAP provided the aggregating services. The BMI decision's rationale rested on three factors: the substantial transaction-cost savings from "single-signature" blanket licenses; the "aggregating service," which the composers could not implement individually; and the fact that there "was no legal, practical, or conspiratorial impediment to [customers'] obtaining individual licenses." Id. at 24. GRIPA's program embodies each factor in varying degrees. The clinically integrated product should result in reduced transaction costs for both GRIPA physicians and customers, albeit not of the magnitude generated by the blanket license; the quality/cost-improvement part of the clinically

integrated product is a form of "aggregating service" affecting all the physicians' practices together in a way that should achieve efficiencies through the partial integration of their operations; and GRIPA will not facilitate any type of conspiracy among physicians not to contract on an individual basis with customers who do not wish to purchase the clinically integrated product.

In sum, there is no reason of which we are aware why the physicians' fee-for-service billing would undercut the applicability of the BMI analysis.

Q2 According to your letter, RCIPA has approximately 3,200 physicians and allied health professionals, yet contracted with Aetna using a "messenger model" arrangement. In view of this experience, what is the basis for your assertion that use of a messenger arrangement by GRIPA, with approximately 600 to 700 physicians, in probably no more than a few hundred separate medical practices, is "not administratively feasible?"

We can't fully answer this question because we don't know the details of how RCIPA operates. It states that it uses a messenger arrangement for contracting, but GRIPA does not know how its messenger process actually works and has no information permitting it to confirm that RCIPA implemented (or did not implement) a bona fide messenger arrangement in dealing with Aetna and other payers. In addition, to the best of GRIPA's knowledge, RCIPA is not offering payers an integrated product of the type that GRIPA intends to offer, and so comparing the feasibility of the two using a messenger-arrangement seems inappropriate.

GRIPA's statement about the administrative infeasibility of operating a messenger arrangement is based on its own experience in messengering non-risk-contract offers in the past and, admittedly, on GRIPA's counsel's experience in advising a number of messenger-arrangement networks. In operating its messenger arrangement, problems included: 1) payers failing to understand (and expressing frustration to GRIPA) that GRIPA, as the messenger, could not make an offer or counter-offer on behalf of the membership as a whole; 2) payers' mistaken belief that GRIPA could guarantee full, or substantial, network participation; and 3) physicians failing to respond to messengered offers in a timely manner, leaving network composition up in the air indefinitely. Counsel has worked with several networks that simply "gave up" on their messenger arrangement because of the confusion and inefficiency the methodology generated. Ironically, one of these networks was Mountain Health Care, which the Antitrust Division later sued because it was contracting without operating a messenger arrangement. If you wish, counsel can provide a relatively long and detailed explanation of all the unanticipated issues and problems that messenger arrangements often raise.

A common problem is what can be called, in technical antitrust jargon, the "messenger screw-up" problem. This occurs when the messenger, who typically is not an antitrust attorney, unknowingly crosses the line and engages in the beginnings of price "negotiations" with customers. Suppose (as actually happens frequently), the customer asks the messenger, "What will it take to ensure that all your doctors participate?" or "Do you believe the doctors will accept X% of Medicare?". The messenger has two choices: the antitrust-savvy messenger will plead the Fifth Amendment ("On the advice of counsel, I respectfully decline to answer your question."). The more usual messenger will try to be as helpful as possible and answer the questions. This leads to more interactive discussions about pricing, and ultimately in "negotiations."

With respect to GRIPA's proposed integrated product, a messenger arrangement will not be feasible because that methodology likely will result in less than all GRIPA physicians participating in all GRIPA contracts. As discussed elsewhere, full participation in all contracts is one of the most important characteristics of GRIPA's integrated product. Absent that, GRIPA could not guarantee that payers desiring full participation would obtain it based on a single negotiation and contract; its in-network referral policy would be compromised, potentially adversely affecting continuity of care, as well as its data-collection and monitoring functions; it would have to implement separate data-gathering and monitoring programs for different networks, some of which might include too few patients to provide significant results; and the free-rider effect would be exacerbated.

Q3 Do GRIPA physicians currently participate with individual payers through varying contracting mechanisms, such as direct contracting, IPAs, TPA-assembled networks, etc.? Approximately what is the current physician participation rate with each payer through all contracting mechanisms?

Most GRIPA physicians were members of RIPA and participated in RIPA's contract with Excellus, which terminated at the end of 2006. Nearly all GRIPA physicians signed individual contracts with Excellus for 2007. Most of GRIPA's SCP members, all of the ViaHealth-employed physicians, and about half of GRIPA's private practice PCPs participate in RCIPA and its contracts with Aetna, POMCO, and several third-party benefits administrators.

Q4 Could a substantial part of the anticipated efficiencies of GRIPA's proposed program be obtained if not all GRIPA physicians participated in all GRIPA payor contracts? Please provide any evidentiary support for your response.

GRIPA's proposed program would generate a certain amount of efficiencies even if the entire panel did not participate in every contract, but there is no way to say

definitively—either positively or negatively—that "a substantial part of the anticipated efficiencies" could be obtained. GRIPA instituted the policy requiring all physicians to participate in all GRIPA payer contracts to do the following: 1) establish a set panel of providers that are easily identifiable to payors, patients, and referring physicians; 2) reinforce GRIPA's in-network referral policy; 3) ensure that all GRIPA physicians are working towards the same financial and quality goals; 4) maximize the opportunities for GRIPA to affect physicians' practice patterns and the quality of care patients receive; 5) maximize the opportunities for collaboration in the care of patients; and 6) reduce GRIPA's administrative burdens. Until it implements its program, GRIPA will not know for certain whether these goals will be realized.

Q5 Could GRIPA implement and sell its monitoring and other cost and quality enhancing functions separately from its function of contracting to provide the professional medical services of its physician members? Could GRIPA operate by having its members agree to participate in such programs with regard to their patients who are covered by any payers that purchase this service from GRIPA?

We admit having a substantial problem envisioning how this separate-sale scenario would actually work in practice, and, if warranted, would appreciate a more detailed operational explanation from you. We suppose it was theoretically possible for the composers in BMI to sell their compositions separately and contract to purchase ASCAP's monitoring and enforcement services separately if they wished to do so, but such an arrangement would have resulted in significant inefficiencies.

In any event, there are relatively minor, discrete parts of its quality/cost-improvement program that GRIPA could sell separately from its members' medical services—disease management is probably the most obvious example. But it would be difficult, if not impossible, to sell the core parts of its quality/cost-improvement program separately from its physicians' services, particularly those parts of the quality/cost-improvement program involving implementation of protocols and the monitoring of compliance because these aspects will be so integrated into the provision of its members' medical services provided under GRIPA contracts. GRIPA (or its individual physicians) certainly could sell physician services without the quality/cost-improvement program (and, indeed, payers will have that choice, if that's what they want, by not purchasing the GRIPA product but by negotiating with GRIPA physicians on an individual basis). But we cannot envision how the quality/cost-improvement program could be sold without the physician services or how the quality/cost-improvement program could operate if sold separately while payers contracted with physicians on an individual basis. How would this work? Would the payer come to GRIPA and say that it has contracted with GRIPA physicians 1-200 but not with physicians 201-500 and thus that the quality/cost-

improvement program it wants to purchase separately should include only the first group of physicians?

And suppose that some large payers decided to purchase the quality-improvement program but not to contract with a number of GRIPA physicians who had been particularly active in, and devoted substantial time (for which they are not reimbursed) to, developing the quality/cost-improvement program and monitoring compliance? No rational physician will donate his or her time to GRIPA with the looming possibility that he or she will be cut out of the revenues the program is intended to generate through the provision of services. Theoretically, it might be possible to compensate those physicians from the revenues generated by the sale of the quality/cost-improvement program itself. This would just raise additional complications in operating the program (both operationally and politically), and GRIPA doubts the physicians would believe the trouble was worth it.

We believe that much of the answer to these questions goes back to the fact that the success of the program hinges in large degree on the ability of GRIPA to require all its physicians to participate in all its contracts because of the integration of the quality/cost-improvement program into the physicians' medical services, at least to the extent that the services are purchased through GRIPA.

Q6 Doesn't the apparently concentrated nature of the Rochester area payer market (*i.e.*, the presence of only a few large payers) make it less necessary for GRIPA's efficient operation that all member physicians commit in advance (through joint contracting) to participate in all contracts? For example, if GRIPA contracted with Excellus or Preferred Care, even if GRIPA determined the relevant physician networks for those contracts by using a messenger arrangement, rather than joint contracting and price agreement, it apparently could "cover" the delivery of most services in the area with only one or two panels, thus simplifying implementation of referral restrictions and monitoring functions. Moreover, aren't the physician panels for most payers likely to be substantially the same in all cases, regardless of whether the panel is established by joint contracting or other means?

We agree with the assumption that the fewer the customers, the easier (all else equal) it would be to administer a messenger arrangement. But the relevant variable is not the degree of concentration per se, but rather the number of customers (and to some extent, the number of different plans offered by those customers), regardless of their market shares. While there are few "large" payers in the Rochester area, there are several smaller ones, as well as a number of self-insured employers.

It's not possible to predict definitively whether the panels would be substantially the same for all customers regardless of the contracting methodology. We would predict they would not be substantially the same because of the different degrees of buyer market power held by different customers. Theory would predict that most or all GRIPA members would participate in Excellus's products (assuming the level of reimbursement offered exceeded the physicians' average costs) because of the degree of its monopsony power. The same, however, would probably not be true with regard to other payers and self-insured employers. High-end GRIPA specialists would probably participate in the networks of all customers because of their own market power; the same would not be true, however, with respect to physicians (PCPs, for example) in more competitive seller-side physician markets.

Other messenger models with which we've worked have ended up with significantly different panels. Indeed, this has been a major criticism of messenger models by both customers ("We want Dr. X in our network. Why can't you force her to participate? I was interested in contracting with a network because I thought that meant I got all the doctors. What good is a network?") and physicians ("What do you mean I'm a member of this so-called 'network' but the customer doesn't want me!?" I thought a network meant that everyone participates."). And experience also shows that before the network becomes "final," even if ultimately substantially all physicians are participants, several time-consuming rounds of offers, counteroffers, counter-counteroffers, and counter-counter-counter offers are usually necessary, stretching the contracting period for substantial periods of time.

Finally, although we know we sound like a broken record by now, it's important to GRIPA, for the reasons we've tried to explain, that the panels not be "substantially similar," but that there be only one panel with all GRIPA physicians participating.

Q7 You state on page 27 of your letter that ". . . if all GRIPA physicians are not required to participate in all GRIPA contracts, GRIPA cannot be assured that there will be sufficient compliance information from the physicians with respect to GRIPA contracts for the monitoring and corrective-action functions of the program to operate and thus achieve . . . efficiencies . . ." What is the basis for this assertion?

The basis for the assertion is the fact that GRIPA can't predict how many or what percentage of its physicians would actually participate in GRIPA contracts if there were no requirement that they do so. It is possible that a small number of physicians would participate in some contracts, resulting in a correspondingly small amount of data reviewed for compliance and monitoring. The smaller the amount of data, the less

statistically significant and unbiased the results of the program will be and the less effective the program is likely to be.

GRIPA has not attempted to determine, objectively and empirically, how much data or what degree of participation is necessary for valid statistics or an effective program. Even having that information would be of little help without the ability to predict which physicians would participate in the contracts.

> Absent sufficient data points -- for example due to GRIPA having few contracts and limited enrollees, or particular GRIPA physicians having insufficient patients covered under GRIPA contracts -- requiring physician participation in all GRIPA contracts might not assure generation of sufficient compliance information for monitoring purposes. What alternative approaches to collecting sufficient compliance data have been considered?

For some guideline measures, GRIPA acknowledges that it may not have sufficient data to generate statistically-significant studies of individual compliance. GRIPA believes, though, that its policy will decrease such occurrences.

GRIPA explored the possibility of collecting physicians' treatment information for all patients, and not just enrollees of GRIPA-contracted payers. Its ability to do this, however, is impaired by state and federal privacy laws governing the exchange of patients' health care information. Until GRIPA and its physicians are able to work through the privacy issues, it will collect only claims data for GRIPA-contracted payers.

> In this regard, rather than requiring all physicians to participate in all contracts, could GRIPA use nationally available information to augment locally collected data when measuring comparative compliance with benchmarks and assessing cost-effectiveness?

GRIPA will use nationally available information as a means of assessing how GRIPA physicians compare to national averages and national benchmarks. The question we believe you are asking is whether nationally available information could somehow be added to the data collected from the physicians in order to increase the sample size. The problem, however, is not the size of the comparative sample, but the size of the sample of GRIPA patients. All sample-size calculations assume equal sample sizes between comparison groups. If the group sizes are unequal, the smaller-sized sample will affect the statistical significance of the results.

The previous questions suggest that you have some concern with GRIPA's proposed requirement that all GRIPA physicians participate in all GRIPA contracts. We

are not sure what that concern is other than the requirement is an important reason that GRIPA needs to negotiate contracts on behalf of its members. If you believe that the requirement raises some independent antitrust issue, we would appreciate the opportunity to learn about the concern and discuss it because we can't discern any anticompetitive effect it might have.

> If GRIPA had a contract with only one payor, representing 25% of area patients, would this provide sufficient compliance information for physician monitoring, if GRIPA required all physicians to participate in the contract with that payer? If GRIPA had a contract with one payor, representing 50% of area patients, would this provide sufficient compliance information for physician monitoring, if only 50% of GRIPA physicians participated in that contract?

GRIPA honestly doesn't know. But the larger practical problem is that it cannot predict how many contracts it might have, how large those contracts will be, and, absent the full-participation requirement, how many physicians would participate in each contract. Related to that, patient and physician percentages provide only two of the variables necessary to determine sufficiency of a sample. The sample size for any given guideline measure is also dependent upon how many GRIPA-contracted patients any individual physician has and the patients' characteristics such as age, sex, and diseases. None of these variables is knowable until actual contracts are in place.

Q8 Even if you require all GRIPA physicians to be in all clinical integration contracts, why do the physicians need to agree on the price of their individual services? For example, why couldn't the physicians individually set a reservation price (standing offer) and if a payor wants the clinical integration panel, then it has to agree to each physician's price to get the panel?

The problem is that there is no way for GRIPA to implement a requirement that all physicians participate in all GRIPA contracts unless GRIPA negotiates the contracts on behalf of all of its physicians. The example in the question—of what, in effect, is a standing-offer messenger arrangement—exemplifies this because, under this approach, it is possible that some GRIPA networks for some payers would not include all GRIPA physicians.

Partial, rather than full, participation might not create a problem, per se, if the only reason for the requirement were to offer payers "single signature contracting with a defined and known network of providers." Opinion Request Letter at 26. As the question indicates, the payer could obtain participation by all GRIPA physicians simply by meeting the fee demand of each physician. (This process would, however, introduce the inefficiencies of a messenger arrangement, e.g., gathering all the fee information,

rounds of counteroffers, etc., which GRIPA wishes to avoid.) But as the Opinion Request Letter explained, GRIPA's ability to offer payers a known, defined network is only one reason for its requirement that all physicians participate in all contracts. See id. at 26-27. Other reasons are assurances to participating physicians that the physicians to whom they refer are participating physicians; the ability of the physicians "'to rely on the participation of other members of the group in the network and its activities on a continuing basis'" (id. at 26 (quoting Staff Advisory Opinion to MedSouth)); administrative burdens if physicians were "in" for some contracts and "out" for others; minimizing the free-rider problem; and helping to ensure sufficient quality/cost-improvement program data to support the program. The standing-offer approach suggested in the question would not solve these concerns because, again, it could not ensure that all GRIPA physicians would participate in all GRIPA contracts.

The relevant question is really whether there is some way for GRIPA to ensure that all physicians participate in all contracts without GRIPA's negotiating contracts on their behalf. We are not aware of any way this can be done.

**Market Power and Effects**

Q1 In your submission (pp. 2-3) you state that GRIPA's proposed program is expected to "fit directly into payer plans and should be well-received by payers." Please explain your basis for this statement, including any specific expressions of payer interest in the proposed program.

Payers (and employers contracting with payers) are looking for transparency of quality and cost. GRIPA will provide this transparency and will also assist payers in additional cost avoidance.

See below for payers' specific expressions of interest in GRIPA's proposed program.

Also, please describe fully and specifically any contacts or discussions that GRIPA has had with potential purchasers of its proposed program, identifying contact persons, and describing what information GRIPA presented to them and their responses, including any competitive or other concerns about, or objections to, the proposed program that they raised.

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Marion.Corbet@Wellcare.com

**COMMENTS:**

Dr. Martin Hickey has expressed strong interest in GRIPA's proposed clinical integration program, though he believes physician groups should take full risk. He is familiar with the type of health-information sharing that GRIPA has proposed, which he has seen work elsewhere in the form of regional health information organizations, or RHIOs. Dr. Hickey did not voice any objections to GRIPA's proposed program.

Mr. John Urban expressed confidence in GRIPA as an organization with which Preferred Care could collaborate. He was interested in new quality and efficiency initiatives that could result from implementation of GRIPA's program. He stated he wished GRIPA had done this years ago.

Prior to the Preferred Care/MVP merger, Ms. Lisa Brubaker suggested she would support the program when she felt the time was appropriate. GRIPA is unsure whether the merger has had any affect on her opinion.

Due to its small patient population in the Rochester area, GRIPA's panel provides the vast majority of services to WellCare subscribers in the area. Both Rick Keller and Marion Corbett are supportive of GRIPA and its efforts and have not voiced any objections regarding the proposed program.

**MEETINGS:**

- 4/27/05
  - Place: Scott Ellsworth's office at Excellus
  - Excellus representatives: Scott Ellsworth, Regional President; Edward Black, MD, CMO; Chris O'Donnell, VP Network Management
  - GRIPA representatives: Gregg Coughlin and Eric Nielsen
  - Purpose: to educate Excellus principals about clinical integration and GRIPA's plans

- 5/10/05
  - Place: GRIPA offices
  - Excellus representatives: Martin Hickey, MD, Sr. VP Health Care Affairs; Jamie Kerr, MD, Medical Director
  - GRIPA representatives: GRIPA Medical Management Committee
  - Purpose: part of Dr. Hickey's initial round of meetings with local physician and hospital groups on beginning his employment with Excellus

- 8/3/05
  - Place: Whitney & Co. (office of Jack Biemiller)
  - Rump Group (self-appointed group of key senior executives in Rochester) representative: Dutch Summers, Chairman
  - GRIPA representatives: Gregg Coughlin; Jack Biemiller, Chairman, GRIPA Finance Committee
  - Purpose: familiarize community leaders with GRIPA's operations and proposed plans

- 8/18/05
  - Place: Dr. Hickey's office at Excellus
  - Excellus representative: Martin Hickey, MD, Sr. VP Health Care Affairs
  - GRIPA representatives: Lisa Smith, GRIPA CFO; Gregg Coughlin; Eric Nielsen
  - Purpose: educate Dr. Hickey about clinical integration and GRIPA's plans

- 8/31/05
  - Place: Preferred Care offices
  - Preferred Care representatives: John Urban, CEO; Lisa Brubaker, COO; Matthew MacKinnon, VP of Network Services

- GRIPA representatives: Lisa Smith, Gregg Coughlin, Eric Nielsen
- Purpose: to educate Preferred Care principals about clinical integration and GRIPA's plans

- 11/7/05
  - Place: offices of Rochester Business Alliance ("RBA")
  - RBA representative: Sandy Parker, CEO
  - GRIPA representatives: Gregg Coughlin, Eric Nielsen
  - Purpose: dispel perception that GRIPA was competing with RBA for HEAL NY health information technology grant funds; generally discuss clinical integration and GRIPA's plans

- 3/31/06
  - Place: GRIPA offices
  - MVP/Preferred Care representatives: David Oliker, MD, CEO MVP; Lisa Brubaker, COO Preferred Care
  - GRIPA representatives: Gregg Coughlin, Eric Nielsen
  - Purpose: meet and greet for Dr. Oliker upon the pending merger of MVP and Preferred Care; generally discussed clinical integration and GRIPA's plans

- 4/3/06
  - Place: Strathallan restaurant
  - Excellus representative: Martin Hickey, MD, Sr. VP Health Care Affairs
  - GRIPA representatives: Gregg Coughlin, Eric Nielsen
  - Purpose: update Dr. Hickey on GRIPA's progress toward clinical integration

- 4/14/06
  - Place: offices of RBA
  - Representatives: Board of RBA and Rump Group
  - GRIPA representatives: Gregg Coughlin; Sam Huston, ViaHealth CEO
  - Purpose: develop strategy for Rochester Regional Health Information Organization

- 8/31/06
  - Place: Pomodoro's restaurant
  - Excellus representative: Martin Hickey, MD, Sr. VP Health Care Affairs
  - GRIPA representatives: Gregg Coughlin, Eric Nielsen
  - Purpose: update Dr. Hickey on GRIPA's progress toward clinical integration

Q2 Please describe how GRIPA intends to develop fee proposals for use in its contract negotiations with payers.

As it has done with its financial risk-sharing contracts, GRIPA will try to determine what the market-driven conversion factor[1] is; that is, they'll try to figure out what conversion factor the payers generally are offering physicians in the area. When selling its integrated product, GRIPA plans to start with the market-driven conversion factor and hopes to add on a financial incentive for meeting quality and cost benchmarks in the form of a payment-for-performance, an upside gain-share, or an increased conversion factor with an accounting at the end of the year if GRIPA fails to meet specified targets.

What fee or other competitively sensitive information will GRIPA obtain from its physician members, and how will GRIPA assure that this or other competitively sensitive information will not be available or shared among the physicians?

GRIPA will receive its physician members' fee information as part of the claims data its members are required to submit for the purpose of populating the electronic prescribing application and the patients' electronic medical records. It will not, however, make any use of this information. And, in fact, GRIPA will not store, analyze, use or disclose for any purpose any information relating to the physicians' reimbursement rates that may be contained in the data.[2]

Q3 What limitations, if any, will be imposed on the number of physicians who will be allowed to participate in GRIPA, in total, or by specialty? What restrictions, if any, will be imposed on adding new physician members to GRIPA?

The only limitation on participation in GRIPA is that the physician must be a shareholder in Rochester General Physicians Organization, Inc. ("RGPO") or Wayne County Physicians Organization. RGPO limits new shareholder status to "active" Rochester General Hospital medical staff in medical specialties in which there is an inadequate number of physicians to service the subscribers of the payers with which GRIPA contracts. GRIPA has no plans to increase the number of its members

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[1] The payers calculate the physicians' fees for services rendered to subscribers by multiplying the negotiated conversion factor by the prior year's Relative Value Units ("RVU") set by the Centers for Medicare and Medicaid Services for each Current Procedural Terminology code. For example, if an office visit CPT code (99212) had an RVU of 1.02 and the conversion factor was $46, then the fee would be $46.92.

[2] Exhibit E, amended Physician Participating Provider Contracts, Section 2.3(e). Also included with the contracts are the letters and contract summary sent to the providers with the amended contract.

Q4 Who does GRIPA view as its primary or important competitors for its proposed program, or for its currently operating programs?

GRIPA's primary competitors are RCIPA, the University of Rochester System, the Unity Health System, and, somewhat ironically, its own members and other individual medical practices. Because customers will be able to contract with GRIPA members and other medical practices on an individual basis, GRIPA must be able to offer a product with a lower quality-adjusted price than the product offered by others, including its own members when contracting individually.

Related to the above, GRIPA intends to differentiate its product from that of others by offering the integrated product. To the best of GRIPA's knowledge, none of its competitors, although in the same relevant product market as GRIPA, will offer a similar product.

**Miscellaneous**

Q1 What is the significance, if any, either for GRIPA's proposed operation and achievement of efficiencies, or for the competitive effects and antitrust analysis of GRIPA's proposed operation, of the fact that 130 GRIPA physicians are employees of ViaHealth?

None. GRIPA will not rely on ViaHealth either to discipline its employed physicians for sub-par performance or to motivate them. GRIPA will perform those functions itself.[3] Like the independent practitioners, the ViaHealth-employed physicians must comply with the GRIPA practice guidelines and GRIPA's quality improvement policies, submit to GRIPA's quality monitoring and corrective action, and are subject to review and, if necessary, discipline by the GRIPA Quality Assurance Council. GRIPA can also expel noncompliant employed physicians from the network panel.[4]

For motivation, all physicians, including ViaHealth employees, will receive individual performance reports, be compared to their peers, and their performance scores will be aggregated with all of the participating physicians for the assessment of the network's improvement. In the past, GRIPA saw that the eligible ViaHealth-employed

[3] *See* Exhibit F, Amended By-laws (reflecting that all physicians are treated the same, regardless of their status as independent or employed physicians). The Amended By-laws have been ratified by two of the three shareholders.

[4] *See* Exhibit G, Participating Provider Employed Physician Contracts.

physicians received their share of financial withhold return and gain-sharing funds. If GRIPA negotiates for pay-for-performance or gain-sharing funds in its clinical integration contracts (as it hopes to do), it will make every attempt to ensure that the employed physicians are rewarded with their portion of the collectively earned bonus.

The employed physicians have been active in the development of GRIPA's clinical integration program, serving on the Board and CIC and providing input through the SAGs. They will be required to serve on the Council if selected.

Q2 Please provide any pre-existing reports, studies, or analyses of physician or health care competition, or pricing or payment levels to providers, in the geographic area (or any part thereof) within which GRIPA proposes to operate its program. Please include the 2005 strategic study that GRIPA undertook, and which is referred to on page 2 of your request letter, as well as any subsequent strategic or market reports or studies.

Sent 11/13/06.

You also requested additional information regarding GRIPA's financial risk-sharing contracts. Exhibit H contains spreadsheets showing numbers of covered lives, by month and year, for each managed care product. Exhibit I provides information on the capitation dollars—the total amount received from the health plan for providing physician services combined with physicians' withhold—and the amount of withhold and gain-sharing money paid to the physicians at the end of each fiscal year. The documents in Exhibit J show financial savings as a result of care management services interventions. The charts included in Exhibit K reflect changes in the patient population resulting from case management. Exhibit L provides updated charts tracking physician improvements in meeting protocol benchmarks for GRIPA's risk contracts. Exhibit M is a case study written by GRIPA staff regarding their Geriatric Assessment Service program, which resulted in improved quality of life for geriatric patients and their caretakers.

GRIPA has attempted to respond to your requests in as complete a manner as possible. If you have any questions regarding any of the above responses, please let us know.

Best regards,

Christi J. Braun

Enclosures

January 10, 2007

_____, MD

Rochester, NY

Dear Dr._____,

As you may know, GRIPA has embarked on a new initiative, GRIPA Connect™ Clinical Integration.

Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care. As a clinically integrated entity, GRIPA will contract on behalf of its members with various payors without accepting financial risk and withholds.

The GRIPA Connect web portal is now being tested, and we are beginning to "populate" the data repository with patient information from several lab and imaging facilities.

In response to many conversations with our physicians concerning patient privacy and their own status as independent businesses, and at the request of the leadership of RGPO and WCPO, GRIPA has made changes to its requirements to be part of GRIPA Connect Clinical Integration. These changes are listed in the enclosed page entitled "Contract Changes for Physicians" Also enclosed are amended contracts for **GRIPA Physician Participating Provider Contract – Clinical Integration** and **ViaHealth PPO Physician Participating Provider Contract - Clinical Integration.**

As a reminder, the GRIPA contract supplements, but does not replace, your prior contracts with GRIPA for HMO business as a financially integrated group accepting capitated risk. The ViaHealth PPO contract, which covers all non-HMO business, will succeed your prior contract with ViaHealth PPO. If you choose not to participate in GRIPA Connect Clinical Integration, your prior ViaHealth PPO contract will remain in place until GRIPA terminates the recently messengered non-risk payer contracts.

As you have **not** signed the original versions of these contracts from July, 2006, you will find enclosed a total of 4 contract signature pages. **If you wish to participate in GRIPA Connect Clinical Integration, you will need to sign and return all 4. We will then send you counter signed copies of these documents by return mail as confirmation of enrollment.**

It is a requirement of GRIPA Connect participation that each provider **individually** sign the enclosed contracts. No one, including your practice manager or an employer, can sign for you; but you should confirm with your employer that you are authorized to sign.

**ViaHealth administration has already signed group contracts for all ViaHealth-employed physicians.**

It is not necessary that other partners or associates in your practice sign these contracts for you to sign.

**Please mail all completed signature pages for both contracts to:**

GRIPA Network Services
60 Carlson Road
Rochester, NY 14610

or fax to 585-922-0016

You can learn more about GRIPA Connect and about Clinical Integration by visiting our web site: http://www.GRIPAconnect.com. Please feel free to contact us with any questions or concerns. I can be reached at eric.nielsen@viahealth.org or 585-922-3062. Kelly Taddeo, Director of GRIPA Network Services can be reached at kelly.taddeo@viahealth.org or 585-922-1525.

Sincerely,

Eric T. Nielsen, MD
Chief Medical Officer

January 10, 2007

_____, MD

Rochester, NY

Dear Dr._____,

As you know, GRIPA has embarked on a new initiative, GRIPA Connect™ Clinical Integration.

Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care. As a clinically integrated entity, GRIPA will contract on behalf of its members with various payors without accepting financial risk and withholds.

The GRIPA Connect web portal is now being tested, and we are beginning to "populate" the data repository with patient information from several lab and imaging facilities.

In response to many conversations with our physicians concerning patient privacy and their own status as independent businesses, and at the request of the leadership of RGPO and WCPO, GRIPA has made changes to its requirements to be part of GRIPA Connect Clinical Integration. These changes are listed in the enclosed page entitled "Contract Changes for Physicians" Also enclosed are amended contracts for **GRIPA Physician Participating Provider Contract – Clinical Integration** and **ViaHealth PPO Physician Participating Provider Contract - Clinical Integration**.

As you have already signed the original contracts from July, 2006, there is nothing that you need to do, and no signature pages are enclosed. The amended contracts will go into effect unless you notify GRIPA in writing within 30 days of the date of the amended contracts that you wish to opt out of the Clinical Integration Program.

**ViaHealth administration has already signed group contracts for all ViaHealth-employed physicians.**

As a reminder, the GRIPA contract supplements, but does not replace, your prior contracts with GRIPA for HMO business as a financially integrated group accepting capitated risk. The ViaHealth PPO contract, which covers all non-HMO business, will succeed your prior contract with ViaHealth PPO. If you choose not to participate in GRIPA Connect Clinical Integration, your prior ViaHealth PPO contract will remain in place until GRIPA terminates the recently messengered non-risk payer contracts.

You can learn more about GRIPA Connect and about Clinical Integration by visiting our web site: http://www.GRIPAconnect.com. Please feel free to contact us with any questions or concerns. I can be reached at eric.nielsen@viahealth.org or 585-922-

3062. Kelly Taddeo, Director of GRIPA Network Services can be reached at kelly.taddeo@viahealth.org or 585-922-1525.

Sincerely,

Eric T. Nielsen, MD
Chief Medical Officer

January 10, 2007

_____, MD

Rochester, NY

Dear Dr._____,

As a new member of Rochester General Physicians Organization or Wayne County Physicians Organization, you are eligible to join the panel of Greater Rochester Independent Physician Organization, Inc. ("GRIPA"), which negotiates contracts with HMO's for its members, and ViaHealth Preferred Provider Organization, Inc. ("ViaHealth PPO"), which manages fee-for-service business for its members.

You should know that GRIPA has embarked on a new initiative, GRIPA Connect™ Clinical Integration.

Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care. As a clinically integrated entity, GRIPA will contract on behalf of its members with various payors without accepting financial risk and withholds.

The GRIPA Connect web portal is now being tested, and we are beginning to "populate" the data repository with patient information from several lab and imaging facilities.

As a new physician member of RGPO or WCPO, you have the option of participating in only risk contracts through GRIPA and ***not*** joining the Clinical Integration Program, in which case you should sign ***only*** the two signature pages each for the contract entitled **Physician IPA Network Services Agreement for Greater Rochester Independent Practice Association, Inc.** and the associated Business Associate Agreement.

If you also wish to join the Clinical Integration Program, you must also sign two signature pages for the contracts entitled **GRIPA Physician Participating Provider Contract – Clinical Integration**, which will allow GRIPA to contract with HMO's without taking a withhold, and **ViaHealth PPO Physician Participating Provider Contract - Clinical Integration**, which will cover all non-HMO business.

It is a requirement of GRIPA Connect participation that each provider **individually** sign the enclosed contracts. No one, including your practice manager or an employer, can sign for you; but you should confirm with your employer that you are authorized to sign.

**ViaHealth administration has already signed group contracts for all ViaHealth-employed physicians.**

It is not necessary that other partners or associates in your practice sign these contracts for you to sign.

**Please mail all completed signature pages to:**

GRIPA Network Services
60 Carlson Road
Rochester, NY 14610

or fax to 585-922-0016

You can learn more about GRIPA Connect and about Clinical Integration by visiting our web site: http://www.GRIPAconnect.com. Please feel free to contact us with any questions or concerns. I can be reached at eric.nielsen@viahealth.org or 585-922-3062. Kelly Taddeo, Director of GRIPA Network Services can be reached at kelly.taddeo@viahealth.org or 585-922-1525.

Sincerely,

Eric T. Nielsen, MD
Chief Medical Officer

# GREATER ROCHESTER INDEPENDENT PRACTICE ASSOCIATION, INC.
# PHYSICIAN PARTICIPATING PROVIDER CONTRACT – CLINICAL INTEGRATION

This participating provider contract ("Contract") is made as of this 10th day of January, 2007 between GREATER ROCHESTER INDEPENDENT PRACTICE ASSOCIATION, INC. ("GRIPA"), a New York business corporation, and the undersigned physician ("Physician").

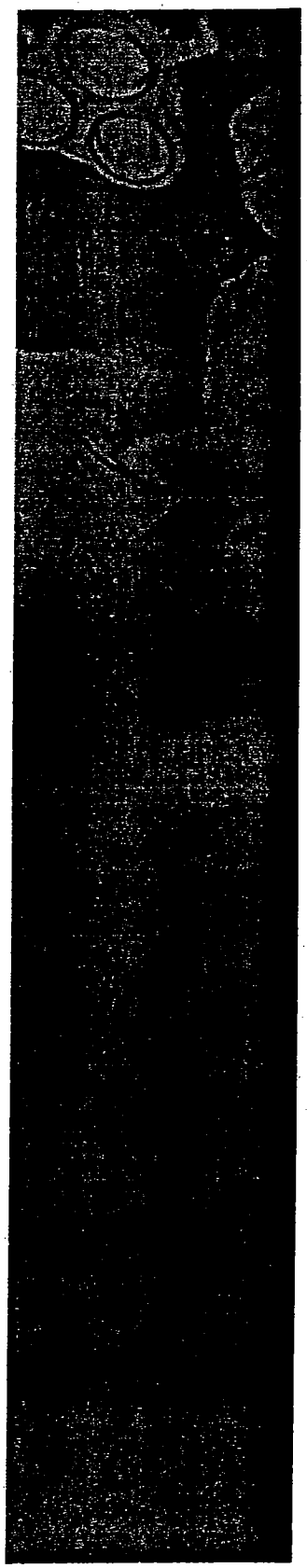
# VIAHEALTH PREFERRED PROVIDER ORGANIZATION, INC.
# PHYSICIAN PARTICIPATING PROVIDER CONTRACT – CLINICAL INTEGRATION

This participating provider contract ("Contract") is made as of this 10th day of January, 2007 between VIAHEALTH PREFERRED PROVIDER ORGANIZATION, INC. ("ViaHealth PPO"), a New York business corporation, and the undersigned physician ("Physician").

GREATER ROCHESTER

GRIPA

INDEPENDENT PRACTICE ASSOCIATION



# By-laws Of The Corporation

**Revision Date:**

**December ____,2006**

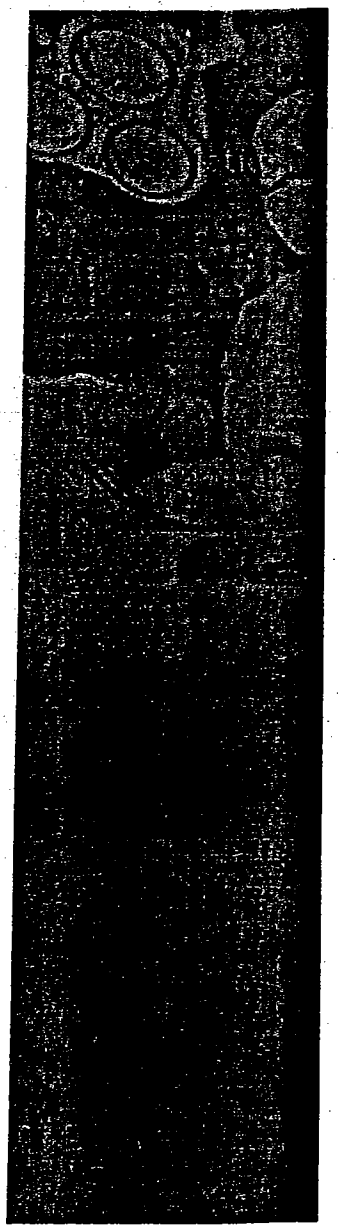
VIAHEALTH

PREFERRED

PROVIDER

ORGANIZATION,

INC.



# By-laws

# Of

# The Corporation

**Revision Date:**

**December ____,2006**

# GREATER ROCHESTER INDEPENDENT PRACTICE ASSOCIATION, INC. PARTICIPATING PROVIDER EMPLOYED PHYSICIAN CONTRACT – CLINICAL INTEGRATION

This participation contract ("Contract") is made as of this _____ day of _____, 2007 between Greater Rochester Independent Practice Association, Inc. ("GRIPA"), a New York business corporation, and Rochester General Hospital, a New York not-for-profit corporation that employs physicians ("Provider").

# VIAHEATH PPO, INC.
# PARTICIPATING PROVIDER EMPLOYED PHYSICIAN CONTRACT – CLINICAL INTEGRATION

This participation contract ("Contract") is made as of this ___ day of _____, 2007 between ViaHealth PPO, Inc. ("ViaHealth PPO"), a New York business corporation, and Rochester General Hospital, a New York not-for-profit corporation that employs physicians ("Provider").

# Covered Lives For Risk-Contracted Payers' Products

| | | Data | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | Month | VHP | PCC | GCC | Total Commercial | PCG | WC | Total Medicare | Total |
| 2005 | Jan | 11,605 | 31,366 | 55,451 | 98,422 | 13,820 | | 13,820 | 112,242 |
| | Feb | 11,510 | 31,880 | 55,031 | 98,421 | 13,900 | | 13,900 | 112,321 |
| | Mar | 11,447 | 32,148 | 54,597 | 98,192 | 14,014 | | 14,014 | 112,206 |
| | Apr | 11,365 | 32,294 | 53,602 | 97,261 | 14,130 | | 14,130 | 111,391 |
| | May | 11,305 | 32,384 | 53,418 | 97,107 | 14,210 | | 14,210 | 111,317 |
| | Jun | 11,318 | 32,463 | 53,154 | 96,935 | 14,244 | | 14,244 | 111,179 |
| | Jul | 11,209 | 32,679 | 52,383 | 96,271 | 14,373 | | 14,373 | 110,644 |
| | Aug | 11,165 | 32,771 | 52,108 | 96,044 | 14,423 | | 14,423 | 110,467 |
| | Sep | 11,035 | 32,888 | 51,585 | 95,508 | 14,420 | | 14,420 | 109,928 |
| | Oct | 10,956 | 32,823 | 51,221 | 95,000 | 14,463 | | 14,463 | 109,463 |
| | Nov | 10,897 | 32,824 | 51,007 | 94,728 | 14,491 | | 14,491 | 109,219 |
| | Dec | 10,712 | 32,887 | 50,416 | 94,015 | 14,533 | | 14,533 | 108,548 |
| 2005 Sum | | 134,524 | 389,407 | 633,973 | | 171,021 | | | |
| 2005 Average | | 11,210 | 32,451 | 52,831 | | 14,252 | | | |
| 2006 | Jan | | 28,360 | | 28,360 | 14,893 | | 14,893 | 43,253 |
| | Feb | | 27,942 | | 27,942 | 14,722 | | 14,722 | 42,664 |
| | Mar | | 27,890 | | 27,890 | 14,724 | | 14,724 | 42,614 |
| | Apr | | 27,856 | | 27,856 | 14,787 | 166 | 14,953 | 42,809 |
| | May | | 27,898 | | 27,898 | 14,869 | 202 | 15,071 | 42,969 |
| | Jun | | 28,202 | | 28,202 | 15,113 | 231 | 15,344 | 43,546 |
| | Jul | | 30,144 | | 30,144 | 15,206 | 286 | 15,492 | 45,636 |
| | Aug | | 31,865 | | 31,865 | 15,151 | 303 | 15,454 | 47,319 |
| | Sep | | 31,827 | | 31,827 | 15,168 | 331 | 15,499 | 47,326 |
| | Oct | | 32,505 | | 32,505 | 15,212 | 353 | 15,565 | 48,070 |
| | Nov | | 32,779 | | 32,779 | 15,238 | 370 | 15,608 | 48,387 |
| | Dec | | 33,045 | | 33,045 | 15,243 | 376 | 15,619 | 48,664 |
| 2006 Sum | | | 360,313 | | | 180,326 | 2,618 | | |
| 2006 Average | | | 30,026 | | | 15,027 | 291 | | |
| 2007 * | Jan | | 33,045 | | 33,045 | 15,268 | 575 | 15,843 | 48,888 |
| | Feb | | 33,045 | | 33,045 | 15,293 | 585 | 15,878 | 48,923 |
| | Mar | | 33,045 | | 33,045 | 15,318 | 595 | 15,913 | 48,958 |
| | Apr | | 33,045 | | 33,045 | 15,343 | 605 | 15,948 | 48,993 |
| | May | | 33,045 | | 33,045 | 15,368 | 615 | 15,983 | 49,028 |
| | Jun | | 33,045 | | 33,045 | 15,393 | 625 | 16,018 | 49,063 |
| | Jul | | 33,045 | | 33,045 | 15,418 | 635 | 16,053 | 49,098 |
| | Aug | | 33,045 | | 33,045 | 15,443 | 645 | 16,088 | 49,133 |
| | Sep | | 33,045 | | 33,045 | 15,469 | 655 | 16,124 | 49,169 |
| | Oct | | 33,045 | | 33,045 | 15,495 | 665 | 16,160 | 49,205 |
| | Nov | | 33,045 | | 33,045 | 15,521 | 675 | 16,196 | 49,241 |
| | Dec | | 33,045 | | 33,045 | 15,547 | 685 | 16,232 | 49,277 |
| 2007 * Sum | | | 396,540 | | | 184,876 | 7,560 | | |
| 2007 * Average | | | 33,045 | | | 15,406 | 630 | | |
| Grand Total | | 134,524 | 1,146,260 | 633,973 | 1,914,757 | 536,223 | 10,178 | 546,401 | 2,461,158 |

* 2007 is estimated based on current trends and information from the health plans

## Covered Lives For Risk-Contracted Payers' Products

VHP - ViaHealth Plan (Excellus managed)
PCC - Preferred Care Commercial
GCC - GRIPA Choice Choice (Excellus managed)
PCG - Preferred Care Gold (managed Medicare)
WC - Wellcare (managed Medicare)

# Care Management Services

**2005 Experience: Projected vs. Actual**

- General CM (Geriatrics included)
- Pharmacy Program
- Diabetes Program

| | Projected† | Actual* | Actual |
|---|---|---|---|
| Enrollment | 2400 | 1411 | 771 |
| # of months eligible for cost savings calculation in 2005** | 6 | 6 | 12 |
| % change IP | -18% | -54% | -51% |
| % change ED | -17% | -15% | -25% |
| PMPM savings | | | |
| Total savings for 2005 | | | |

† Based on historical experience of patients enrolled since January 2003:

- Aggregate of 4 programs
- Pre = 12 months prior to enrollment
- Post = 12 months after program closed
- LOS is variable
- total count of members = 2237

* Total enrollment for year 2005 was 2285. Actual = the number of members eligible for cost savings calculation

** Based on average duration of months in care management and consistent enrollment during measurement year

**2006 Experience: Preliminary** (There is very little run out on the post time, expect more dollars here)

- General CM
- Geriatric Program
- Pharmacy Program
- Diabetes Program

| | Actual* |
|---|---|
| Members Enrolled in 2006 | 1079 |
| # of months eligible for cost savings calculation in 2006** | 6 |
| % change IP | -72% |
| % change ED | -18% |
| % change PMPM | -40% |

**Based on average duration of months in care management and consistent enrollment during measurement year

**2007 Projected:**

| Outcome Measure | 12 Months Pre | 12 Months Post | Difference (Rate/PMPM) | % Change |
|---|---|---|---|---|
| ED Visits/1000 | | | | -17% |
| IP Admits/1000 | | | | -14% |
| Total Medical PMPM | | | | -10% |

† Based on historical experience of patients enrolled since January 2003 to December 2005:

- Aggregate of 4 programs
- Pre = 12 months prior to enrollment
- Post = 12 months after program closed
- LOS is variable
- total count of members = 4211

** Based on average duration of months in care management and consistent enrollment during measurement year

| | Projected† |
|---|---|
| Enrollment | 2400 |
| | |
| # of months eligible for cost savings calculation in 2005** | 6 |
| | |
| % change IP | -18% |
| | |
| % change ED | -17% |
| | |
| PMPM savings | |
| | |
| Total savings for 2005 | |
| | |

OUTCOMES - DIABETIC PATIENTS IN CASE MANAGEMENT
Patients reviewed after 1/1/2005 (excludes "low touch" patients)

**CLINICAL OUTCOMES**

| STATUS | Baseline A1C | # of patients | # of patients improved | Average Change in A1C Scores |
|---|---|---|---|---|
| Enrolled/Closed | < 8 | 74 | 33 | 0.18 |
| | 8 - 10 | 48 | 32 | -0.48 |
| | > 10 | 10 | 9 | -2.61 |
| Not Enrolled | < 8 | 91 | 36 | 0.18 |
| | 8 - 10 | 27 | 20 | -0.69 |
| | > 10 | 10 | 7 | -1.39 |

| | Baseline A1C in 12 months prior to enrollment | # of patients | # of patients improved |
|---|---|---|---|
| Enrolled/Closed | None | 24 | 3 |
| Not Enrolled | None | 54 | 15 |

| STATUS | Baseline LDL | # of patients | # of patients improved | % change b/w baseline and follow-up |
|---|---|---|---|---|
| Enrolled/Closed | < 100 | 64 | 28 | 7.19 |
| | 100 or > | 27 | 21 | -16.63 |
| Not Enrolled | < 100 | 61 | 30 | 3.05 |
| | 100 or > | 29 | 24 | -20.34 |

| | Baseline LDL in 12 months prior to enrollment | # of patients | # of patients improved |
|---|---|---|---|
| Enrolled/Closed | None | 49 | 7 |
| Not Enrolled | None | 88 | 20 |

**FLU VACCINE RATE/100 MEMBERS**

| | PRE/100 | POST/100 |
|---|---|---|
| ENROLLED/CI | 52 | 185 |
| Not Enrolled | 45 | 78 |

**EYE EXAM RATE/100 MEMBERS**

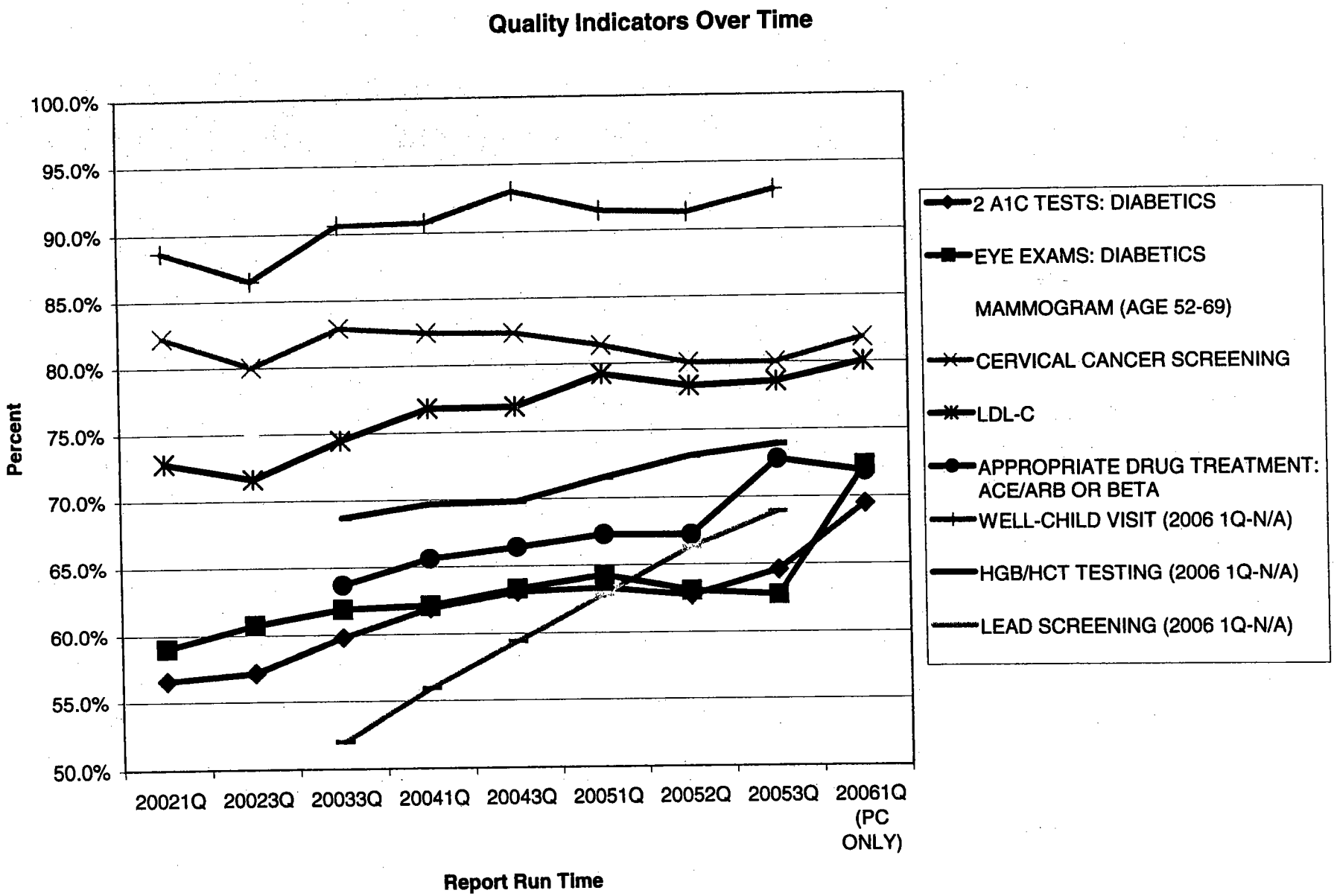
| | PRE/100 | POST/100 |
|---|---|---|
| ENROLLED/CI | 61 | 227 |
| Not Enrolled | 56 | 102 |

**OUTCOMES - Cost & Utilization** (Only includes patients that have been enrolled for 6 months or more)

| STATUS | PATIENTS | PRE ADMITS/1000 | POST ADMITS/1000 | PRE ED VISITS/1000 | POST ED VISITS/1000 | PRE PMPM | POST PMPM |
|---|---|---|---|---|---|---|---|
| ENROLLED/CLOSED | 330 | 186 | 172 | 195 | 135 | | |
| Not Enrolled | 450 | 179 | 235 | 204 | 235 | | |

**RANK SCORE**

| STATUS | AVG RANK SCORE |
|---|---|
| ENROLLED/CLOSED | 3.22 |
| Not Enrolled | 3.05 |


Quality Indicators Over Time
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Percent
20021Q
20023Q
20033Q
20041Q
20043Q
20051Q
20052Q
20053Q
20061Q (PC ONLY)
Report Run Time
2 A1C TESTS: DIABETICS
EYE EXAMS: DIABETICS
MAMMOGRAM (AGE 52-69)
CERVICAL CANCER SCREENING
LDL-C
APPROPRIATE DRUG TREATMENT: ACE/ARB OR BETA
WELL-CHILD VISIT (2006 1Q-N/A)
HGB/HCT TESTING (2006 1Q-N/A)
LEAD SCREENING (2006 1Q-N/A)

GREATER ROCHESTER

GRIPA

INDEPENDENT PRACTICE ASSOCIATION

| MEASURES | 20021Q | 20023Q | 20033Q | 20041Q | 20043Q | 20051Q | 20052Q | 20053Q | 20061Q (PC ONLY) |
|---|---|---|---|---|---|---|---|---|---|
| 2 A1C TESTS: DIABETICS | 56.6% | 57.1% | 59.8% | 61.9% | 63.0% | 63.2% | 62.7% | 64.6% | 69% |
| EYE EXAMS: DIABETICS | 59.0% | 60.7% | 61.9% | 62.1% | 63.2% | 64.2% | 63.0% | 62.7% | 72% |
| MAMMOGRAM (AGE 52-69) | 76.0% | 75.3% | 76.9% | 75.9% | 76.5% | 77.0% | 76.9% | 77.8% | 78% |
| CERVICAL CANCER SCREENING | 82.2% | 80.0% | 82.9% | 82.4% | 82.4% | 81.4% | 80.0% | 80.0% | 82% |
| LDL-C | 72.8% | 71.6% | 74.4% | 76.8% | 76.9% | 79.2% | 78.3% | 78.5% | 80% |
| APPROPRIATE DRUG TREATMENT: ACE/ARB OR BETA | | | 63.6% | 65.6% | 66.4% | 67.3% | 67.2% | 72.8% | 72% |
| WELL-CHILD VISIT (2006 1Q-N/A) | 88.7% | 86.5% | 90.6% | 90.8% | 93.0% | 91.5% | 91.3% | 92.9% | NA |
| HGB/HCT TESTING (2006 1Q-N/A) | | | 68.7% | 69.6% | 69.8% | 71.5% | 73.1% | 73.9% | NA |
| LEAD SCREENING (2006 1Q-N/A) | | | 52.0% | 55.9% | 59.4% | 62.8% | 66.3% | 68.9% | NA |

# A Consultant Pharmacist's Role on a Geriatric Assessment Service

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**Abstract**

**Objective**: This paper describes the role of a consultant pharmacist on a geriatric assessment service.

**Setting**: The Geriatric Assessment Service is part of an Independent Practice Association (IPA) in Rochester, New York.

**Practice Description**: The consultant pharmacist is responsible for the promotion of rational, cost-effective prescribing of drug therapy in physician offices affiliated with the IPA.

**Practice Innovation**: A team was formed comprised of a consultant pharmacist, social worker and registered nurse with the objective of providing support to community physicians in the care of at-risk, frail, medically complex, community dwelling adults > 75 years of age. Assessments completed varied according to patient needs. Recommendations were made to the primary care provider based on the results of each patient's assessment.

**Main Outcome Measurements**: Patient satisfaction, physician satisfaction, Caregiver Strain Index, and Drug Appropriateness Measure.

**Results**: Enrollment in the program rose from 19% in the first quarter to 63% in the fourth quarter. The Drug Appropriateness Measure on average improved greater than 60% for patients enrolled. Member satisfaction rated 9 out of 10. The Caregiver Strain Index showed an improvement of 28%. Comparison of GAS enrolled patients to non-interventional patients showed a lower per member per month cost change from 2005 to 2006.

**Conclusions**: The GAS provided assistance to primary care providers caring for community dwelling at-risk seniors resulting in improved pharmaceutical care as well as reduction in caregiver strain. Benefits from program may impact on the increased cost of care for these seniors.

**Key words:** geriatric, assessment, at-risk, drug appropriateness measure, caregiver strain

**Abbreviations**: IPA=independent practice association, GAS=Geriatric Assessment Service

## Introduction

Individuals over the age of 65 make up 12% of the United States population and account for one third of U.S. health care expenditures.[1] This group accounts for 36% of hospital stays and 50% of all physician hours.[2] Training necessary to care for this special needs population is lacking. While just over 90% of all internal medicine residency programs include some geriatric curriculum, only 40% require geriatric medicine clinical training exceeding 25 half-days and about one-third these programs require fewer than twelve half-days.[3] Primary care providers may find it difficult to adequately assess the needs of an increasingly frail, at-risk senior population in the short visit times allowed in their busy schedules.

## Purpose

This paper describes the first year of a program designed to provide support to community physicians caring for at-risk, frail, medically complex, community dwelling adults $\geq$ 75 years of age currently part of their practices. The Geriatric Assessment Service (GAS) is an interdisciplinary team comprised of a consultant pharmacist, social worker and registered nurse that provides multidimensional evaluations for this elderly population. The hallmarks of the assessment are the use of standardized instruments to evaluate aspects of patient functioning, impairments and social supports. The goal is to develop a coordinated and integrated plan of care, treatment and family caregiver education. This covers medical, cognitive, functional, psychological and social domains.

## Setting

The Geriatric Assessment Service (GAS) is one of many programs provided by the Care Management Services department of the Greater Rochester Independent Practice Association (GRIPA), a unique partnership of physicians and hospitals in the Monroe and Wayne Counties of New York State. There are approximately 1100 physicians in the GRIPA network. Services provided by GRIPA include contract management, data analysis and evaluation, actuarial services, physician network services and physician credentialing as well as Care Management Services.

## Enrollment Process

Referrals to the Geriatric Assessment Service (GAS) were obtained from 3 main sources: (1) direct primary care provider (PCP) referral, (2) the members of the IPA's Care Management Services team and (3) through screening of PCP practices that agreed to accept assistance in managing their frail elderly patients. A small number of referrals were received from patient family members, third party insurances and colleagues not employed by GRIPA. A referral was defined as a request for evaluation by a unique member of the GAS team. Each team member (pharmacist, nurse and social worker) would receive a referral if they worked on a case. Therefore 1 patient could generate up to 3 referrals.

Referral criteria for the GAS program included patients 75 years of age or greater identified as medically complex with one or more of the following problems: memory deficits, falls, incontinence, depression, anxiety and/or malnutrition. The Geriatric Needs Assessment (GNA) was a list of 10 questions (table 1) used to screen all patients being considered for enrollment in the GAS program. It was the primary trigger for enrollment into the program. The first two questions covered ability of patients to consistently take as well as afford their medications. Question 3 assessed the history of patient falls or fear of falling. Question 4 related to the emotional state of the patient and question 5 dealt with memory problems. Question 6 and 7 focused on the patient's ability to manage caring for a loved one and for maintaining their home. An answer "yes" to one of the first 7 questions, with an agreement by the individual to accept assistance from the GAS team, resulted in enrollment in the program. Two additional questions, one related to pain unreported to the PCP and another involving patient concerns about sleep, weight change, hearing or vision changes, were also included and usually resulted in patient enrollment if answered "yes".

Any specific request from a PCP to have a patient evaluated by the GAS team was defined as a direct physician referral. All direct PCP referrals were enrolled in the GAS program and evaluated. Referrals from the Care Management Services team may or may not already be open to other Care Management Services and were referred if the case manager felt the needs of the patient could be best provided by the GAS team. The GAS team also proactively approached PCP practices with a heavy concentration of seniors 75 years of age or greater and offered to screen these patients for potential assistance. Referrals from this source were obtained by providing the PCP with a list of at-risk, community dwelling adults $\geq$ 75 years of age currently part of their practices. Many of these patients were identified from claims data with diagnoses of dementia, Parkinson's disease, incontinence, malnutrition, anxiety or depression besides the more frequent diagnoses of diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and cerebral vascular disease. The PCP then identified patients from this list he/she agreed to have the GAS team contact and screen using the Geriatric Needs Assessment screening tool. The (GNA) could be administered by one of the GAS team members by telephone.

**Evaluation**

Based on the results of the GNA, the GAS team members determined which disciplines would initiate the evaluation. For example, if the needs of the patient were primarily functional and social, the nurse and the social worker would open the case. If the needs of the patient were primarily financial related to medication costs, the pharmacist and the social worker would open the case. During the evaluation, if additional information became available that suggested needs existed that could best be met by a team member not currently open to the case, a referral could be made to that team member for their input.

Assessments completed for each evaluation varied according to the needs of the patient. A baseline Functional assessment was done on all patients using the Katz ADL and Lawton IADL tools.[4,5] A baseline Caregiver Strain Index (CSI) was done when primary

caregivers were involved.[6] A follow-up CSI was completed at closure if the initial CSI score was seven or greater. Cognitive function was assessed using the Mini Mental Status Exam (MMSE), Clock Drawing and Trail Making A and B standardized assessment tools. Depression was evaluated on all patients without cognitive impairment, using the Patient Health Questionnaire-9 (PHQ-9) screening tool derived directly from the DSM-IV diagnostic criteria for major depression. The Primary Care Falls Assessment and Tinetti-Gait and Balance tools were used routinely on any patient with a history of falls or appeared to be at future risk. Home safety was evaluated during home visits if it was apparent that deficiencies existed that might place the patient at risk for injury. Pharmacy safety was evaluated by counting pills and evaluating refill history if there is a concern about medication compliance. The Hearing Handicap Inventory-Elderly was also employed by the nurse based on the needs of the patient.

**Consultant Pharmacist Role**

The consultant pharmacist was actively involved in screening patients identified at-risk by PCP as well as evaluating the appropriateness of the medication regimens of patients identified by the team. Every patient enrolled in the GAS program that required a pharmacist evaluation received a Drug Appropriateness Measure (DAM). This tool was adapted from the Brief Medication Questionnaire.[7] It consisted of six questions (table 2) that evaluated the appropriate indication of each medication, any untreated needs of the patient, optimization of the present drug regimen, dosage of each medication in light of any renal dysfunction, any drug interactions or adverse effects due to the current medication regimen and any potential barriers the patient may have to properly taking their medications. For example, a typical evaluation might have identified a proton pump inhibitor that was no longer indicated since discharge from the hospital, or the need for antidepressant therapy based on the results of the depression screen. Each question had 3 possible answers with a score attached:

- "Yes" the problem existed (2 points)
- The problem was being worked on (1 point)
- "No" the problem did not exist or the problem no longer existed (0 points)

The DAM score was the total number of points from the sum of all 6 questions. The DAM was done at the time of the initial assessment and again after recommendations made to the PCP were addressed and the case was closed.

**Summary Letter**

Once an evaluation was completed, the GAS team communicated the results of the assessments in a summary letter. The letter was broken down into categories including cognitive assessment, emotional assessment, safety assessment, pharmacy assessment, social support, other (hearing or other pertinent findings), goals and lastly recommendations and plan. The team's findings and recommendations were sent to the PCP's office for review. It was the PCP's responsibility to determine what action should

be taken that involved a change in the current patient medical care plan (eg. starting/stopping medications, referral to specialists etc). Psychosocial issues including financial, safety and compliance assistance needs were addressed by the team with the acceptance of the patient, family and notification to the physician. This might involve application for medication assistance programs, arranging medical or social daycare, removing scatter rugs that posed a fall risk or teaching the patient how to use a medication box to organize his/her drug regimen.

**Results**

The enrollment rate of the GAS program rose each quarter from 19% in the 3rd quarter of 2005 to 63% in the second quarter of 2006 (table 3). The source of referrals was primarily through the PCP (table 4). Each patient received on average 1.6 disciplines referred to their case. Enrollment by discipline remained fairly balanced with the pharmacist enrolling about a quarter of the patients and the remaining 75% split between the nurse and the social worker (table 5). The reason for a patient not being enrolled in the program was primarily due to the criteria of the program not being met (table 6). The GNA was the program's criteria as discussed in the enrollment process.

The program outcome measures were patient satisfaction, physician satisfaction, Caregiver Strain Index improvement and Drug Appropriateness Measure improvement. Patient satisfaction averaged 9 out of 10 on the assessment tool sent to the patient or family member (table 7). The physician satisfaction survey was sent quarterly to PCPs who had patients enrolled in the program. This measure was not implemented until the third quarter of the program. Only 1 survey was returned with a score of 9 out of 10. Caregiver Strain Index improvement averaged around 28% (table 8)

The goal of the pharmacist was to demonstrate at least a 50% improvement on the Drug Appropriateness Measure. This would mean that on average all problems identified by the evaluation tool were at least being worked on by the PCP, patient or caregiver. An improvement score greater than 50% would mean that besides working on the problems identified, some of the problems were being completely resolved. The improvement in DAM varied between quarters but averaged 62% overall (table 9). The results of the second quarter 2006 DAM improvement scores were weighed down by 1 case in which the PCP neglected all recommendations made by the pharmacist leading to a score of zero. This patient ended up having an acute exacerbation of delirium that resulted in admission to a long term care facility.

Each of the six questions on the DAM was analyzed for total score results on the pre-test and post-test to evaluate what areas were most commonly identified as problems and what areas showed the greatest improvement after the pharmacist's interventions (table 10). Compliance barriers, non-optimal medication regimen and drug induced problems were the 3 most common problem areas. The greatest improvement was seen in drug induced problems, inappropriate dosage for renal function and non-optimal medication regimen respectively.

Finally, a financial impact of the program was attempted to be evaluated. A comparison was run by the analysis department comparing the group of patients enrolled in the GAS program to a similar group of elders not part of the program. The intervention group represented patients from 10 PCPs in 5 community practices compared to patients from 104 PCPs in 58 practices. The average age in each group was 78 years old. The average retroactive risk score was slightly higher in the intervention group (3.05) compared to the non-intervention group (3.02). The retroactive risk score was based on the diagnoses associated with each patient. The risk weights were created using a national patient database. The retroactive risk score was used to predict the dollars a patient should have cost in the past 12 months. A value of one is the average risk. It was expected that patients with a risk score of 3 would have an increase in their cost of medical expenses. The GAS intervention group showed a lower per member per month increase in cost of care from 2005 to 2006 YTD compared to the non-intervention group (Table 11).

**Discussion**

The need to care for seniors in the community is growing. In 1996, there were almost 4 million people in the U.S. over 85 years old. The U.S. Census Bureau projects by 2040, 13 million Americans will be older than 85.[8] As our population grows older, we will have an increased demand for health care services, along with a dramatic rise in cost of providing this care. By the year 2030, costs of caring for elderly Americans will represent more than half of all health care dollars.[9] Coordinating the care of seniors may be the most effective way of delivering the services necessary for community dwelling elders to live in a safe and healthy environment. The federal government's PACE project is an example of a coordinated care program designed to keep frail elders living safely in a community setting. PACE, the Program of All-inclusive Care for the Elderly, advocates a multidisciplinary approach to treatment that meets both social and medical needs of its enrollees.[10]

The GAS program was developed to assist primary care providers with the daunting task of keeping their frail seniors safe in a community setting. Too often office visits with seniors revolve around the immediate needs of overt illness like bronchitis, CHF exacerbations and various pain conditions. This leaves little time to address underlying conditions like incontinence, gait instability, memory difficulties and others that increasingly put their patient at risk in a community setting. A referral to the GAS program provided the PCP with a more complete picture of how well his patient was coping in his/her present environment. It linked these patients with services that might not have been known necessary and reported problems that frequently go unnoticed until a disaster occurs.

The consultant pharmacist had a unique role on the GAS team by providing greater insight to the complex role medications play in the care of this at-risk population. It provided the equivalent of medication treatment management (MTM) in the context of coordinated care provided by the PCP, social worker and registered nurse. This allowed the pharmacist to assess the real pharmaceutical needs of the patient rather than the theoretical needs that might be determined by some forms of MTM. The pharmacist many times had knowledge of compliance issues, potential financial difficulties, overt

and underlying medical conditions, clinical lab data and other social dynamics which all influence the ability of a PCP to properly treat a patient with medications in the community. The resultant improvement in DAM scores demonstrated that this forum for pharmacy consultation can effectively impact on medication related problems. The recommendations made by the pharmacists were routinely addressed and in some cases resulted in total resolution of the problem and in many others initiated attempts to improve the problem.

A geriatric assessment service can provide assistance to primary care providers caring for community dwelling at-risk seniors. The GAS program is an example how such a program can improve pharmaceutical care, reduce caregiver stress and provide patient satisfaction. Benefits from the interventions made by this type of program may impact on the increased cost of care for frail community-dwelling seniors.

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**Table 1. Geriatric Needs Assessment**

**1.** Do you have a difficult time taking the medications the Doctor has prescribed?

**2.** Do you have a difficult time affording the medications the Doctor has prescribed?

**3.** Over the past 6 months have you fallen or been afraid that you would fall?

**4.** Over the last 6 months have you felt unusually sad, anxious and or irritable?

**5.** Have you had more trouble than in the past with memory for day-to-day things?

**6.** Do you help care for a family member or friend?

If yes, do you have difficulty with any of the following:

____ Physically overexerting yourself

____Managing all the day to day things

____ Dealing with some difficult/upsetting behaviors that need to be done

____ Do you have a hard time asking for help

**If yes to ≥ 1 of the above, patient qualifies for enrollment**

**7.** Is the patient interested in assistance by our GAS team?

**If yes to any of the questions below, patient may be considered for enrollment:**

**8.** Do you have concerns about pain that your Doctor is not aware of?

**9.** Are there things that make it difficult for you to manage at home (ie. meals, stairs, lack of bathroom equipment, etc)

**10.** Do you have concerns about sleep, weight (loss or gain), vision and/or hearing?

**Table 2. Drug Appropriateness Measure**

| | |
|---|---|
| Are there any medications without an appropriate indication? | 2= YES<br>1= WORKING ON PROBLEMS<br>0 = NO |
| Are there any untreated indications? | 2= YES<br>1= WORKING ON PROBLEMS<br>0 = NO |
| Are there any medications that are not optimal (not monitored appropriately, subtherapeutic dose, pt not compliant with tests) | 2= YES<br>1= WORKING ON PROBLEMS<br>0 = NO |
| Are there any medications that are not dosed appropriately for renal function? | 2= YES<br>1= WORKING ON PROBLEMS<br>0 = NO |
| Are there any suspected drug induced diseases/problems? | 2= YES<br>1= WORKING ON PROBLEMS<br>0 = NO |
| Are there any barriers to compliance? (cost of med, complicated regimen, language barriers, lack of basic knowledge about disease or medication) | 2= YES<br>1= WORKING ON PROBLEMS<br>0 = NO |

**Source:** Reference 4

**Table 3. Program Enrollment Rate**

| | 3rd Quarter 2005 | 4th Quarter 2005 | 1st Quarter 2006 | 2nd Quarter 2006 |
|---|---|---|---|---|
| Number of Referrals | 77 | 103 | 99 | 95 |
| Number Enrolled | 15 | 30 | 44 | 60 |
| Enrollment Rate | 19% | 29% | 44% | 63% |

**Table 4. Unique Referrals by Source**

| | 3rd Quarter 2005 | 4th Quarter 2005 | 1st Quarter 2006 | 2nd Quarter 2006 |
|---|---|---|---|---|
| PCP | * | 81 | 76 | 63 |
| CMS Staff | * | 10 | 11 | 21 |
| Patient/Family | * | 2 | 1 | 2 |
| Other | * | 0 | 3 | 0 |
| 3rd Party Insurance | * | 3 | 0 | 0 |
| Program Total | * | 96 | 2098 | 86 |

* Referrals by source not broken down the initial quarter or the program.

**Abbreviations:**
PCP = Primary care provider
CMS = Care Management Services

**Table 5. Enrollment by Discipline**

| | RPh | RN | SW | Total All |
|---|---|---|---|---|
| 3rd Quarter 2005 | 4 | 3 | 8 | 15 |
| 4th Quarter 2005 | 7 | 12 | 11 | 30 |
| 1st Quarter 2006 | 10 | 15 | 19 | 44 |
| 2ndQuarter2006 | 16 | 24 | 20 | 60 |
| First Year Total | 37 | 54 | 58 | 149 |

**Abbreviations:**
RPh = pharmacist
RN = registered nurse
SW = social worker

**Table 6. Non-Enrollment by Reason**

| | 3rd Quarter 2005 | 4th Quarter 2005 | 1st Quarter 2006 | 2nd Quarter 2006 |
|---|---|---|---|---|
| Appt cancelled | * | 1 | 0 | 0 |
| Disenrolled | * | 1 | 1 | 1 |
| Expired | * | 1 | 1 | 0 |
| Hospice | * | 0 | 3 | 0 |
| Ineffective | * | 5 | 4 | 0 |
| Internal program referral | * | 9 | 5 | 4 |
| No Rx related needs | * | 1 | 0 | 0 |
| Other | * | 0 | 1 | 3 |
| Patient refusal | * | 6 | 4 | 3 |
| Physician Refusal | * | 1 | 0 | 0 |
| Program criteria not met | * | 31 | 21 | 12 |
| Refer to payer CM/DM | * | 0 | 1 | 1 |
| Rx review completed | * | 1 | 0 | 0 |
| SNF-Long Term Care | * | 1 | 3 | 0 |
| Total | | 58 | 2051 | 34 |

* Non-enrollment by reason was not broken down the initial quarter of the program.

**Abbreviations:**
Appt = appointment
Rx = pharmacy
CM/DM = case management / disease management
SNF = skilled nursing facility

**Table 7. Patient Satisfaction**

| | 3rd Quarter 2005 | 4th Quarter 2005 | 1st Quarter 2006 | 2nd Quarter 2006 |
|---|---|---|---|---|
| Total Sent | * | 14 | 43 | 10 |
| Total Received | * | 6 | 12 | 9 |
| % returned | * | 43% | 28% | 90% |
| % Satisfied | * | 100% | 90% | 90% |

* Patient satisfaction was not evaluated the initial quarter of the program.

**Table 8. Caregiver Strain Index**

| | 3rd Quarter 2005 | 4th Quarter 2005 | 1st Quarter 2006 | 2nd Quarter 2006 |
|---|---|---|---|---|
| # eligible (baseline) | * | 6 | 20 | 24 |
| # administered | * | 5 | 20 | 24 |
| % compliance | * | 83% | 100% | 100% |
| | | | | |
| # eligible (closure) | * | 0 | 7 | 5 |
| # administered | * | 0 | 7 | 5 |
| % compliance | * | 100% | 100% | 100 |
| % improvement | * | 0 | 26.5% | 30% |

* Caregiver Strain Index not quantified for the group of patients enrolled in the initial quarter of the program.

**Table 9. Drug Appropriateness Measure**

| | 3rd Quarter 2005 | 4th Quarter 2005 | 1st Quarter 2006 | 2nd Quarter 2006 |
|---|---|---|---|---|
| # eligible (baseline) | * | 8 | 8 | 12 |
| # administered | * | 8 | 8 | 12 |
| % compliance | * | 100% | 100% | 100% |
| | | | | |
| # eligible (closure) | * | 7 | 4 | 11 |
| # administered | * | 7 | 4 | 11 |
| % compliance | * | 100% | 100% | 100% |
| % improvement | * | 64% | 79% | 54% |

* Drug Appropriateness Measure was not quantified for the group of patients seen the initial quarter of the program.

**Table 10. Drug Appropriateness Measure Totals Broken Down by Question**

| Question | Pre-Test | Post-Test | % Improvement |
|---|---|---|---|
| 1. Meds without indication | 14 | 7 | 50% |
| 2. Untreated indications | 44 | 18 | 59% |
| 3. Med regimen not optimal | 60 | 22 | 63% |
| 4. Dose inappropriate based on renal | 7 | 2 | 71% |
| 5. Drug induced disease/problems | 50 | 14 | 72% |
| 6. Barriers to compliance | 68 | 29 | 57% |
| Total score: | 243 | 92 | 62% |

**Table 11. Per Member Per Month Change in Cost of Care 2005 to 2006 Year to Date**

| Patient Group | Count of PCP/Practices | PMPM change 2005 to 2006 | Average Age | % female | Average Retroactive Risk Score |
|---|---|---|---|---|---|
| GAS patients | 10 PCPs/ 5 practices | 0.35% | 78 | 56% | 3.05 |
| Non-GAS patients | 104 PCPs/ 58 practices | 11.12% | 78 | 58% | 3.02 |

**Abbreviations:**
GAS = geriatric assessment service
PCPs = primary care providers
PMPM = per member per month

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**VIA COURIER**

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Phone: (202) 326-2744

**Re:** Greater Rochester Independent Practice Association, Inc.
Advisory Opinion Request

Dear David,

Per our recent discussion, our client, Greater Rochester Independent Practice Association, Inc. ("GRIPA"), has decided to respond to your request for additional information, dated September 21, 2006, on a rolling basis. In this first installment, GRIPA is providing responsive documents. To assist in your review, we have organized the documents according to the question to which they are most responsive.

GRIPA requests that certain documents be treated as confidential under Federal Trade Commission Procedure Rule 4.10, 16 C.F.R. § 4.10(a)(2) (2006), and § 6(f) of the Federal Trade Commission Act, 15 U.S.C. § 46(f) (2006). We have marked as "confidential" all documents containing competitively sensitive, commercial, or financial information.

If you have any questions, please do not hesitate to call me at the above number.

Best regards,

Christi J. Braun

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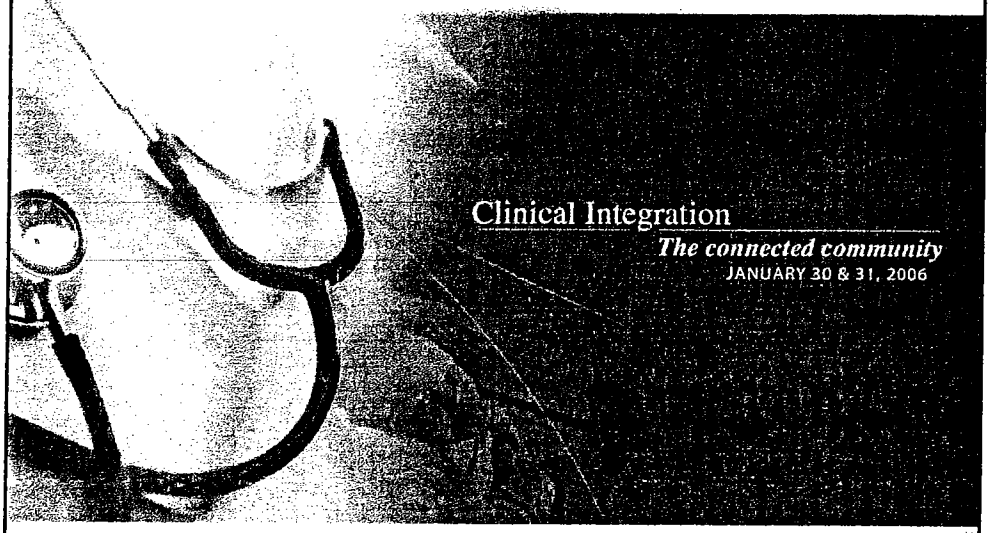
Enclosures

**Program Description**

2. Please provide copies of all materials regarding the proposed program that have been presented, provided, or distributed to any potential physician participants in the program, or to any potential customers for the program.

1/30/06 SCP Dinner Meeting

GRIPA



# Clinical Integration

*The connected community*

JANUARY 30 & 31, 2006

GRIPA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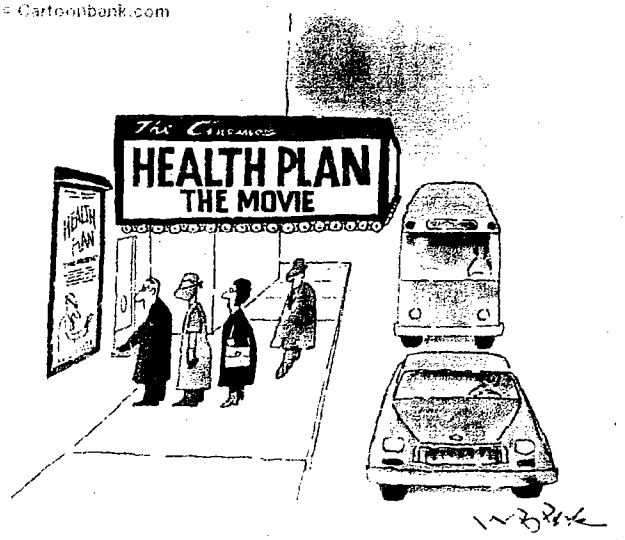


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GRIPA

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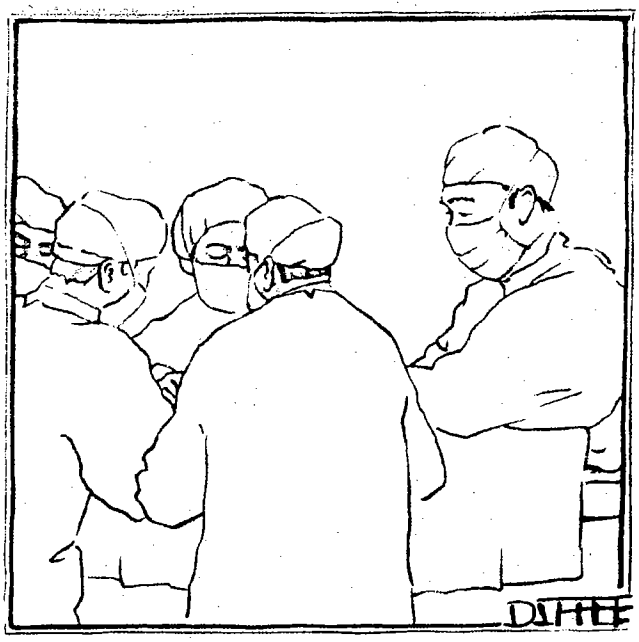

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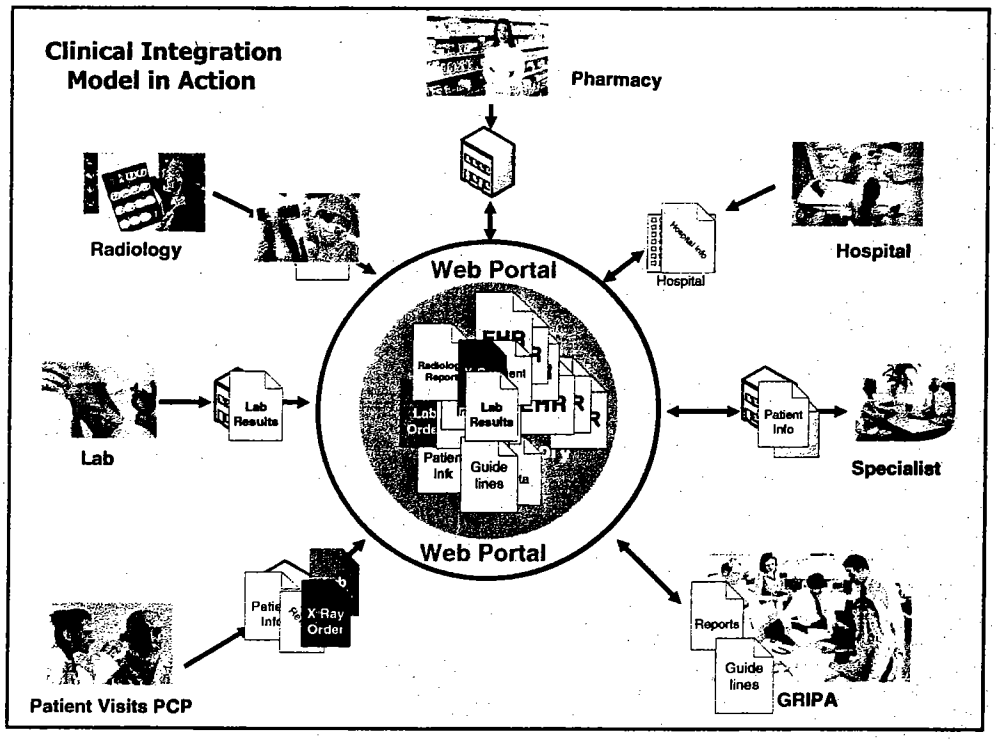
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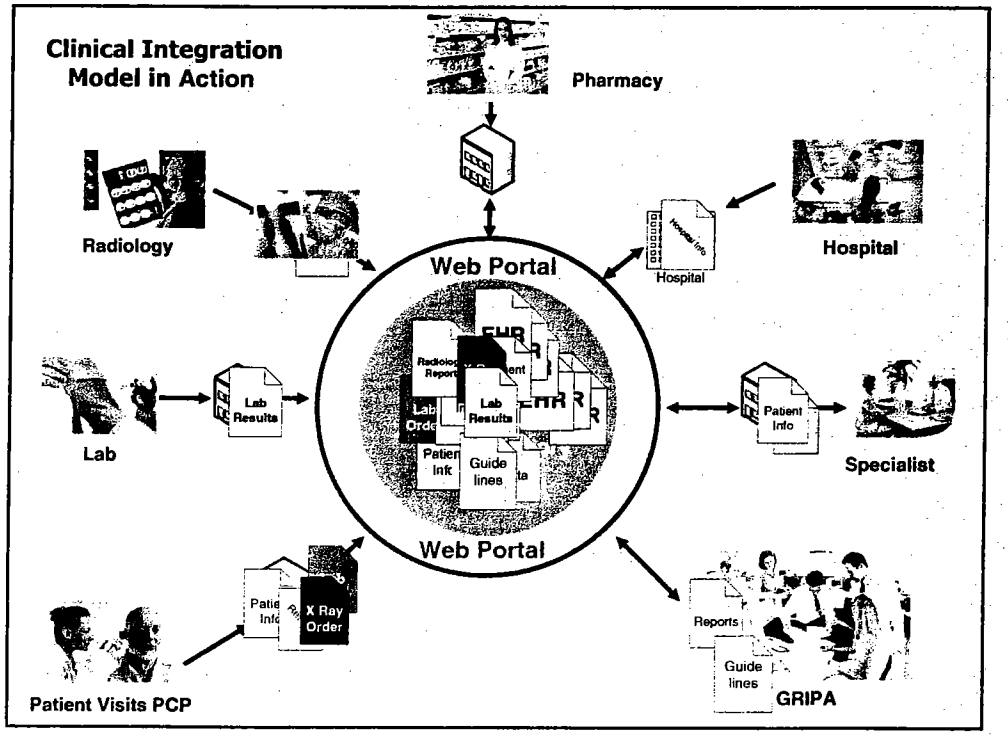
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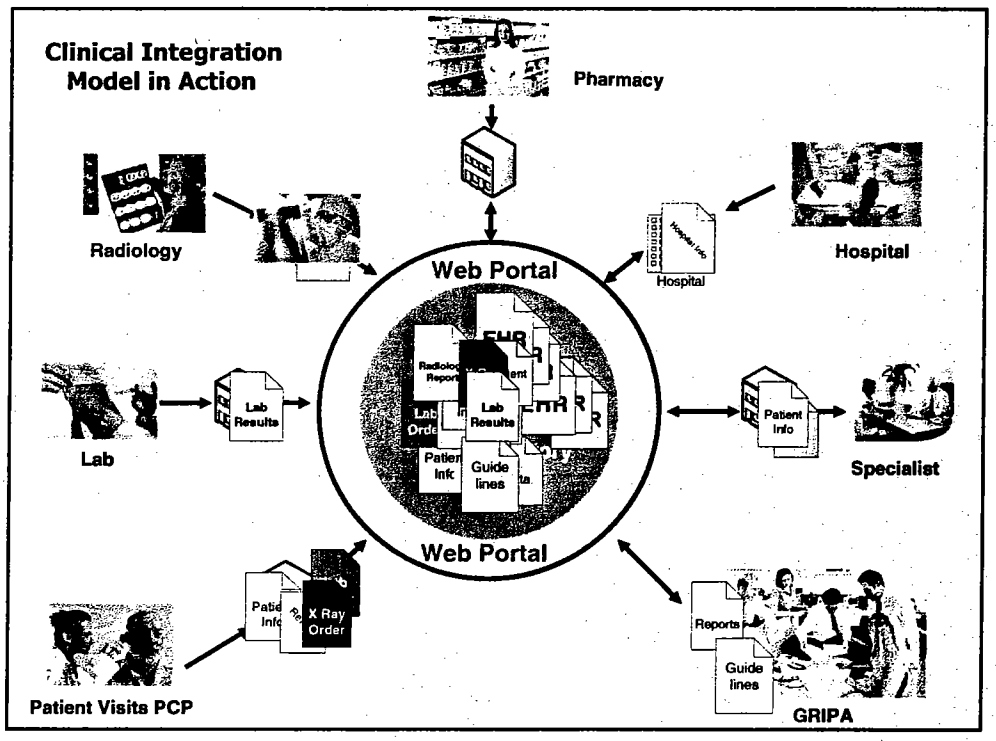
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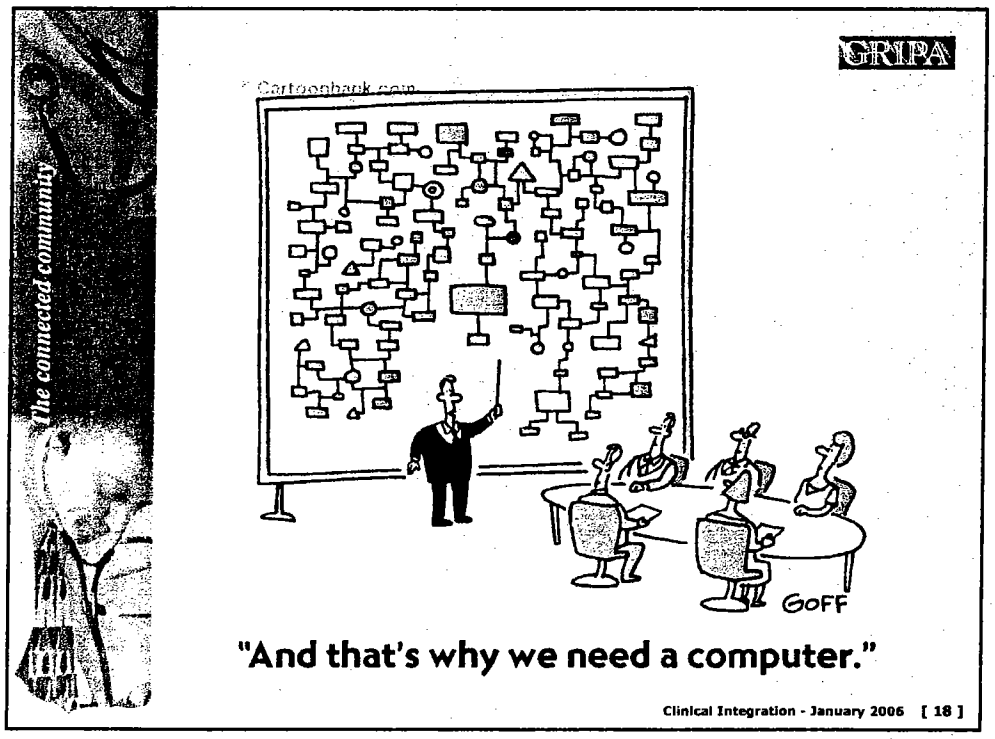
the connected community
GRIPA
Cartoonbank.com
GOFF
"And that's why we need a computer."
Clinical Integration - January 2006 [ 18 ]


GRIPA

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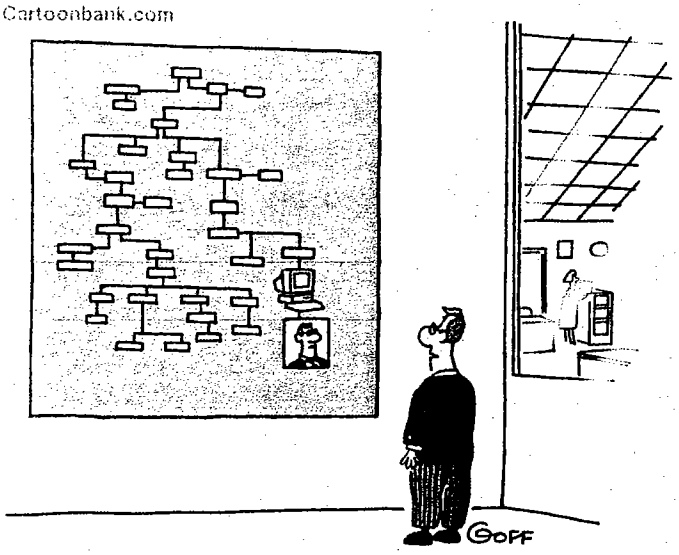


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GRIPA

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GRIPA

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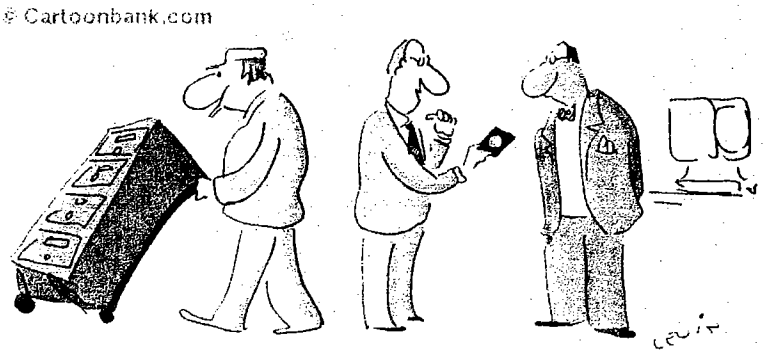


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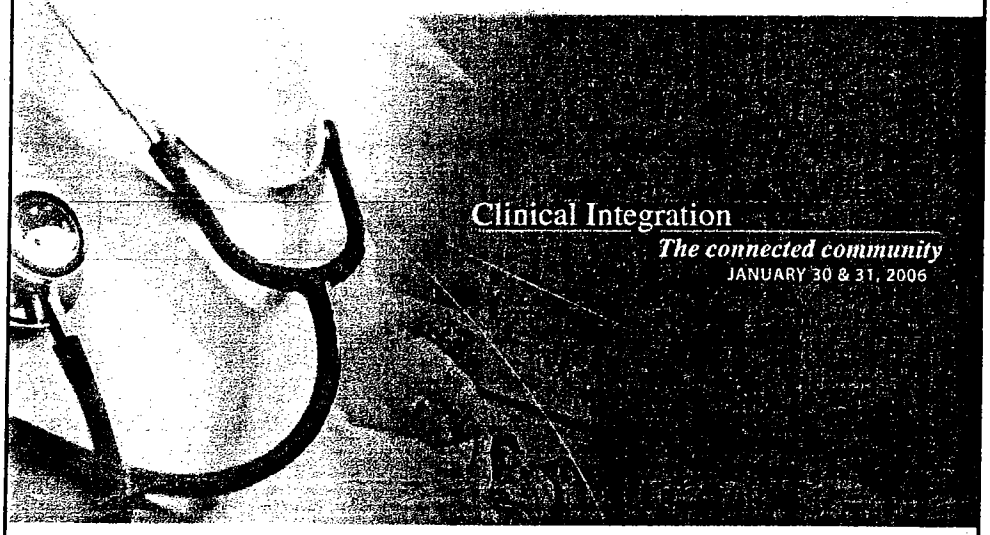

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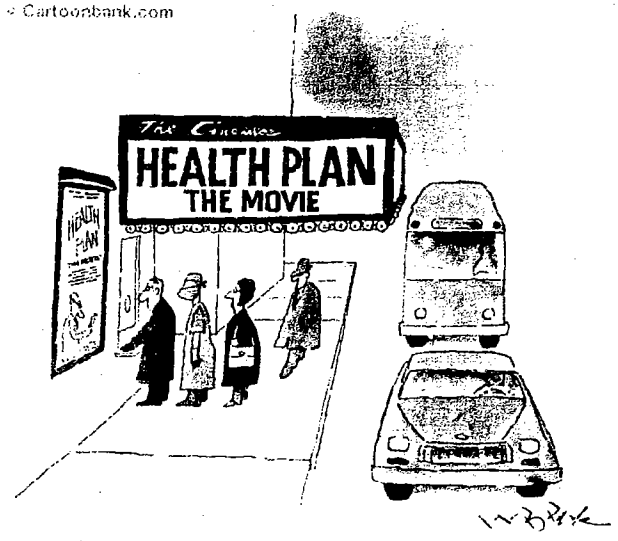


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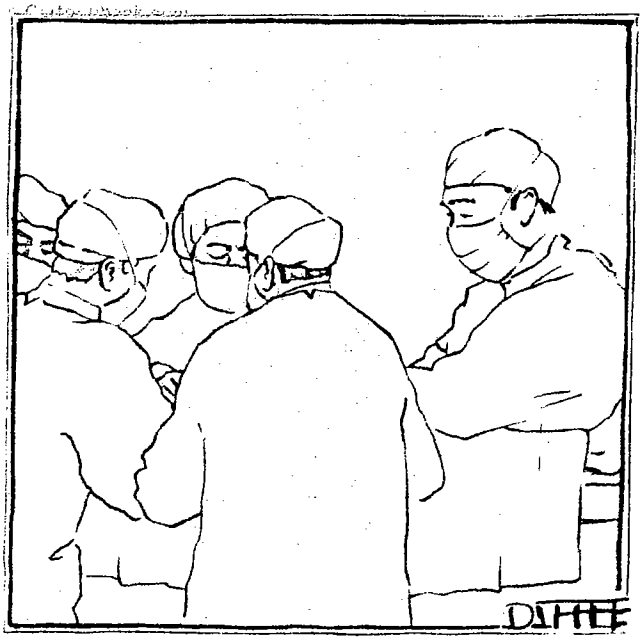

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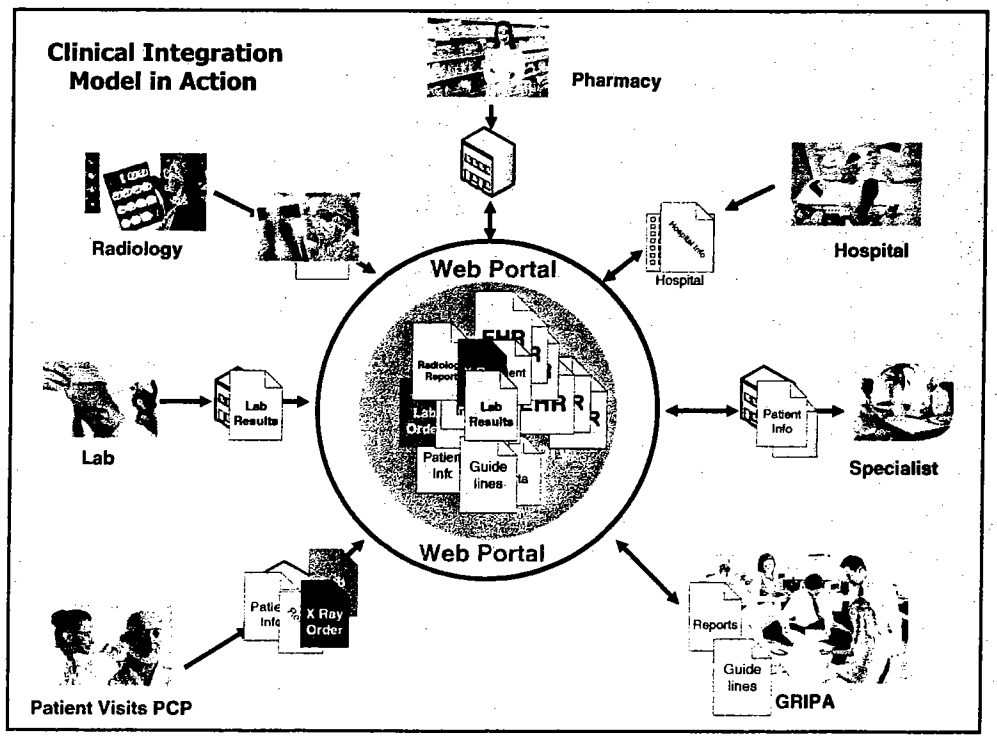

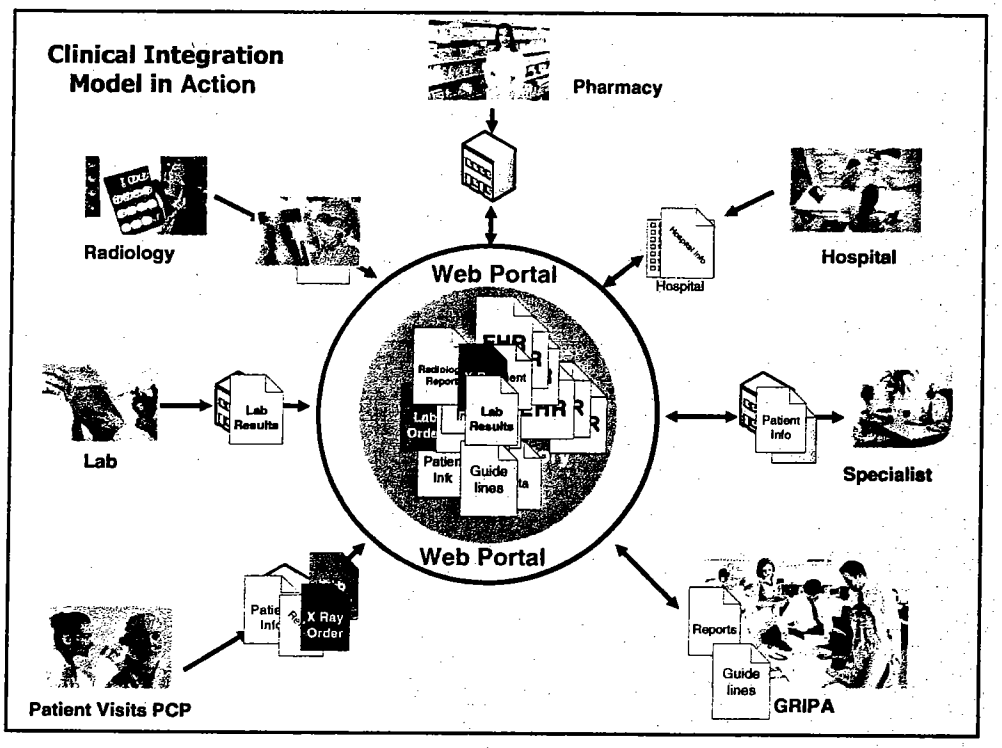
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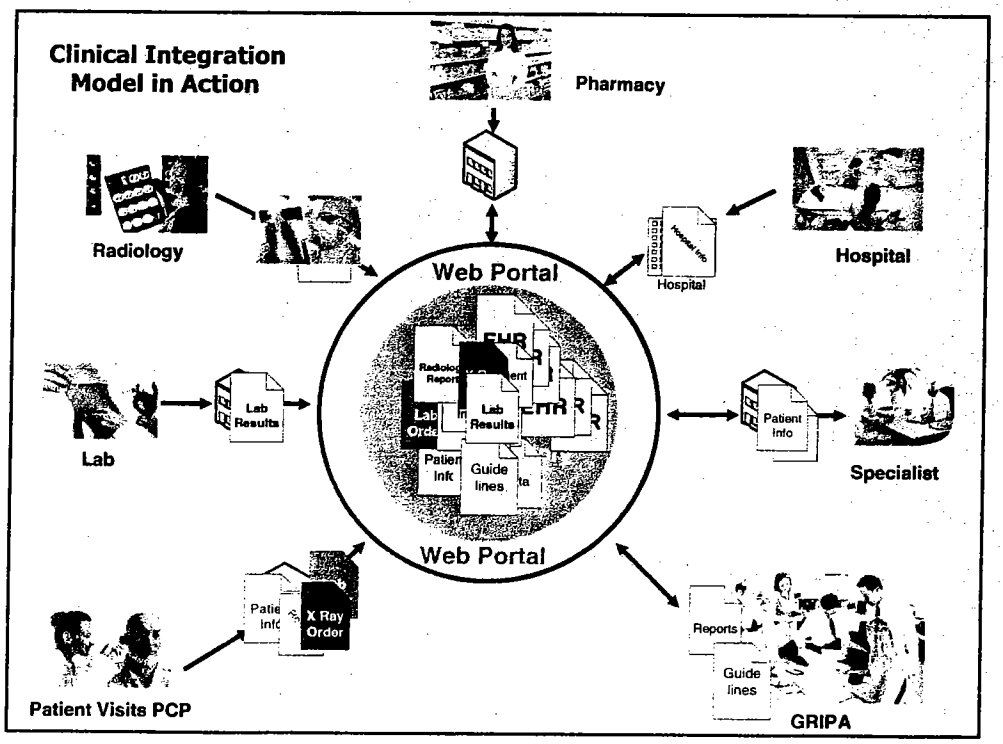
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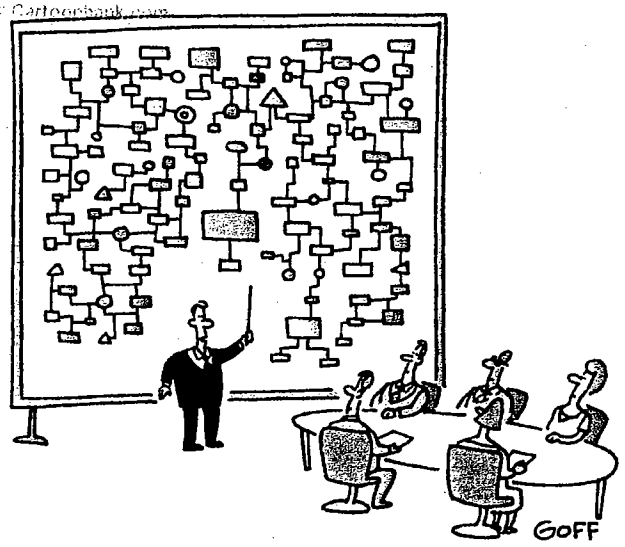


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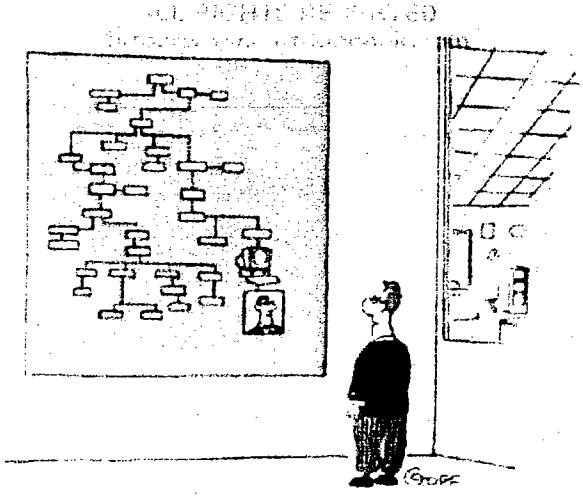

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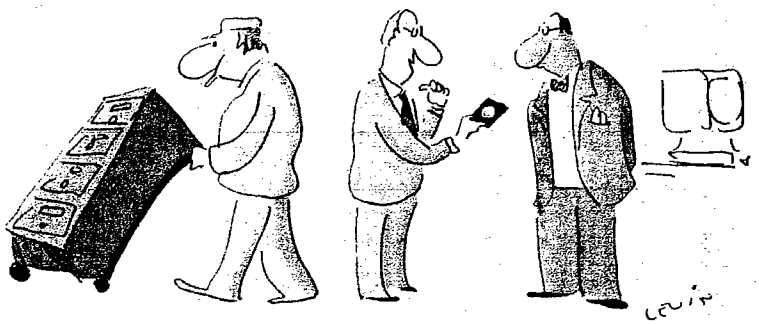

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3/13/06 MD Users Group

GRIPA

# Clinical Integration as a reason to form a Connected Community

for MD Users Group

3/13/05

Eric T. Nielsen, MD

CMO, GRIPA

1

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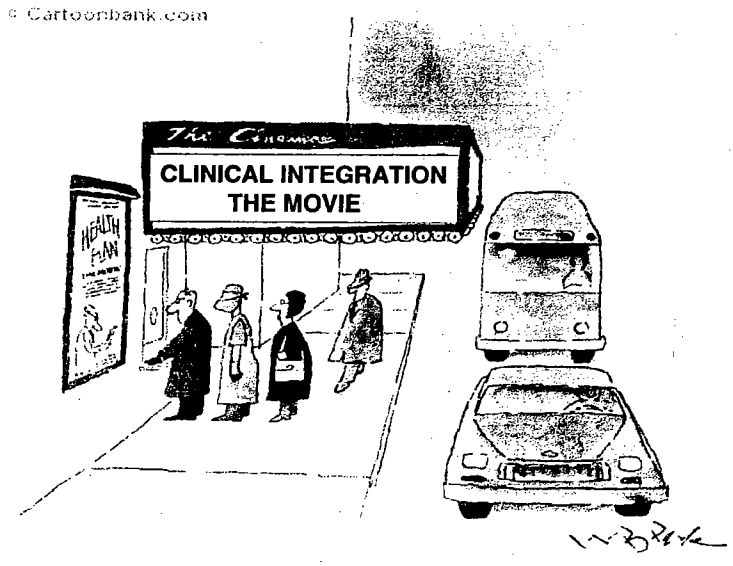



2

GRIPA

## Physician Contracting

- Per FTC & DOJ, it is illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
- Waiver only for
  - Financial Integration
    - employed group
    - group accepting capitated risk & withhold
  - Clinical Integration
    - Hard to do. MedSouth is only group in the country to get prior approval of FTC

3

GRIPA

## Why IPA's Have To Change

- HMO's unpopular, Capitation decreasing
- Insurers want to direct contract with each MD
- Insurers want to set up their own P4P's
- Employers want "0" premium increases
- Anti-trust constraints on physician organization fee-for-service contracting
- Most private MD's in groups <5, by choice, but compete with large employed groups

4

## "Clinical Integration"

GRIPA

*is not a medical term*

- Can we as an IPA continue to contract for our physicians without taking capitation or another type of financial risk?
- without running afoul of FTC/DOJ?

5

## Yes....

GRIPA

*if we have the following three key elements of Clinical Integration:*

1) Evidence-based guidelines, agreed upon by the physicians, on utilization to control costs and assure quality of care
2) Monitor guideline-related performance to control costs and improve outcomes with sanctions for poor performance
3) Common electronic medical records systems or software and data warehouse to permit shared access to patient records

6

## What do you get *with Clinical Integration?*

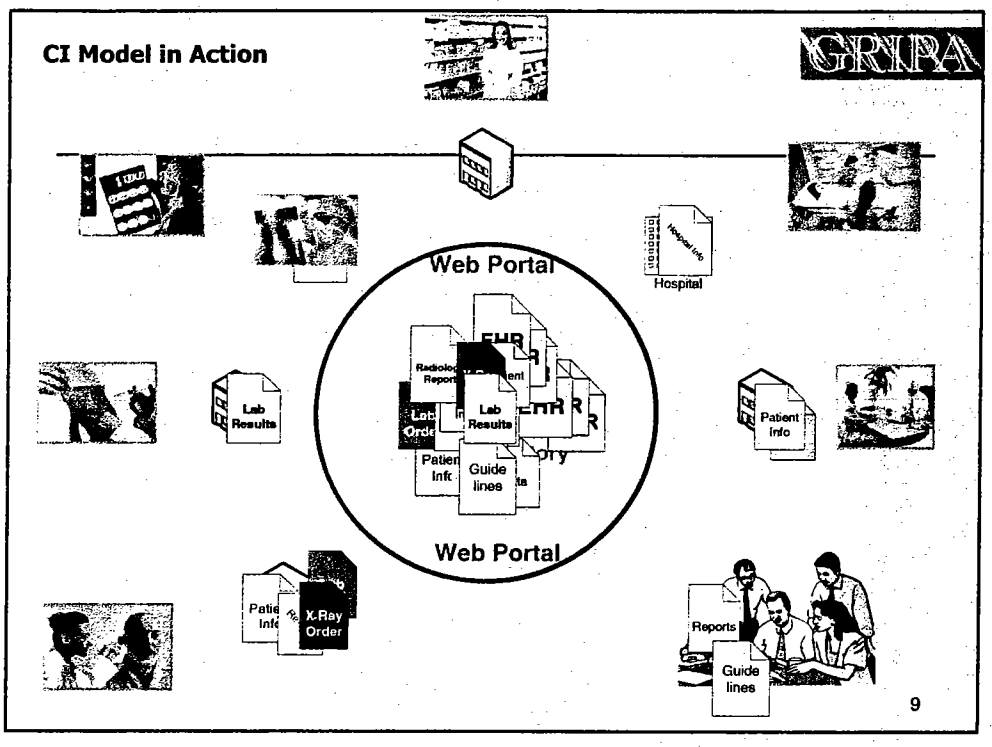
- Improved Quality
- Lower Costs
- Maintain a stable network of independent physicians
- Shared commitment to clinical improvement using guidelines, care mgmt, and IT
- Present a common product to the community
- Better reimbursement to physicians for a better product
- A way for IPA's to continue to contract for both capitated risk & fee-for-service business

- *NOT market power: must be <35% of providers in service area*

7

# Clinical Integration Model In Action

8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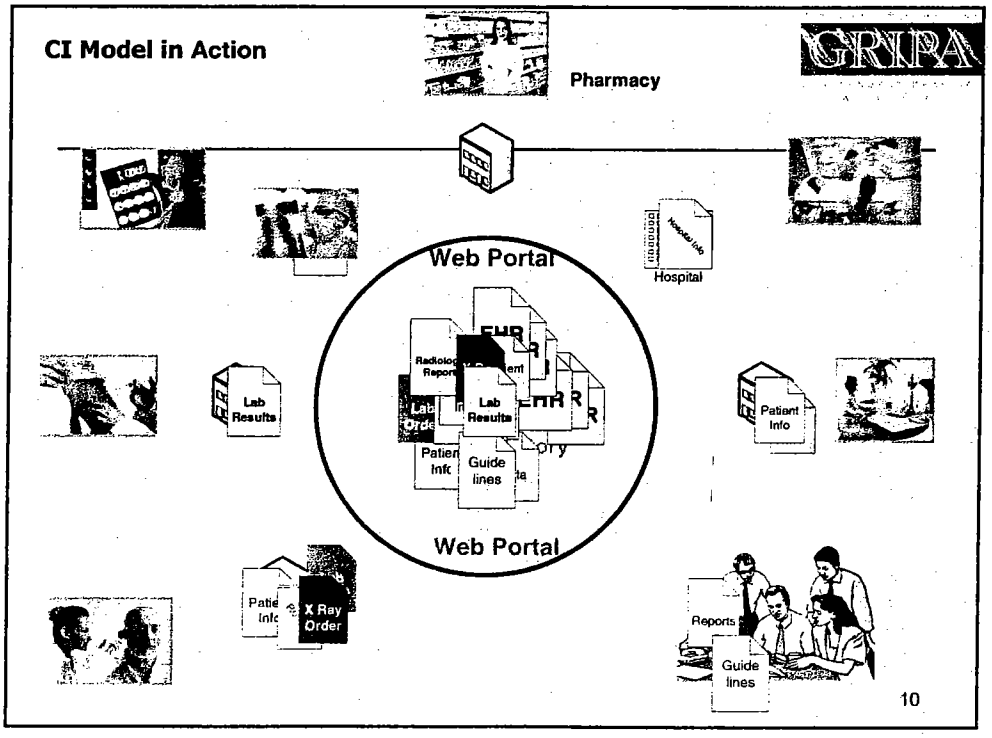
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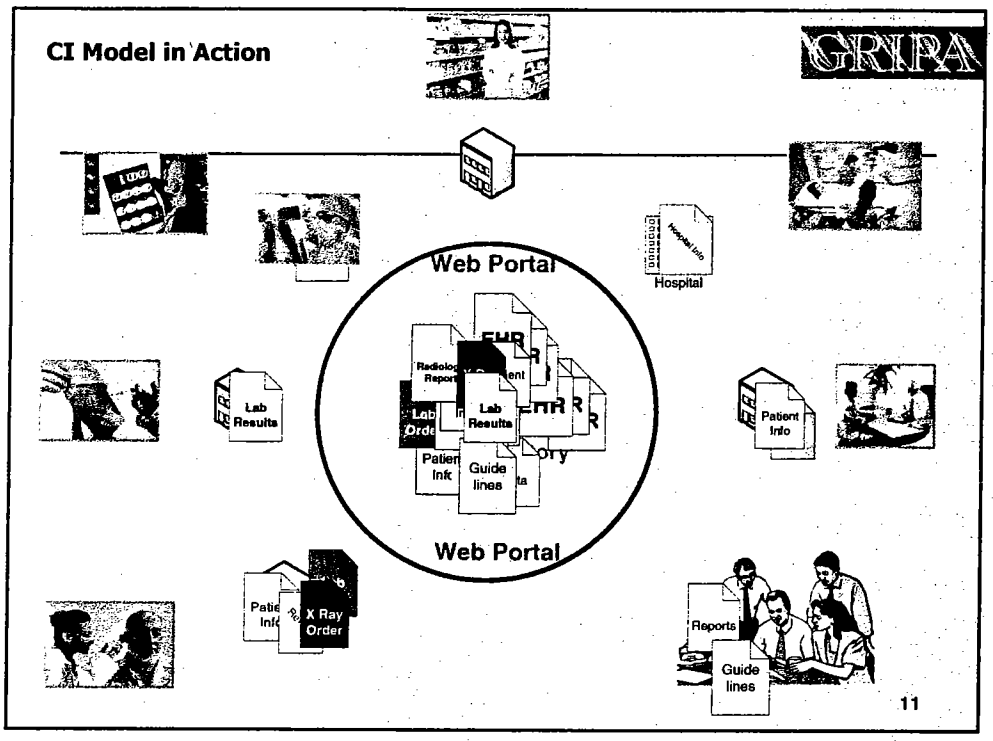


# Clinical Integration

GRIPA

## *GRIPA Version*

- Clinical Integration Committee
  - and MD Advisory Committees by specialty (?virtual)
- Evidence-based guidelines, measures, & goals prepared and updated by committees and expanded to multiple specialties
- Processes for disseminating guidelines, monitoring adherence, feedback to MD's, and reporting to IPA
- Care Mgmt assisting MD's with compliance
- Sanctioning for non-compliance

12

## *The Connected Community — first steps*

GRIPA

- **VIEW AND PRINT LAB & X-RAY REPORTS**
  - During patient appointment, missing report
  - Have staff print lab, x-ray reports
  - Could be printed ahead of time by office staff for the patient paper file
  - Least impact to your office workflow
  - Next step: view the report on PC, laptop
  - Next step: use the portal to send / make available patient notes to SCP
  - Next step: migrate all patient records to portal

13

## *The Connected Community — first steps*

GRIPA

- **FROM SIMPLEST TO FULLY INTEGRATED**
  - Flexibility
  - Works with offices that are completely paper and those that already have EMR
  - Adding data will be helpful but not mandatory
  - PCPs will be first adopters

14

# GRIPA's Goals

- ~~Provide physicians with the most complete history of~~ medical care at the point of care
- Provide physicians with e-tools to replace manual processes (i.e. referrals, admissions, disease registers)
- Provide IPA with comprehensive clinical data to develop P4P, incentive and quality programs
- Include employed and private physicians in contracts
- Be accountable to insurers, employers, community, regulators
- Differentiate the network based on technology and quality of care

15

# Our Plans

- 12/2005 contracted with **Health**vision for IT infrastructure, e-prescribing, referral mgmt
- Early 2006 data source interfaces & portal design
- Late 2006 roll-out web portal to physicians offices
- FTC advisory opinion in 2006
- Negotiate/charge a premium for a better product by 2007
- Continue risk contracting for 640, FFS for ?400

16

# Our Stretch Goals

- Obtain a copy of all electronic billing from practice management systems, clearinghouses, or billing services to augment clinical data
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- Co-development with Healthvision
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  - patient-specific prompts at the point of care (phase 2)
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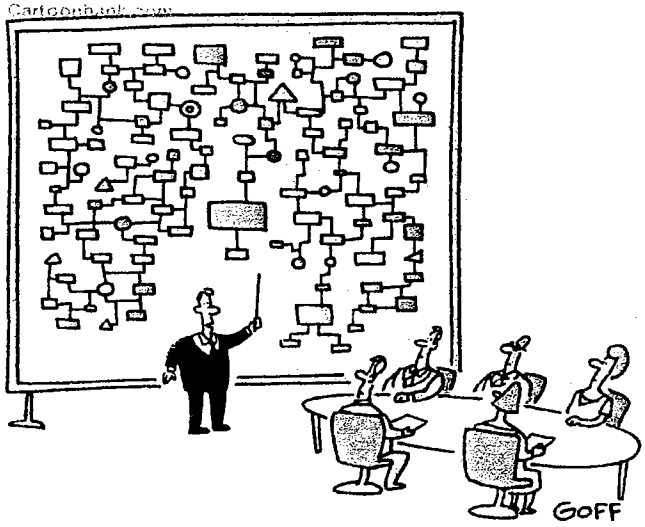
- Help Healthvision to become able to support clinical integration for other physician groups in other markets
- Guide other physician groups in other markets toward clinical integration as the next model of physician contracting

17

## Simplify new technology




**"And that's why we need a computer."**

18

3/14/06 Monroe County Medical Society BOD

GRIPA

# Clinical Integration as a reason to form a Connected Community

for MCMS BOD 3/14/05

Eric T. Nielsen, MD
CMO, GRIPA

1

GRIPA

# ~~Clinical Integration~~ *Contracting & Quality*

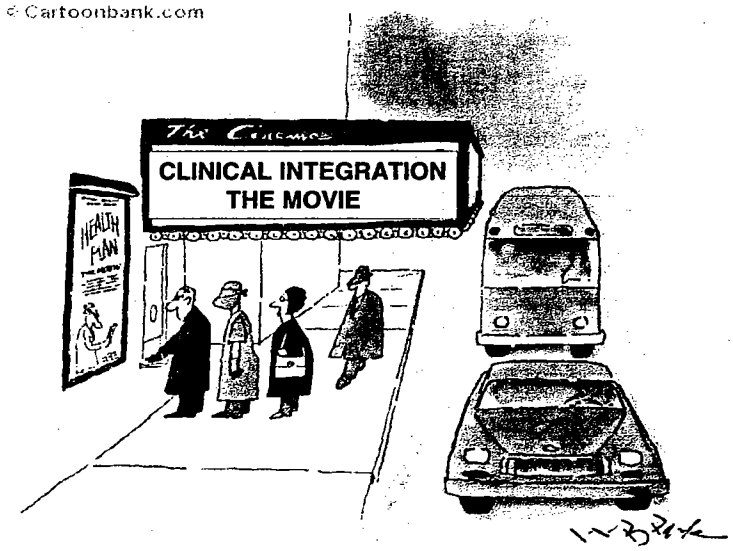
**www.GRIPAconnect.com**

**for RGH Quarterly Staff Mtg**
**3/17/05**

**Eric Nielsen, MD**
**CMO, GRIPA**

2

GRIPA




3

GRIPA

# Physician Contracting

- Per FTC & DOJ, it is illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
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  - Financial Integration
    - employed group
    - group accepting capitated risk & withhold
  - Clinical Integration
    - Hard to do. MedSouth is only group in the country to get prior approval of FTC

4

## Why IPA's Have To Change

- HMO's unpopular, Capitation decreasing
- Insurers want to direct contract with each MD
- Insurers want to set up their own P4P's
- Employers want "0" premium increases
- Anti-trust constraints on physician organization fee-for-service contracting
- Most private MD's in groups <5, by choice, but compete with large employed groups

5

## "Clinical Integration"

*is not a medical term*

- Can we as an IPA continue to contract for our physicians without taking capitation or another type of financial risk?
- without running afoul of FTC/DOJ?

6

## Yes....

*if we have the following three key elements of Clinical Integration:*

1) Evidence-based guidelines, agreed upon by the physicians, on utilization to control costs and assure quality of care

2) Monitor guideline-related performance to control costs and improve outcomes with sanctions for poor performance

3) Common electronic medical records systems or software and data warehouse to permit shared access to patient records

7

## What do you get *with Clinical Integration?*

- Improved Quality
- Lower Costs
- Maintain a stable network of independent physicians
- Shared commitment to clinical improvement using guidelines, care mgmt, and IT
- Present a common product to the community
- Better reimbursement to physicians for a better product
- A way for IPA's to continue to contract for both capitated risk & fee-for-service business

- *NOT market power: must be <35% of providers in service area*

8

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# Clinical Integration Model In Action

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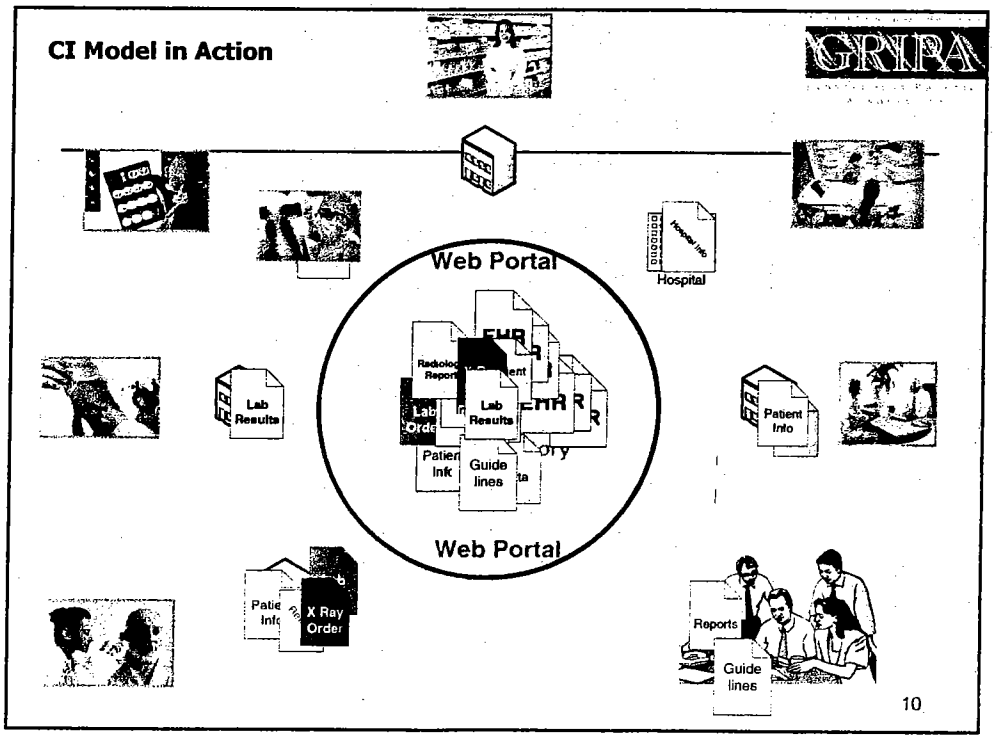

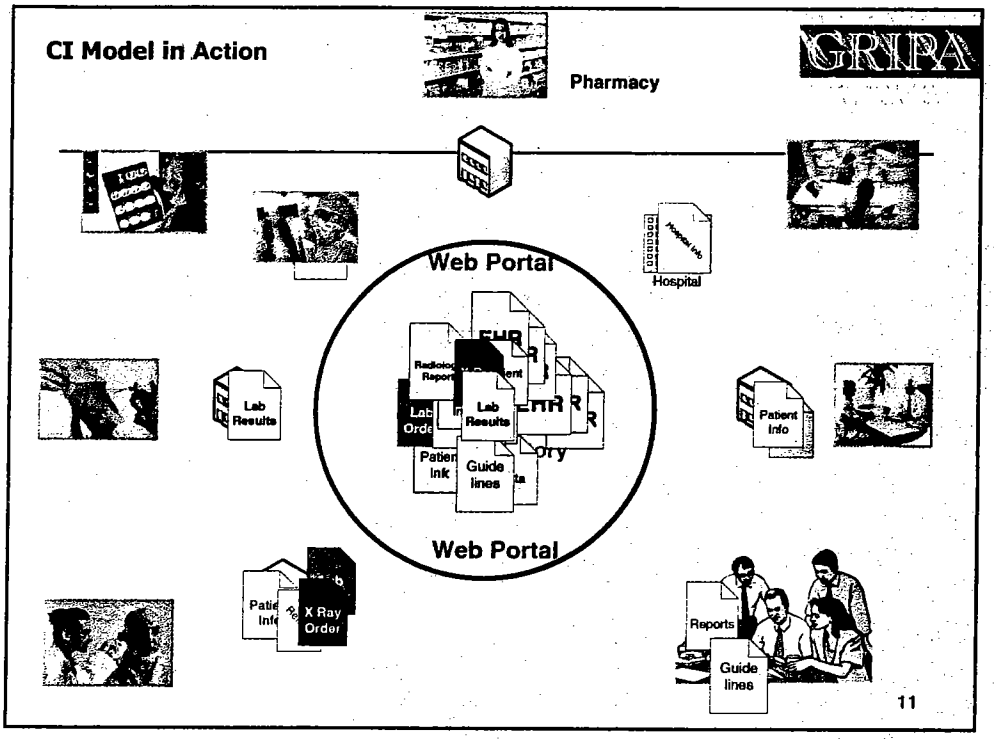


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## *The Connected Community — step by step*

GRIPA

**First Step: view or print lab and images**

- During patient appointment, missing report
- Have staff print lab, x-ray reports before visit
- Least impact to your office workflow

**Next step: view the report on PC in exam room**

**Next step: use the portal to send /make available patient notes/attachments to other physicians**

13

## *The Connected Community — step by step*

GRIPA

**FROM SIMPLEST TO FULLY INTEGRATED**

- Flexibility
- Works with offices that are completely paper and those that already have EMR
- Adding data from physicians' offices would be helpful but not mandatory

14

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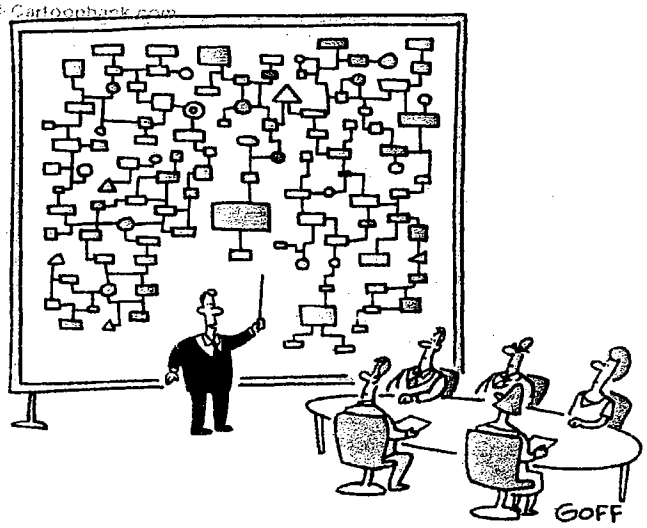



"And that's why we need a computer."

18

# Clinical Integration
# &
# GRIPA Connect

**www.GRIPAconnect.com**

**for RGH Quarterly Staff Mtg**
**3/17/05**

**Eric Nielsen, MD**
**CMO, GRIPA**



## Physician Contracting

- Per FTC & DOJ, it is illegal for independent groups of "competing" physicians to contract together (or even compare fees)
- Waiver only for:
  - Financial Integration
    - Employed group
    - Group accepting capitated risk & withhold
  - Clinical Integration
    - Not easy, Risk of investigation, lawsuits
    - FTC/DOJ prior approval of plans (only MedSouth)

## Why IPA's Have To Change

GRIPA

- Capitation decreasing
- Insurers want to direct contract with each MD
- Insurers want to set up their own P4P's
- Employers want "0" premium increases
- Most private MD's in groups <5, by choice

3

## *Key elements of Clinical Integration:*

GRIPA

1) Evidence-based guidelines to control costs and assure quality of care, agreed upon by the physicians

2) Monitor guideline-related performance with sanctions for poor performance

3) Common EMR system or another way to electronically share access to patient records

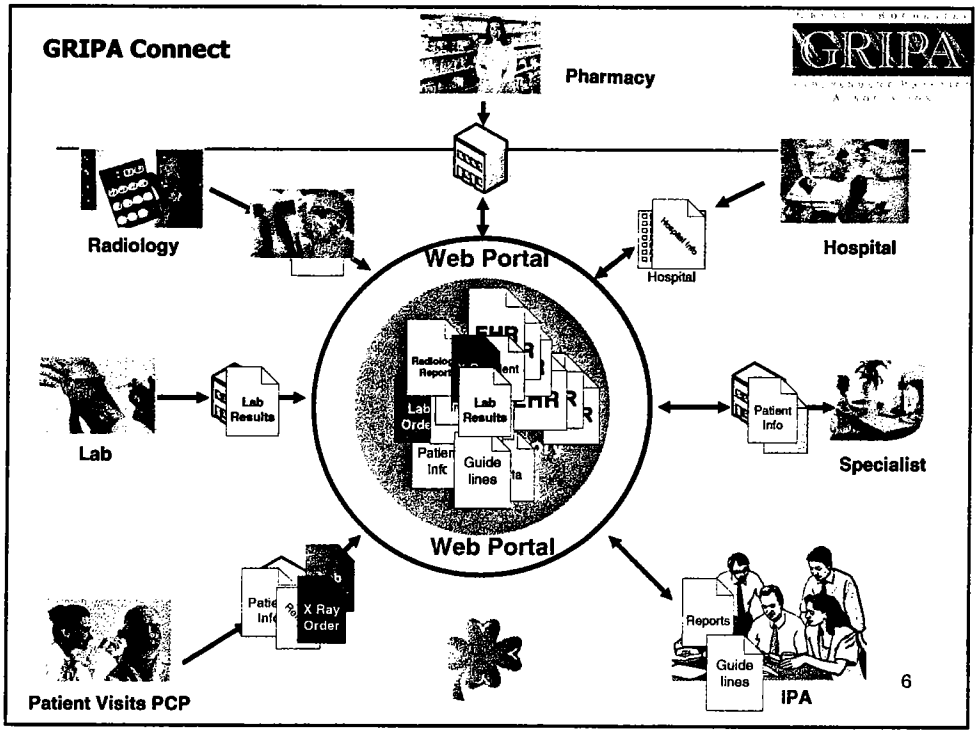
4

# What do you get
## *with Clinical Integration?*

- Improved Quality
- Lower Costs
- Stable network of independent physicians contracting together
- Shared commitment to clinical improvement using evidence-based guidelines, care mgmt, and IT
- Better reimbursement to physicians for a better product

- *DON'T GET market power*
  *– must be <35% of providers in service area*

5

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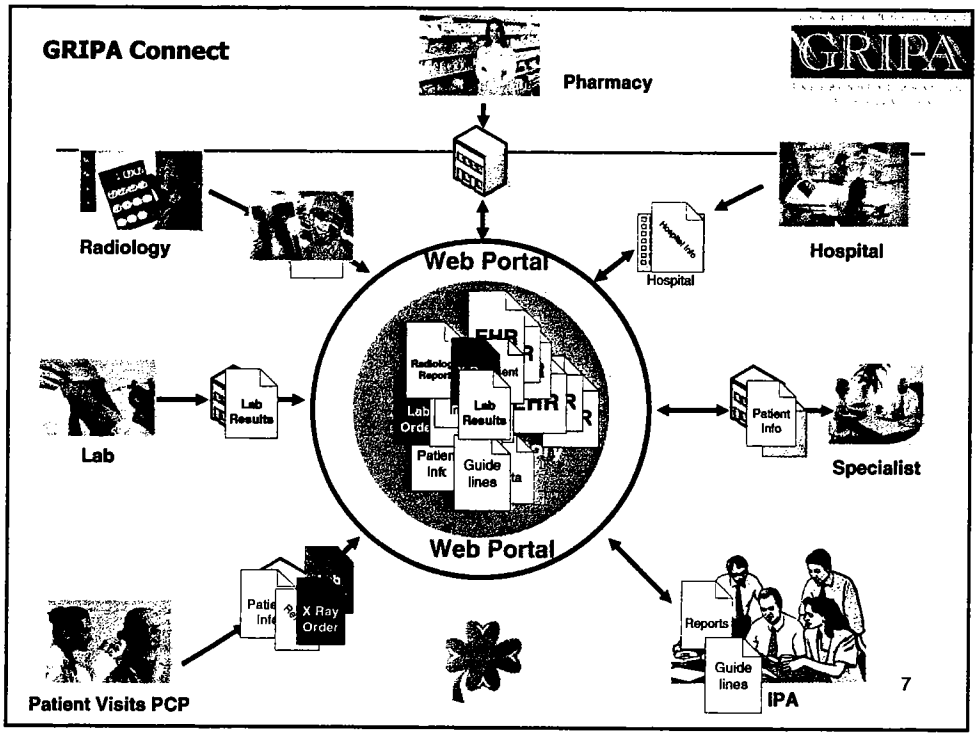
GRIPA Connect
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Pharmacy
Radiology
Hospital
Web Portal
Hospital
Lab
Lab Results
Patient Info
Specialist
Guide lines
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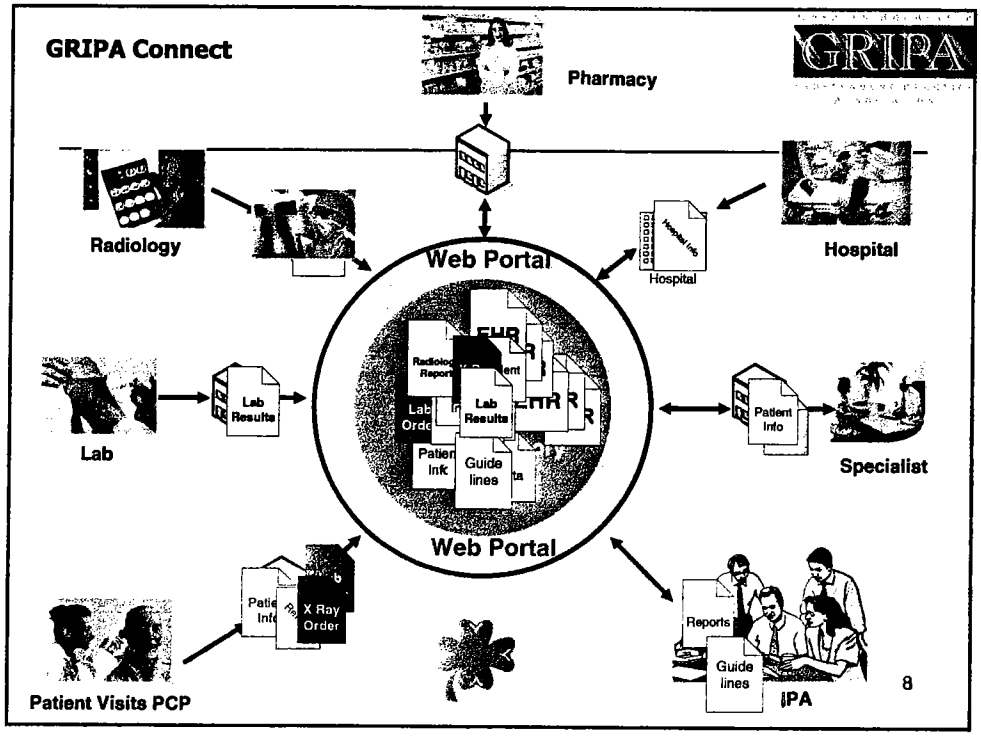
X Ray Order
Reports
Guide lines
IPA
Patient Visits PCP
7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# GRIPA's Goals

- Provide physicians with the most complete history of medical care at the point of care
- Provide physicians with e-tools to replace manual processes (i.e. referrals, admissions, disease registers)
- Include employed and private physicians in contracts
- Differentiate the network based on technology and quality of care

9

After Monday 3/20/06, check out

**www.GRIPAconnect.com**

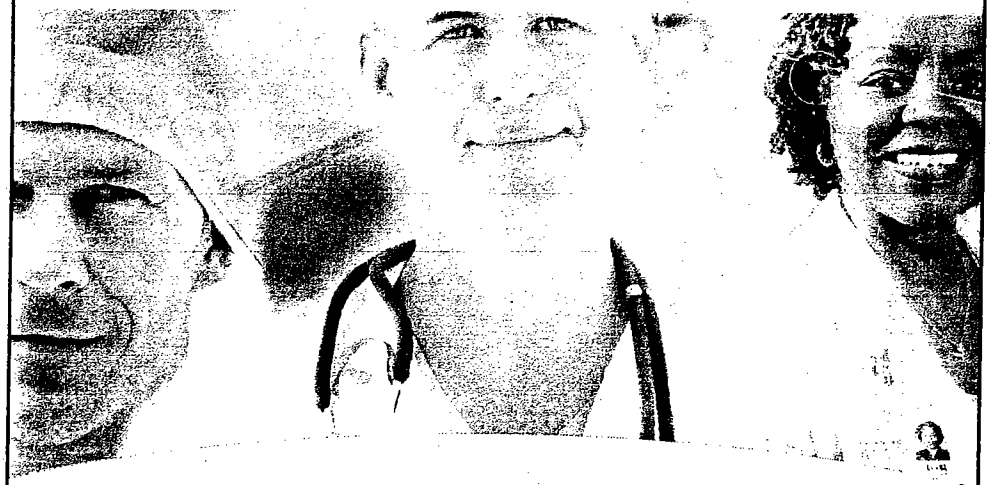
**Questions?**

10

## 3/27/06 Physician dinner meeting

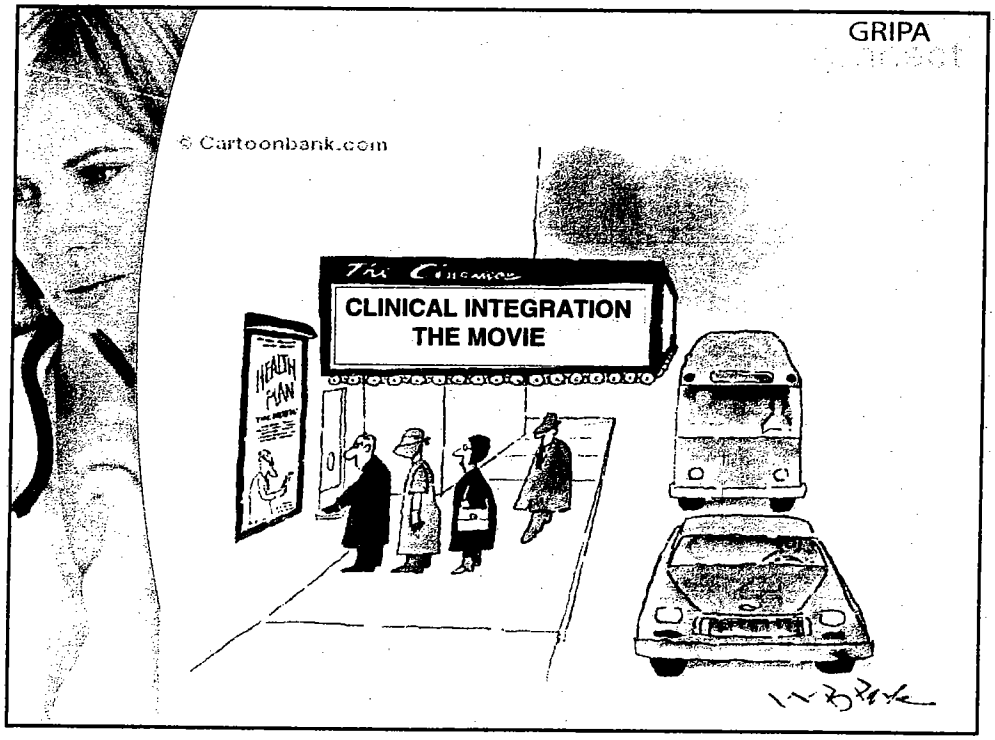
CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA

GRIPA



GRIPA

## Clinical Integration

- ☐ Natural outgrowth—pioneering step
- ☐ Short presentation followed by Q&A
- ☐ The presenters
- ☐ Collaborative spirit - input and feedback
- ☐ Why the change?

3

GRIPA

## Physician contracting

- ☐ Per FTC & DOJ, illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
- ☐ Waiver only for
  - Financial Integration
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GRIPA

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GRIPA

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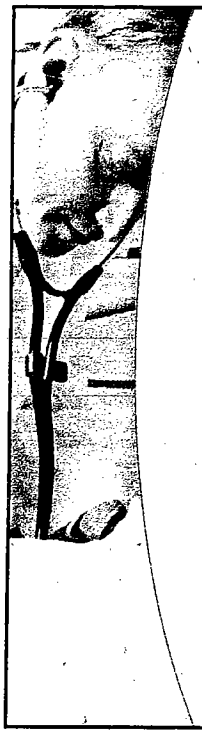

GRIPA

## Yes, with three key components

1. Evidence-based guidelines on utilization – agreed upon by physicians – to control costs and assure quality of care
2. Monitor guideline-related performance to control costs and improve outcomes with sanctions for poor performance
3. Common electronic medical records system or software and data warehouse to permit shared access to patient records

7

GRIPA

## Benefits of Clinical Integration

- ☐ Improved quality
- ☐ Lower costs
- ☐ Maintain stable network of independent physicians
- ☐ Shared commitment to clinical improvement using guidelines, care management, and IT
- ☐ Present a common product to the community
- ☐ Better reimbursement to physicians for a better product
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- ☐ *NOT market power: must be <35% of providers in service area*

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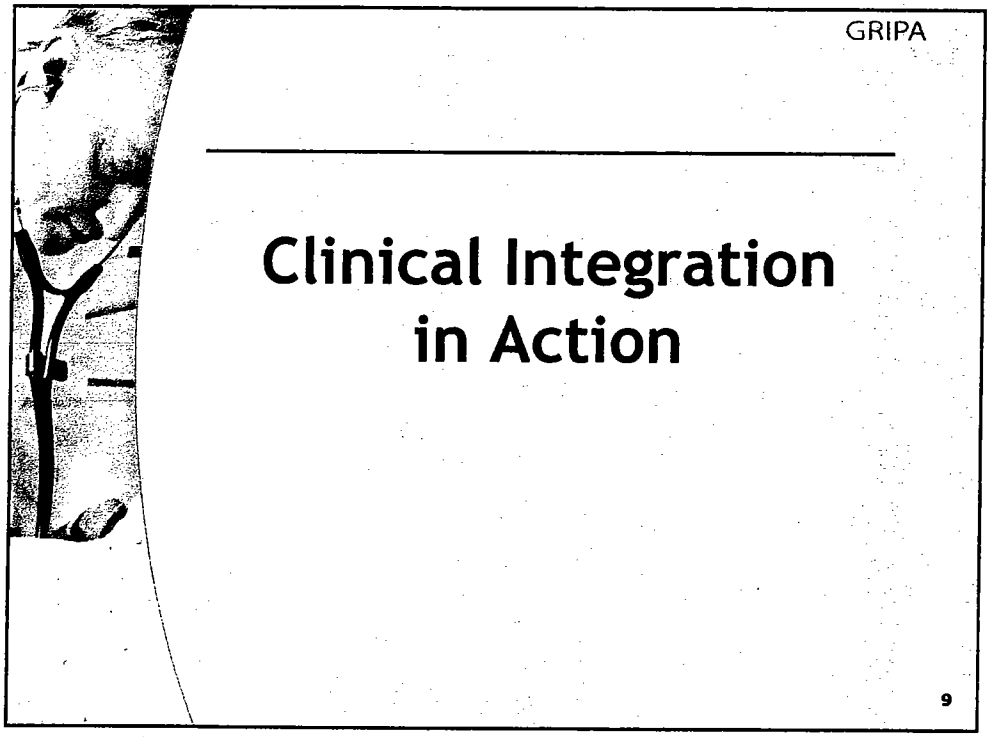
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Clinical Integration
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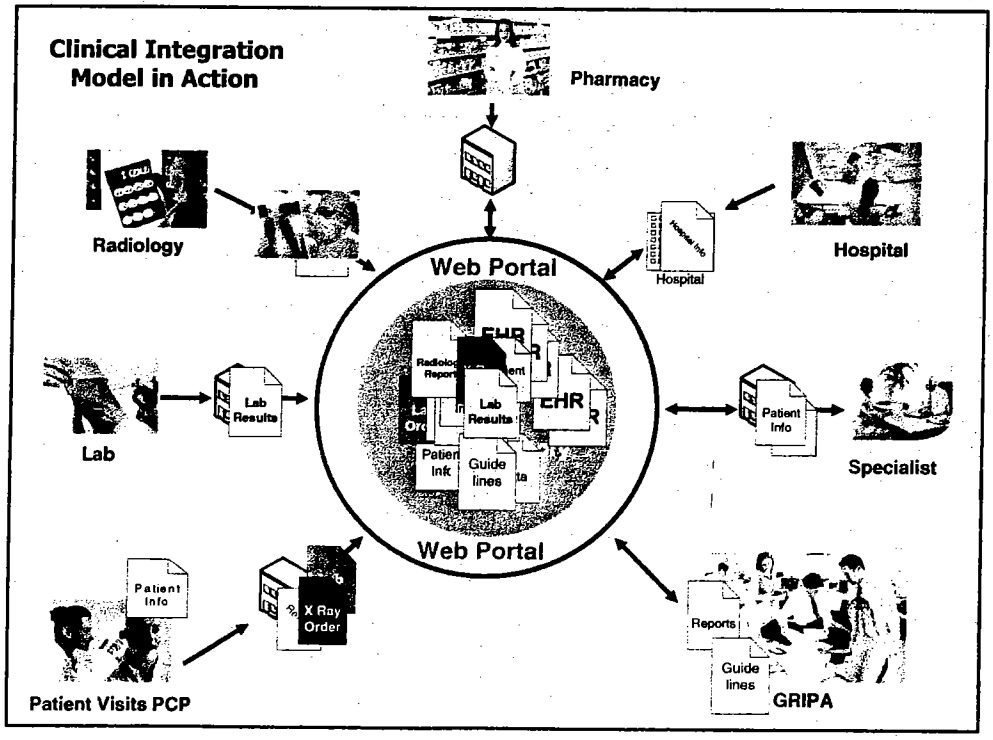
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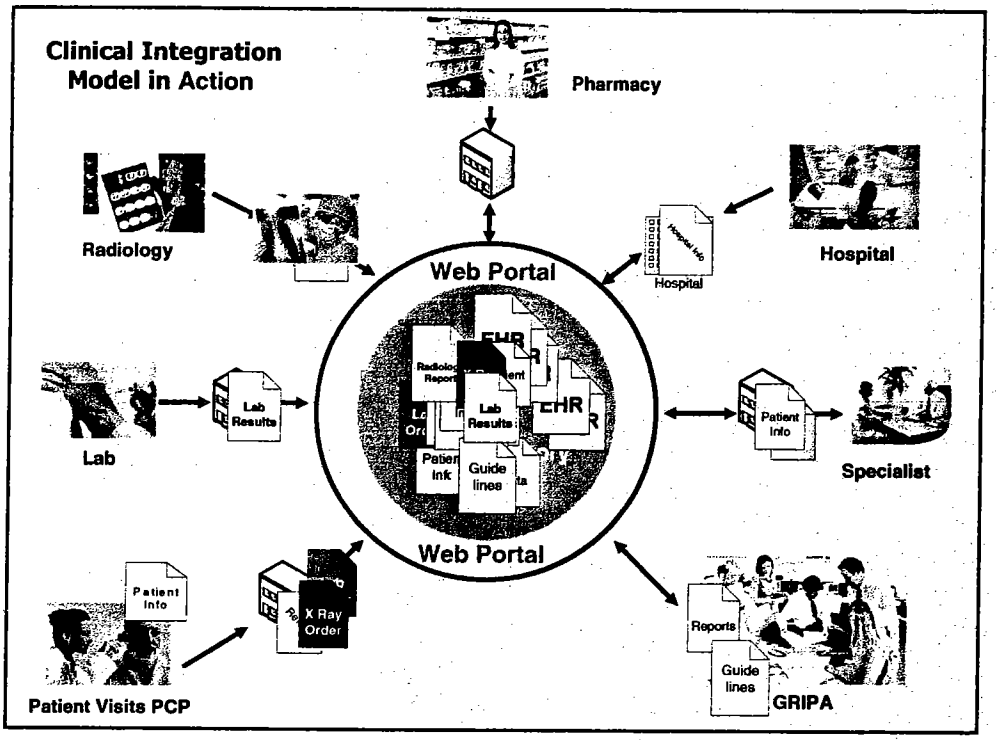
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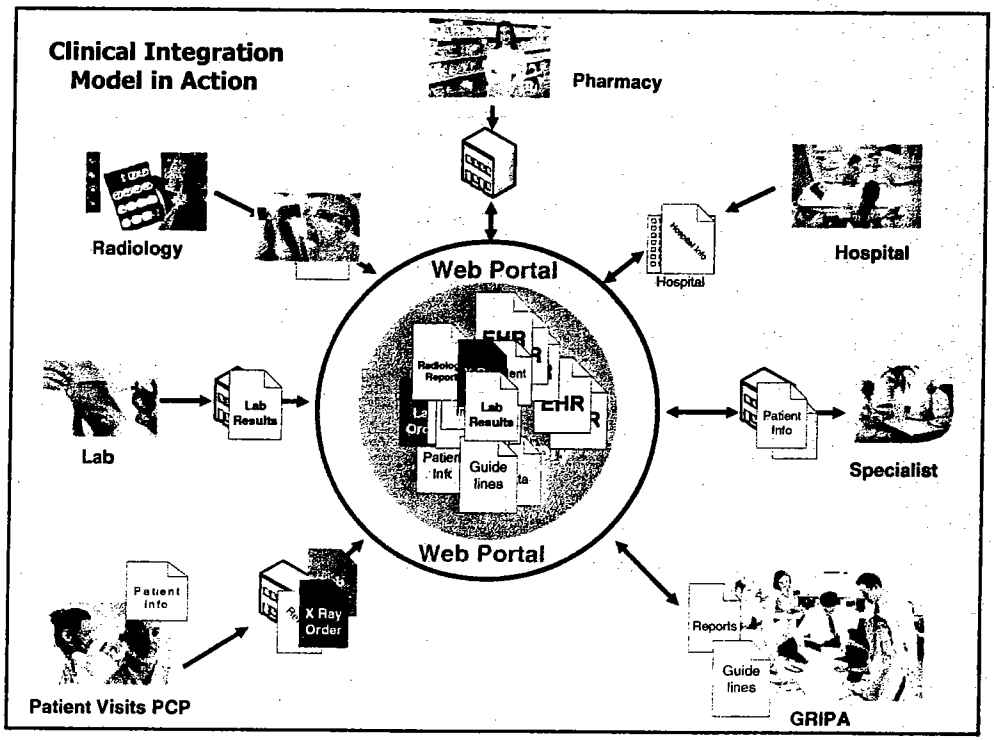
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## GRIPA Connect – our version

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## GRIPA Connect – first steps

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  - Have staff print lab, x-ray reports during patient appointment
  - Office staff prints ahead of appointment for patient paper file
  - Least impact to office workflow
  - Next step: view report on PC, laptop
  - Next step: use portal to send patient notes to SCP
  - Next step: migrate all patient records to portal

GRIPA

## From simplest to fully integrated

- ☐ Flexibility
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GRIPA

## Goals of GRIPA Connect

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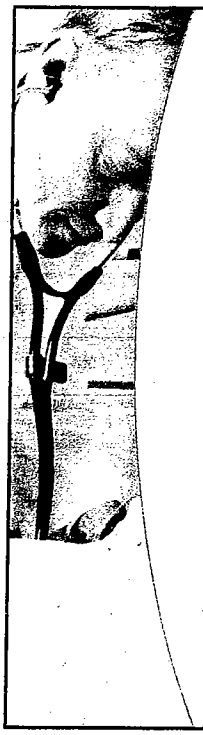



## Goals of GRIPA Connect | 2

- ☐ Include employed and private physicians in contracts
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- ☐ Differentiate the network based on technology and quality of care

17



## GRIPA's plans & timelines

- ☐ 12/05 - contracted with Healthvision for IT infrastructure
- ☐ Early 2006 - data source interfaces & portal design
- ☐ Late 2006 - roll-out web portal to physician offices
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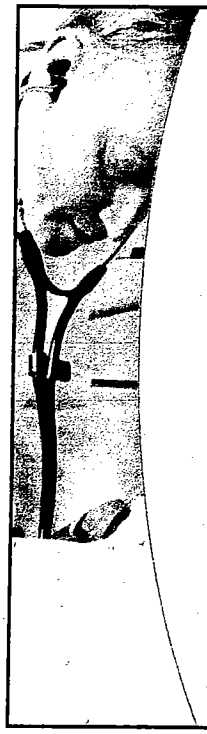



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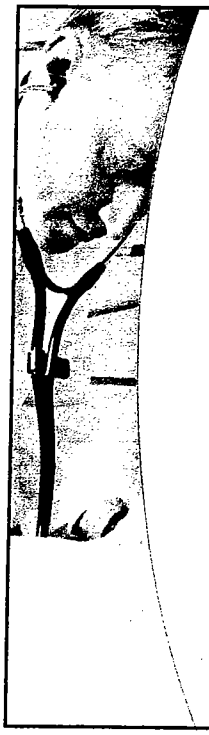



## GRIPA Connect Stretch Goals | 2

- ☐ Help Healthvision support Clinical Integration for physician groups in other markets
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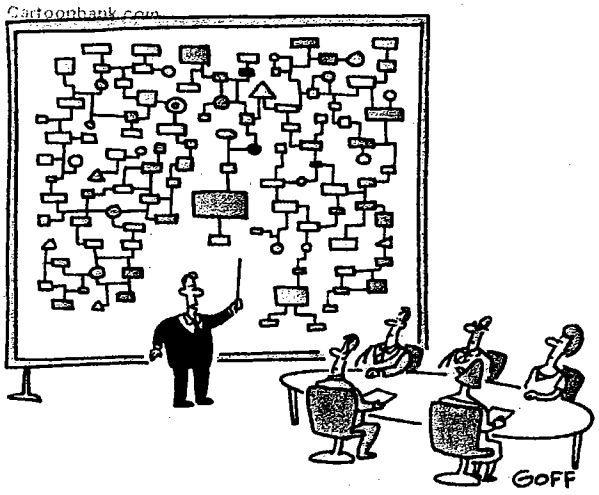
GRIPA

## Simplify technology




**"And that's why we need a computer."**

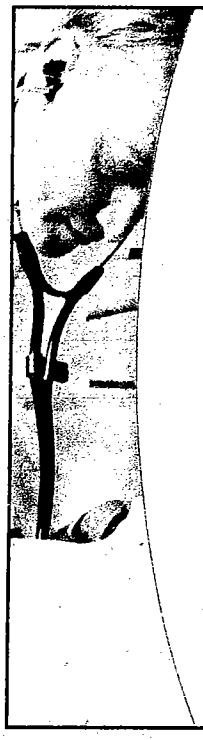
21

GRIPA

## ViaHealth perspective

- ☐ Physician recruitment & retention very important to RGH & VOW
- ☐ Connectivity key to future success
- ☐ Relationship to GRIPA and POs highly valued
- ☐ Risk contracting appears to be disappearing
- ☐ Loss of the risk model leaves physicians bare & with few options
- ☐ Some aspects of CI may be mandated in next 5 years
- ☐ Makes sense to pursue now if it is to be mandated

22



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## Physician perspective

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## Your Comments & Questions

**HOW CAN WE MAKE IT WORK FOR YOU?**

☐ GRIPA commitment:

- Integration
- Seamlessness
- Ease of use
- Ease of transition

☐ After Q&A - Brief survey, contact form

24

GRIPA

## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

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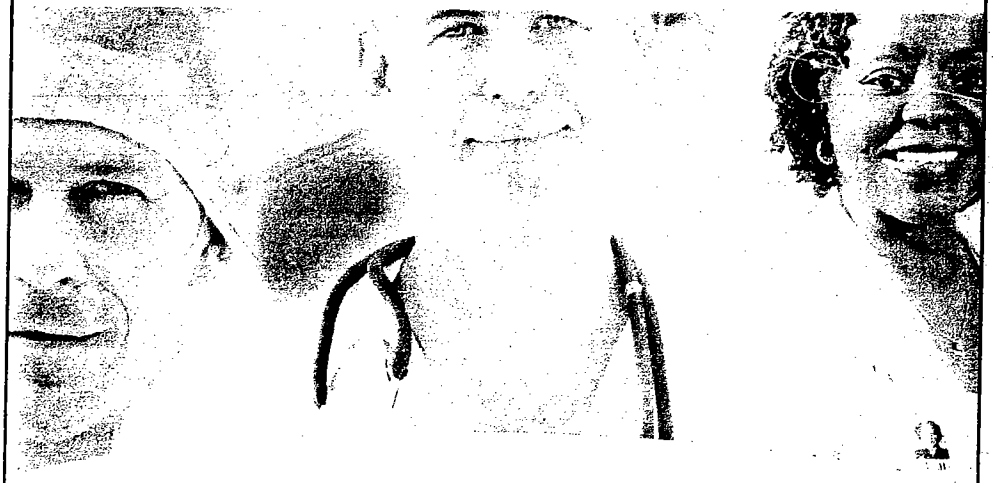
CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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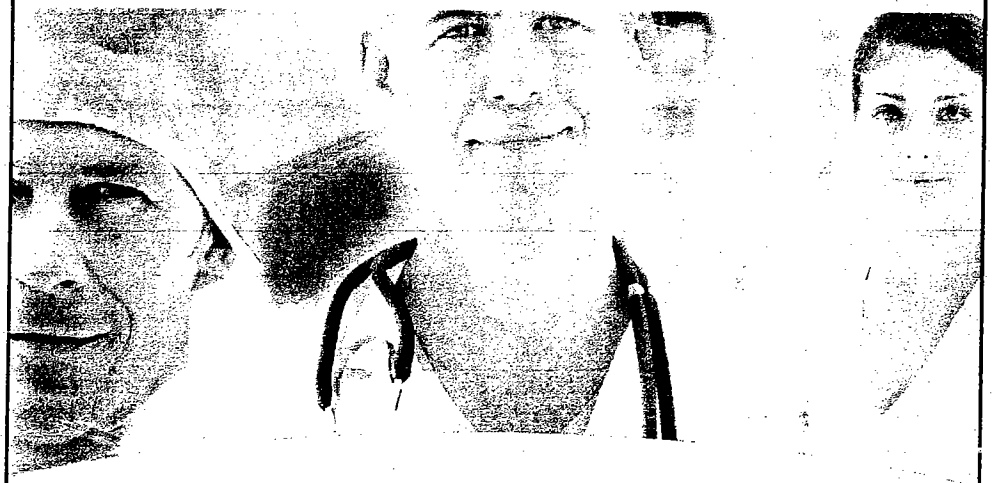
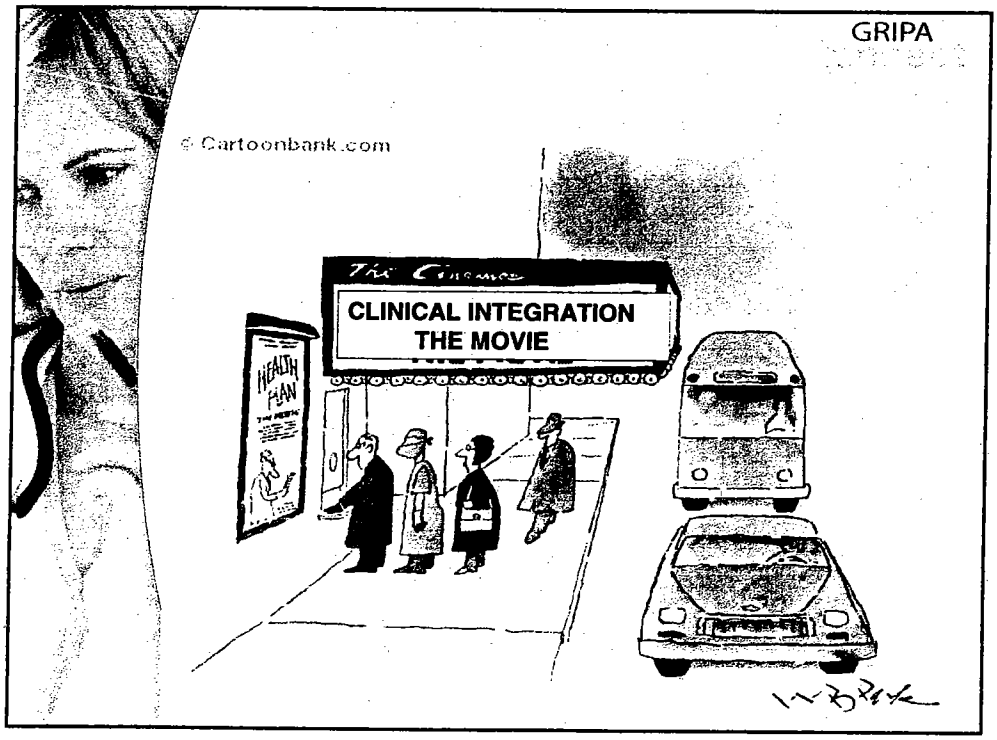
## 3/30/06 Rochester General Hosp Dept of Med.

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA



GRIPA

## Clinical Integration

- ☐ Natural outgrowth—pioneering step
- ☐ Short presentation followed by Q&A
- ☐ The presenters
- ☐ Collaborative spirit - input and feedback
- ☐ Why the change?

3

GRIPA

## Physician contracting

- ☐ Per FTC & DOJ, illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
- ☐ Waiver only for
  - Financial Integration
    - employed group
    - group accepting capitated risk & withhold
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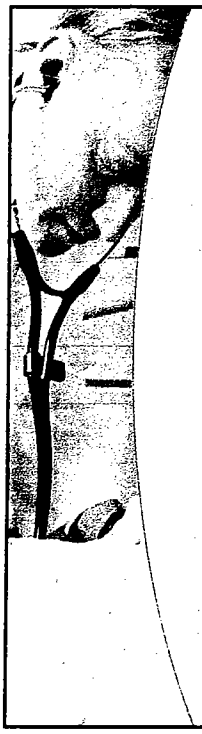

GRIPA

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- ☐ Insurers want to set up their own P4Ps
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5

GRIPA

## Clinical Integration not a medical term

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6

GRIPA

## Yes, with three key components

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7

GRIPA

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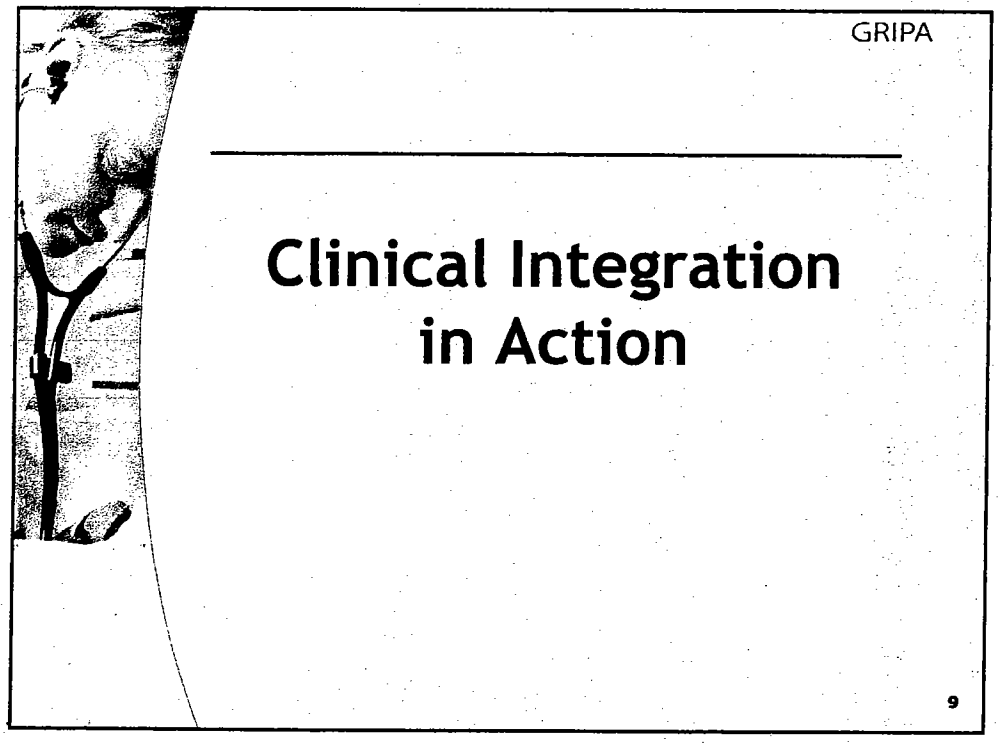
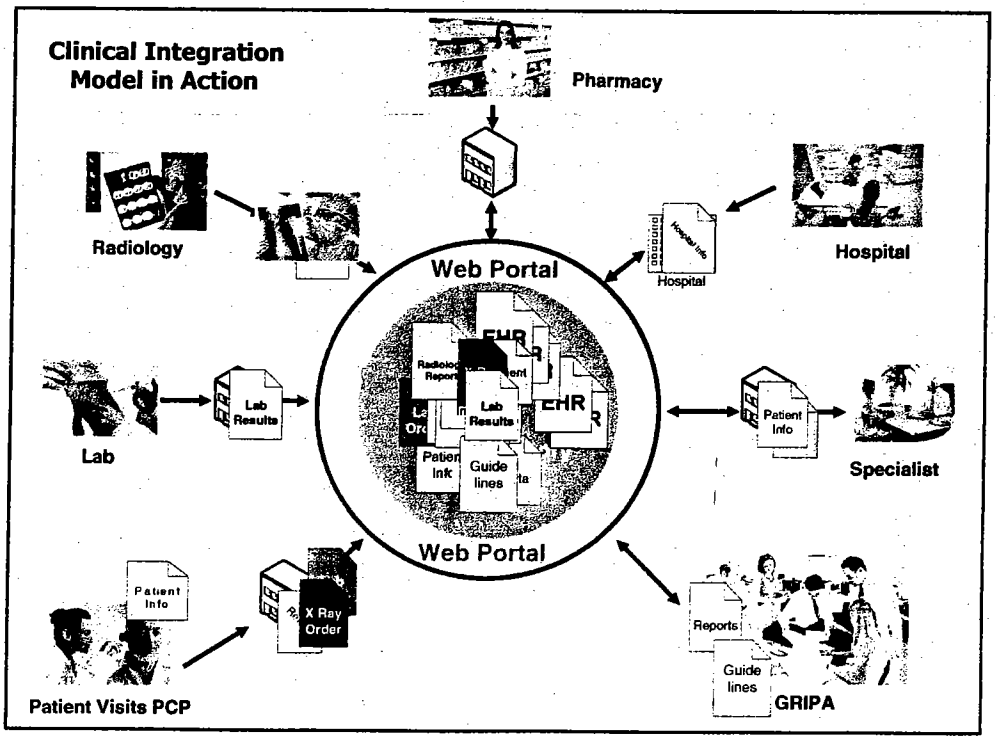
- ☐ Present a common product to the community
- ☐ Better reimbursement to physicians for a better product
- ☐ A way for IPAs to continue to contract for both capitated risk & fee-for-service business
- ☐ *NOT market power: must be <35% of providers in service area*

8


GRIPA
Clinical Integration
in Action
9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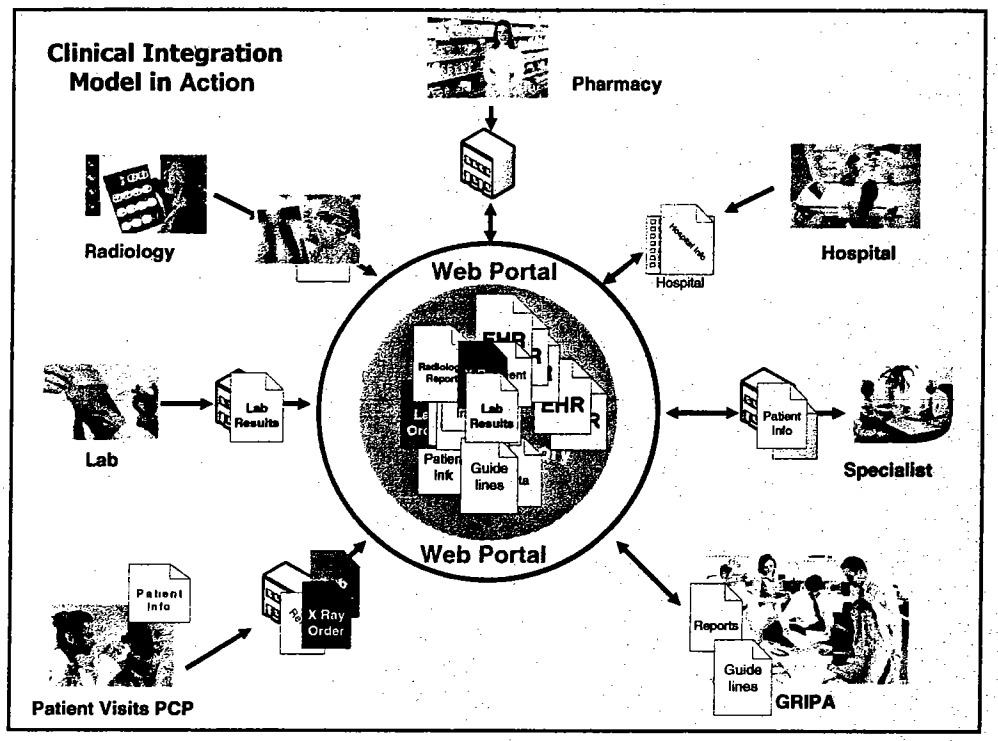
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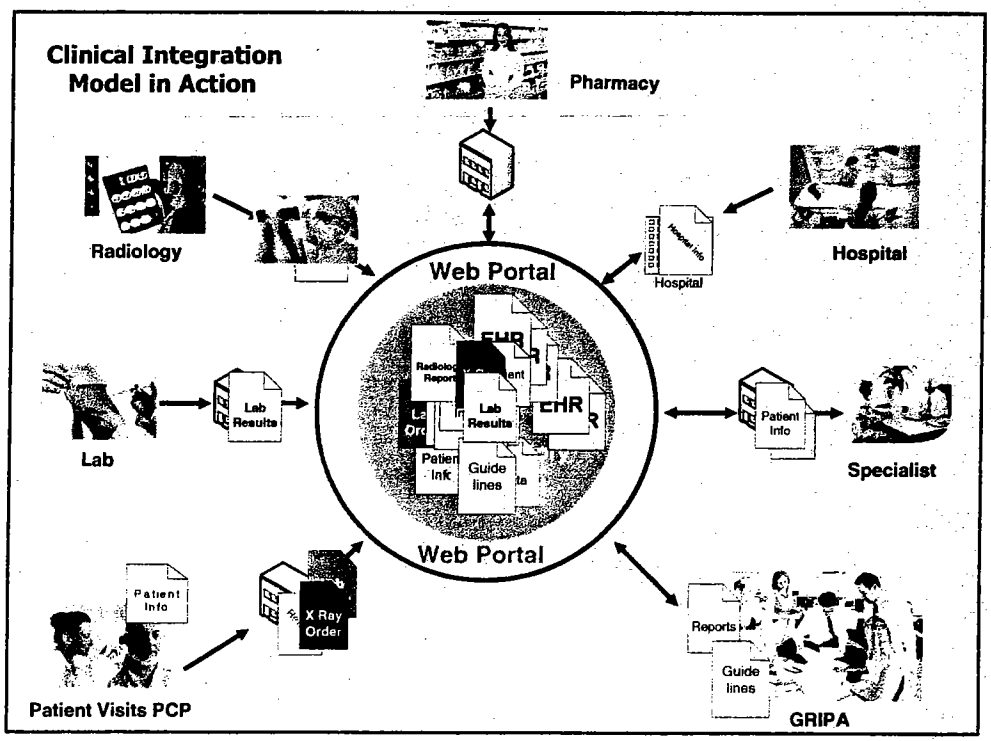
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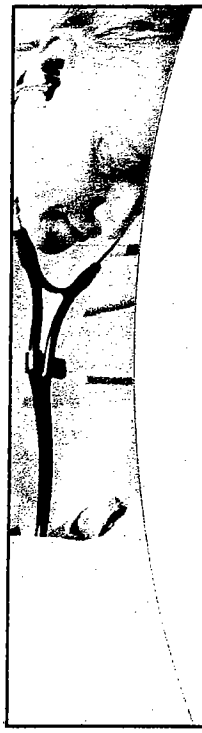
## GRIPA Connect – our version

- ☐ Clinical Integration Committee
  - and MD Advisory Committees by specialty (virtual?)
- ☐ Evidence-based guidelines, measures, & goals prepared and updated by committees and expanded to multiple specialties
- ☐ Processes for disseminating guidelines, monitoring adherence, feedback to MDs, and reporting to IPA
- ☐ Care management assisting MDs with compliance







## GRIPA Connect – first steps

**View and print lab and x-ray reports**

- Have staff print lab, x-ray reports during patient appointment
- Office staff prints ahead of appointment for patient paper file
- Least impact to office workflow

**Next step: view report on PC or wireless laptop in exam rooms**

**Next step: use portal to send patient notes to other physicians**

**Next step: migrate all patient records to portal or EMR**

GRIPA

## From simplest to fully integrated

- ☐ Flexibility
- ☐ Works with offices that are completely paper and those that already have EMR
- ☐ Optional e-prescribing & lab order entry
- ☐ Adding data from physician's offices will be helpful but not mandatory

15

GRIPA

## Goals of GRIPA Connect

- ☐ Provide physicians with most complete medical history at time of care
- ☐ Provide physicians with e-tools to replace manual processes
- ☐ Provide IPA with comprehensive clinical data to develop incentive and quality programs
- ☐ Employed and private physicians in contracts
- ☐ Be accountable to insurers, employers, community, regulators
- ☐ Differentiate the network based on technology and quality of care

16



## GRIPA's plans & timelines

- ☐ 12/05 - contracted with Healthvision for IT infrastructure
- ☐ Early 2006 - data source interfaces & portal design
- ☐ Late 2006 - roll-out web portal to physician offices
- ☐ 2006 - FTC advisory opinion
- ☐ 2006 - negotiate / charge premium for better product
- ☐ Continue risk contracting for 640, FFS for 400?

17



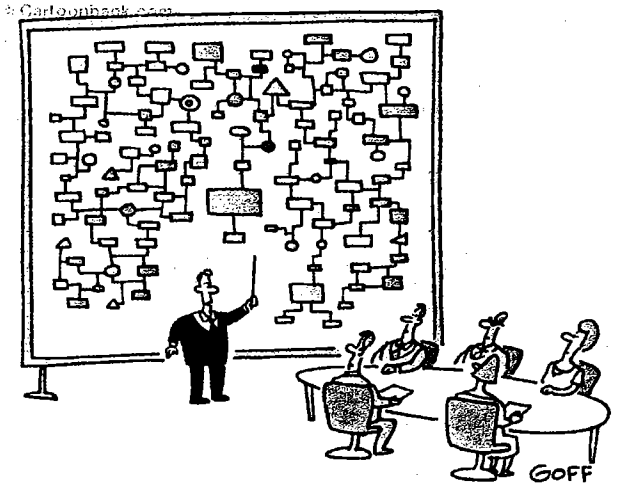
## GRIPA Connect Stretch Goals

- ☐ Obtain a copy of all electronic billing from practice management systems, clearinghouses, or billing services to augment clinical data
- ☐ Encourage, but not require, MD offices to adopt EMRs interoperable with Healthvision
- ☐ Co-development with Healthvision:
  - Guideline availability on the portal (phase 1)
  - Patient-specific prompts at point of care (phase 2)
  - Monitoring & reporting on compliance (phase 2)

18



## Simplify technology




**"And that's why we need a computer."**

19



## ViaHealth perspective

- ☐ Physician recruitment & retention very important to RGH & VOW
- ☐ Connectivity key to future success
- ☐ Relationship to GRIPA and POs highly valued
- ☐ Risk contracting appears to be disappearing
- ☐ Loss of the risk model leaves physicians bare & with few options
- ☐ Some aspects of CI may be mandated in next 5 years
- ☐ Makes sense to pursue now if it is to be mandated
- ☐ ViaHealth commitment to Clinical Integration

20



## Physician perspective





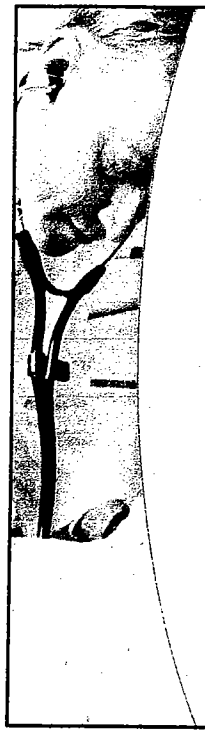
## Your Comments & Questions

**HOW CAN WE MAKE IT WORK FOR YOU?**

☐ GRIPA commitment:

- Integration
- Seamlessness
- Ease of use
- Ease of transition

☐ After Q&A - Brief survey, contact form



GRIPA

## Clinical Integration

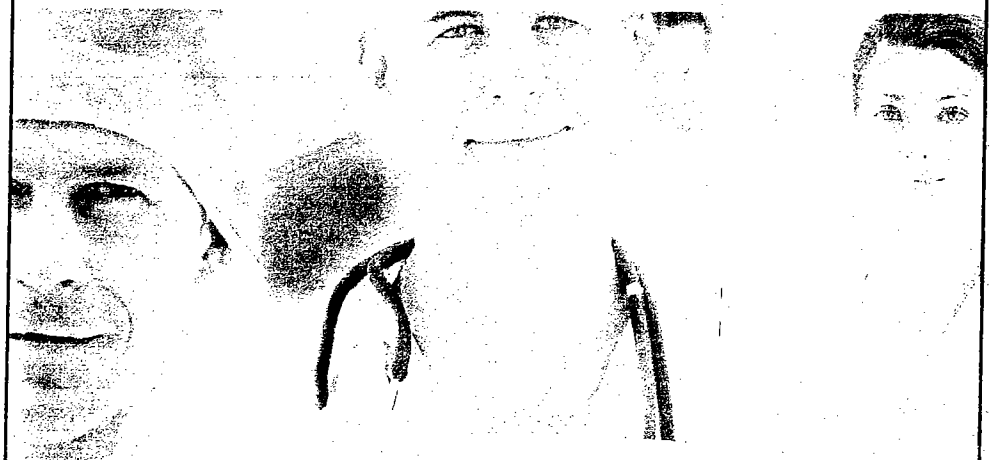
. . . . . thank you!

Stay in touch with
GRIPAconnect.com

23

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA

## 4/4/06 Rochester General medical staff

CLINICAL INTEGRATION

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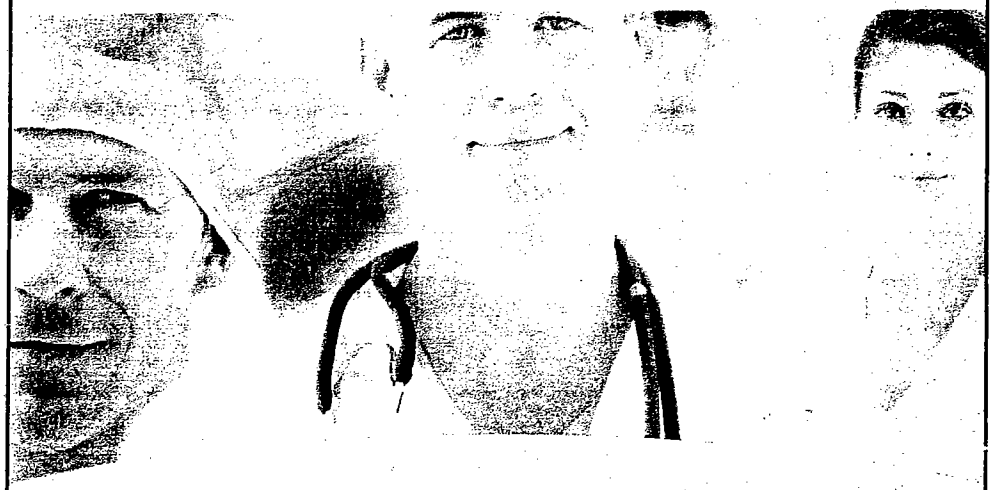

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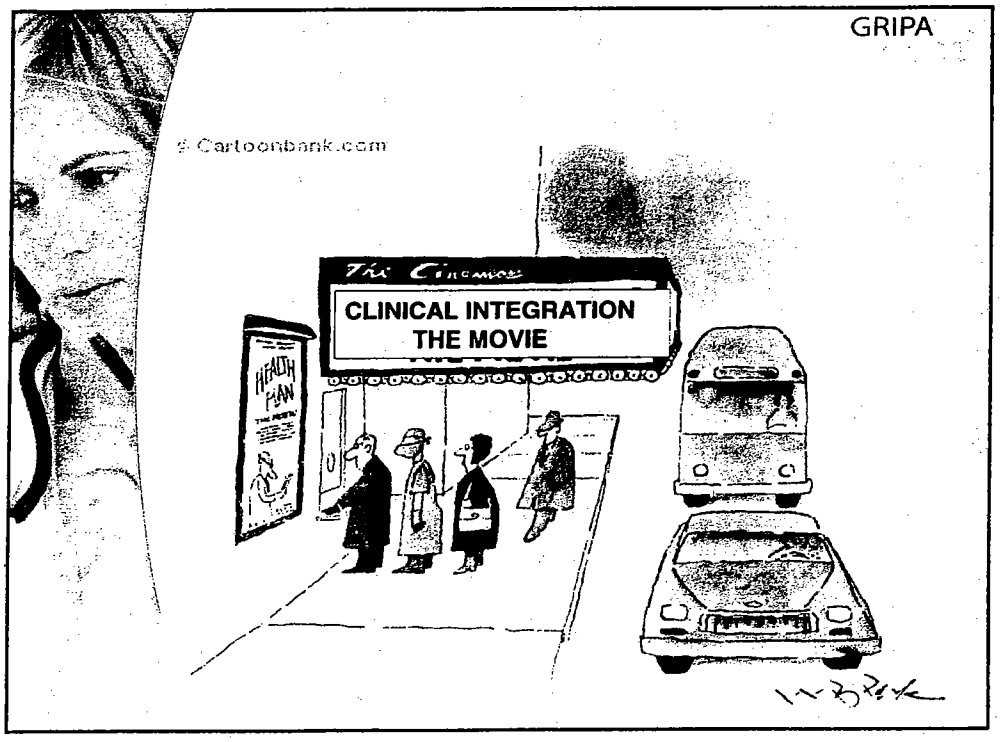



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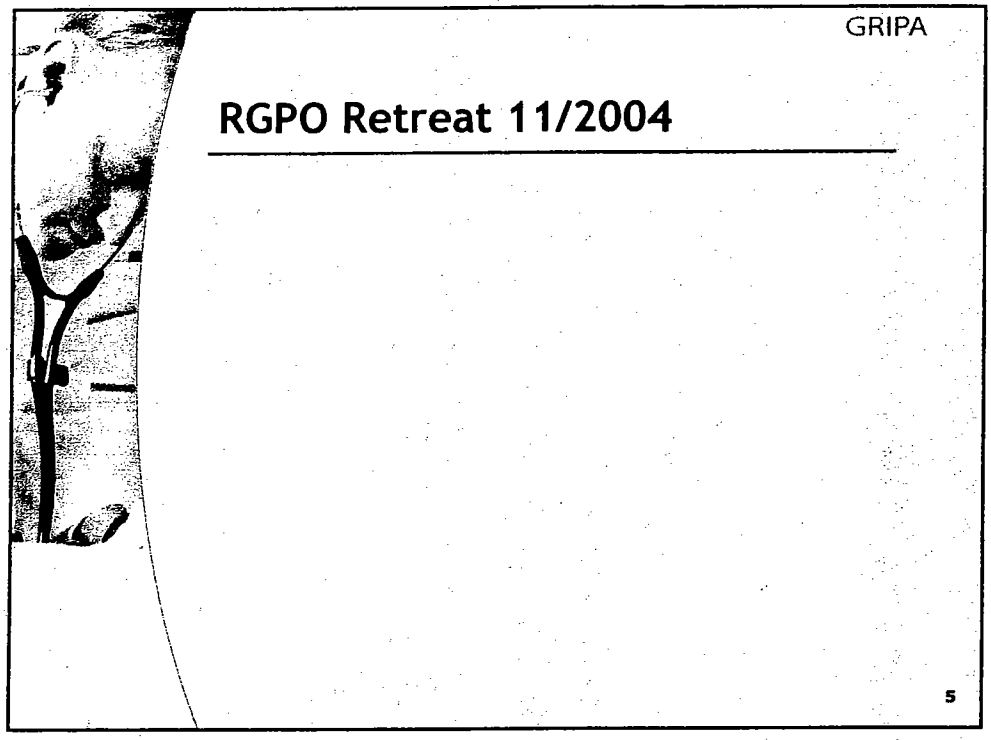
## GRIPA Retreat 8/2004

REDACTED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RGPO Retreat 11/2004
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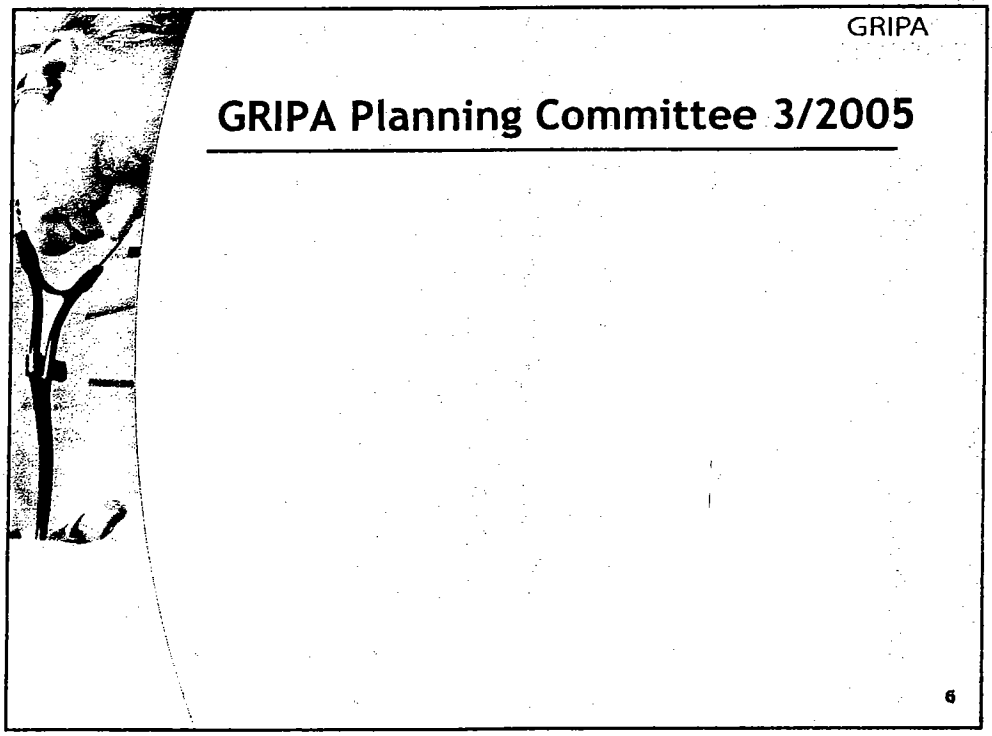
GRIPA
GRIPA Planning Committee 3/2005
6



## GRIPA Retreat 6/2005

- ☐ Clinical Integration ratified as goal
- ☐ Consultants and legal team identified

**12/2005**

- ☐ GRIPA BOD approves C.I. business plan





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GRIPA

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GRIPA

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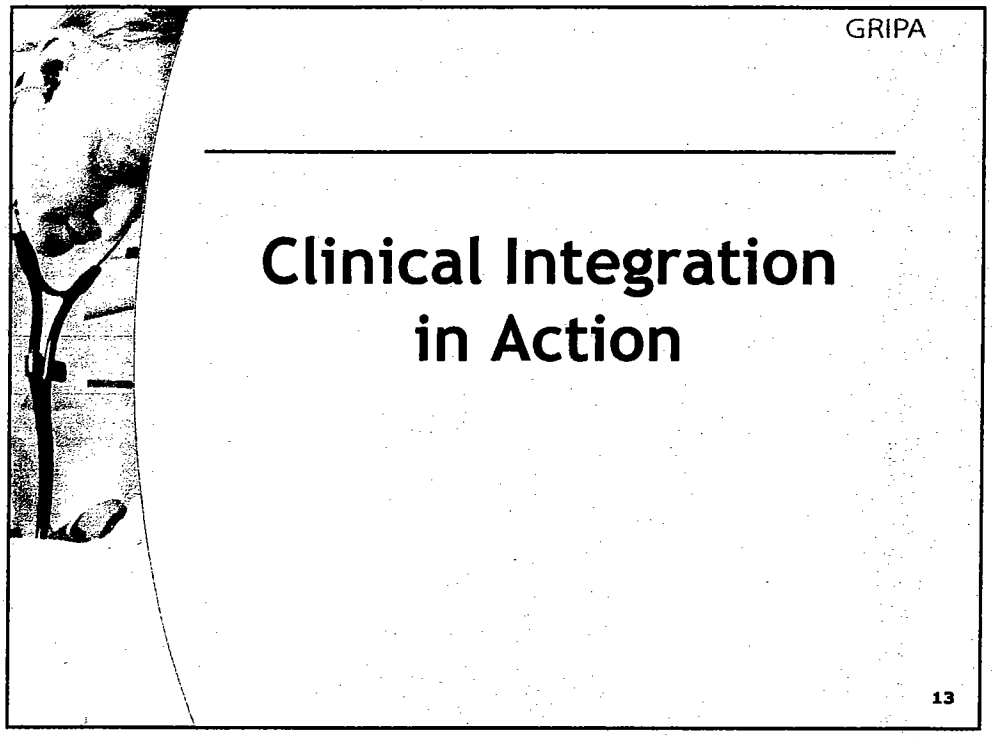
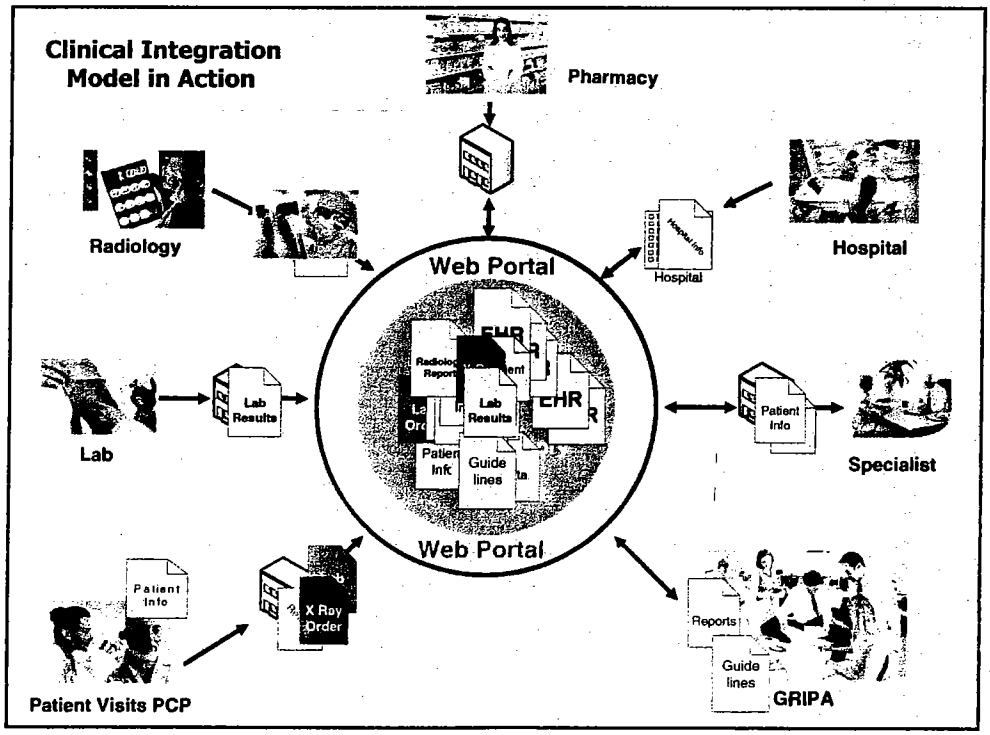

GRIPA
Clinical Integration in Action
13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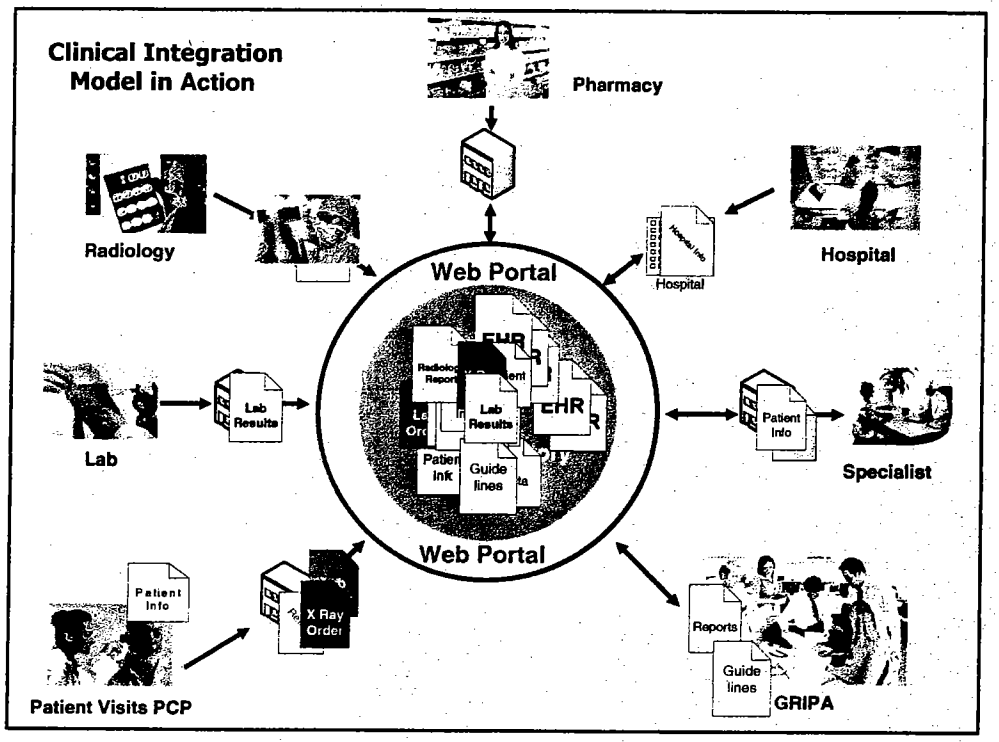
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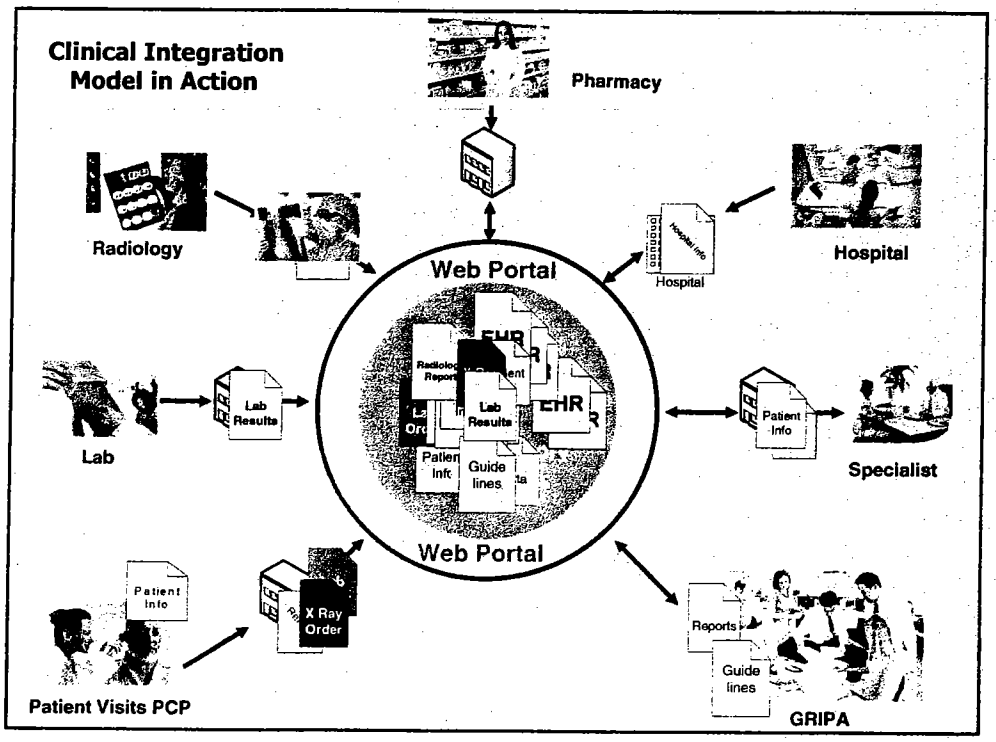
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GRIPA

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GRIPA

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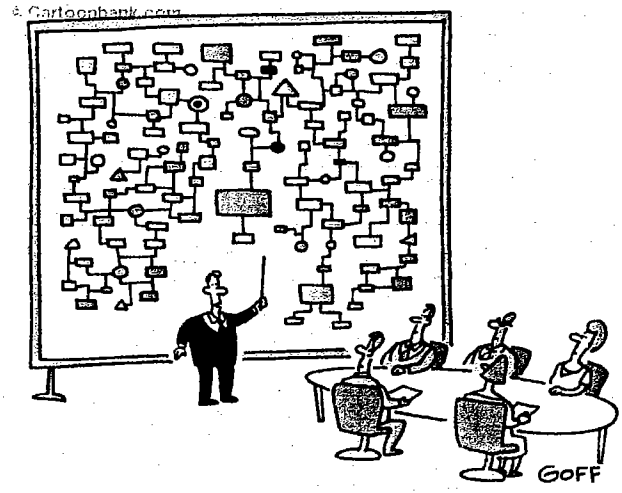


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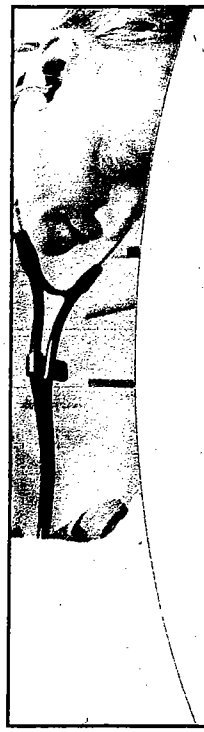

GRIPA

## Physician perspective

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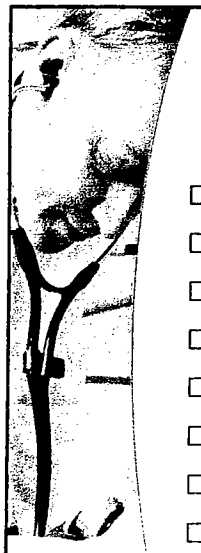
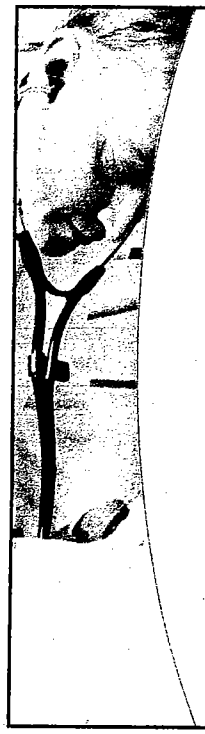


GRIPA

## RGPO Board Members

- ☐ Joseph DiPoala – Pres.
- ☐ John Genier – Treas.
- ☐ Michael Jacobs
- ☐ Michael Kukfa
- ☐ Paul Mikus
- ☐ David Schlageter
- ☐ Christine Stewart
- ☐ Robert Thomson
- ☐ David Cheeran
- ☐ Mark Chodoff
- ☐ Karin Dunnigan
- ☐ Lyle Praire
- ☐ Patrick Riggs – V.Pres.
- ☐ Andrew Swinburne
- ☐ Edward Tanner

26



GRIPA

## GRIPA Board Members

RGPO

- ☐ Joseph DiPoala
- ☐ John Genier
- ☐ Michael Kukfa – Chair
- ☐ Patrick Riggs

WCPO

- ☐ Richard Endres
- ☐ David Hannan

ViaHealth

- ☐ John Biemiller – Treas.
- ☐ Richard Gangemi
- ☐ Richard Hogg
- ☐ Samuel Huston
- ☐ Daniel Meyers – V.Chair
- ☐ Robert Wayland-Smith

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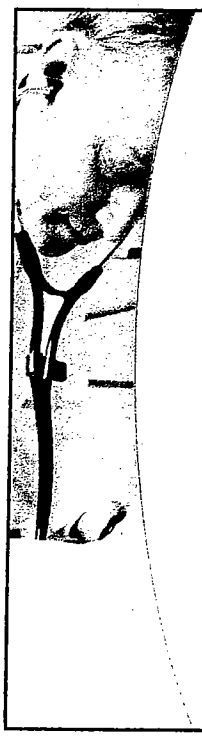

GRIPA

## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

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4/12/06 GRIPA BOD

# Clinical Integration

GRIPA

# Clinical Integration Project

| Initiatives | Leader |
|---|---|
| 1. Communications – Physicians | M. Benjamin/Brand Cool Marketing |
| 2. Communications – Community | G. Coughlin/J. Garnham |
| 3. Legal & Regulatory | E. Nielsen M.D. |
| 4. Contracting | G. Coughlin |
| 5. Physician Enrollment | TBD |
| 6. Clinical Guidelines | D. Lange |
| 7. IT – Healthvision | V. Viglucci/D. VanHousen/Consultant |
| 8. IT – All Other | V. Viglucci/Consultant |
| Project Coordinator | L. Jackson |
| Consultants | |
| Marketing | Brand Cool Marketing |
| IT | TBD |
| General | David Kantor |

GRIPA

# Clinical Integration Project
# Status of Initiative Development

| | Leader | Objectives | Workplan | Milestones |
|---|---|---|---|---|
| 1. Communications – Physicians | x | x | x | x |
| 2. Communications – Community | x | x | 6/30 | 6/30 |
| 3. Legal & Regulatory | x | x | x | x |
| 4. Contracting | x | x | x | x |
| 5. Physician Enrollment | 5/31 | 5/31 | 5/31 | 5/31 |
| 6. Clinical Guidelines | x | x | x | x |
| 7. IT – Healthvision | x | x | x | x |
| 8. IT – All Other | x | x | 6/15 | 6/15 |

GRIRA

# Clinical Integration Project
# Special Communication Protocols

| | Physician Organizations | Hospitals | Attorneys |
|---|---|---|---|
| 1. Communications – Physicians | x | x | x |
| 2. Communications – Community | | | x |
| 3. Legal & Regulatory | | | x |
| 4. Contracting | | | x |
| 5. Physician Enrollment | x | x | |
| 6. Clinical Guidelines | x | x | |
| 7. IT – Healthvision | x | x | |
| 8. IT – All Other | x | x | |

GRIRA

# Communications – Physicians

**Leader: Marianne Benjamin/Brand Cool Marketing**
**Reports To: Eric Nielsen M.D.**
**Support: Marketing Committee**

**2006 Objectives**

1. **Develop and Implement a CI Education Program targeted at GRIPA owner physicians**
   - Attempt to meet and/or speak with every physician by December 31, 2006
   - Utilize group/individual meetings supplemented with print and WEB media
   - Minimum target – direct contact with every owner office
   - Monthly Newsletter
     - Integrate program with Physician Enrollment plan

GRIPA

# Communications – Physicians (Continued)

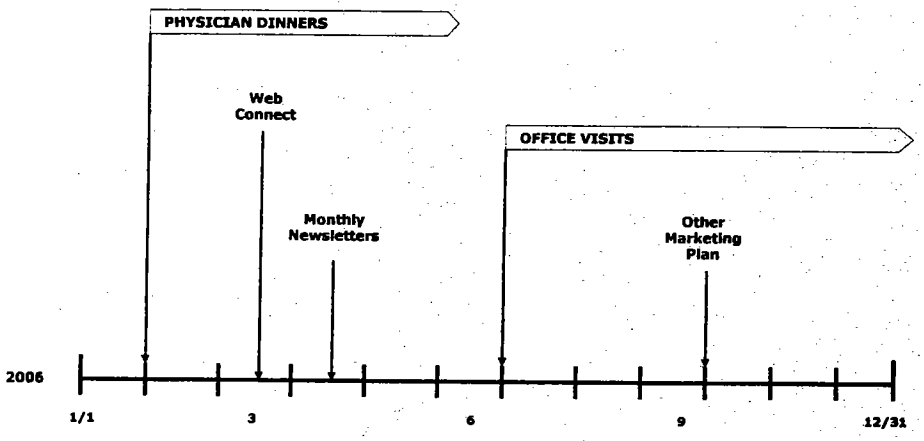
**Leader: Marianne Benjamin/Brand Cool Marketing**
**Reports To: Eric Nielsen M.D.**
**Support: Marketing Committee**

**2006 Objectives**

2. **Develop and implement a robust marketing program to maintain and build enthusiasm for CI Program**
   - Monthly Newsletter
   - WEB Site
   - Target Mailings
   - WEB Site
   - Publications
   - Champions and endorsements
3. **Investigate the feasibility of branding the CI program**
4. **Develop and implement a comprehensive marketing plan for GRIPA**

GRIPA

# Communications - Physicians Milestones




GRIRA

# Communications – Community

**Leader: Marianne Benjamin/Jim Garnham, Brand Cool Marketing**
**Reports To: Gregg Coughlin**
**Support: Marketing Committee**

**2006 Objectives**

1. **Develop and Implement a CI Education and Marketing Program targeted to employers, regulatory groups, city and county governmental units, state agencies, trade associations and the community.**
   - Educate and seek support for the Clinical Integration Program
   - Explore contract opportunities

2. **Develop and Implement a CI Education and Marketing Program for insurers and third party administrators**

3. **Evaluate feasibility of a CI Education Program for consumers and general public**

GRIRA

# Legal & Regulatory

**Leader: Eric Nielsen MD, Gregg Coughlin**

**2006 Objectives**

1.

2.

3.

4.

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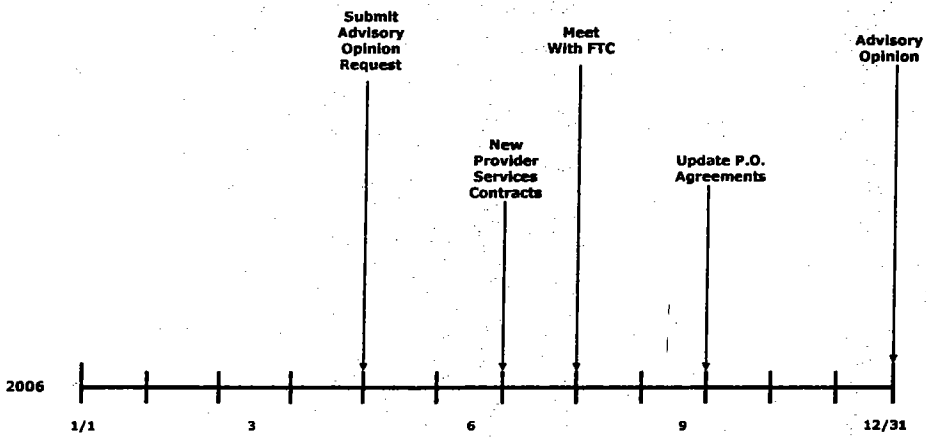
# Legal & Regulatory Milestones




GRIRA

# Contracting

**Leader: Gregg Coughlin, Jim Garnham**

**2006 Objectives**

**1.**

**2.**

**3.**

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# Contracting

**Leader: Gregg Coughlin, Jim Garnham**

**2006 Objectives**

**4.**

**5.**

GRIRA

# Clinical Guidelines

**Leader: Deb Lange**
**Reports to: Eric Nielsen, MD**
**Support: Clinical Integration Committee (CIC)**

**2006 Objectives**

1. **Develops inventory of guidelines and measures from national and local repositories and local payors.**
   - Compare to national Standards
   - Complete financial impact studies
   - Complete analysis requested by CIC
   - Propose guidelines and measures to CIC

2. **Clinical Integration Committee approval**
   - Reviews and analyzes guidelines
   - Solicits input from Specialty Advisory Committees as needed
   - Approves guidelines

GRIRA

# Clinical Guidelines (continued)

**Leader: Deb Lange**
**Reports to: Eric Nielsen, MD**
**Support: Clinical Integration Committee (CIC)**

**2006 Objectives**

3. **Develops process for monitoring adherence to guidelines and standards**
   - Develops procedures and protocols
   - Establishes standards
   - Corrective Action plan guidelines
   - Sanction guidelines

4. **Designs reporting system for monitoring and reporting**

5. **CIC refers poor performing providers to Quality Assurance Council for follow-up action.**

GRIRA

# IT - Healthvision

**Leader: Vicky Viglucci/Donna VanHousen/Consultant**
**Reports to: Eric Nielsen, MD**
**Support: IT Steering Committee**

**2006 Objectives**

1. **Design portal functions and features**
   - Physician Advisor Group
   - Rules & roles
   - Display and transmission of guideline
   - Select features

2. **Develop links between Data Sources & Portal**
   - RGH
   - Other

GRIRA

# IT – Healthvision (continued)

**Leader: Vicky Viglucci/Donna VanHousen/Consultant**
**Reports to: Eric Nielsen, MD**
**Support: IT Steering Committee**

**2006 Objectives**

3. **Assess office readiness and develop deployment strategy**
   - Hardware & connectivity to Portal
   - Office Flow assessment
   - Vendor negotiations

4. **Install technology to connect office to Healthvision**
   - Implementation Plan
   - Training - education
   - Help Desk

5. **Design and development of clinical database for guideline monitoring**

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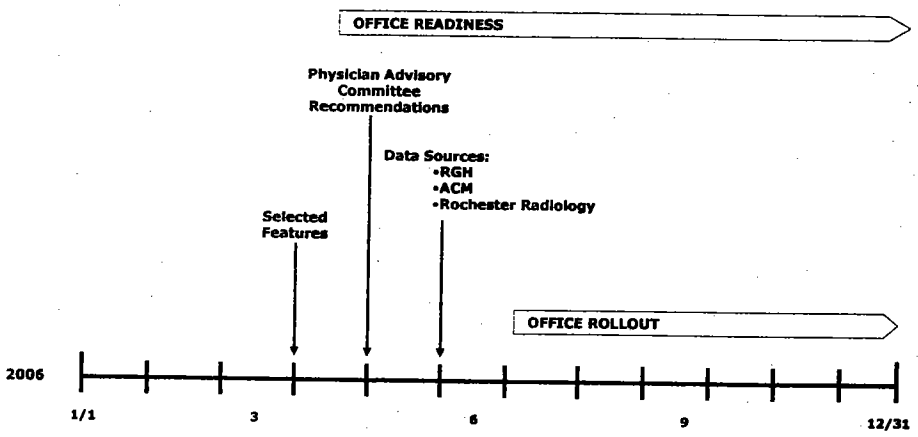
# IT Milestones




GRIPA

# IT - Other

**Leader: Vicky Viglucci/Consultant**
**Reports to: Eric Nielsen, MD**
**Support: IT Steering Committee**

**2006 Objectives**

1. **Evaluate alternative data sources to enhance guideline compliance & monitoring**

2. **Evaluate alternative communication links between GRIPA and participating providers**

GRIPA

# Clinical Integration Project
# Project Oversight

1. Communications – Physicians
2. Communications – Community
3. Legal & Regulatory
4. Contracting
5. Physician Enrollment
6. Clinical Guidelines
7. IT – Healthvision
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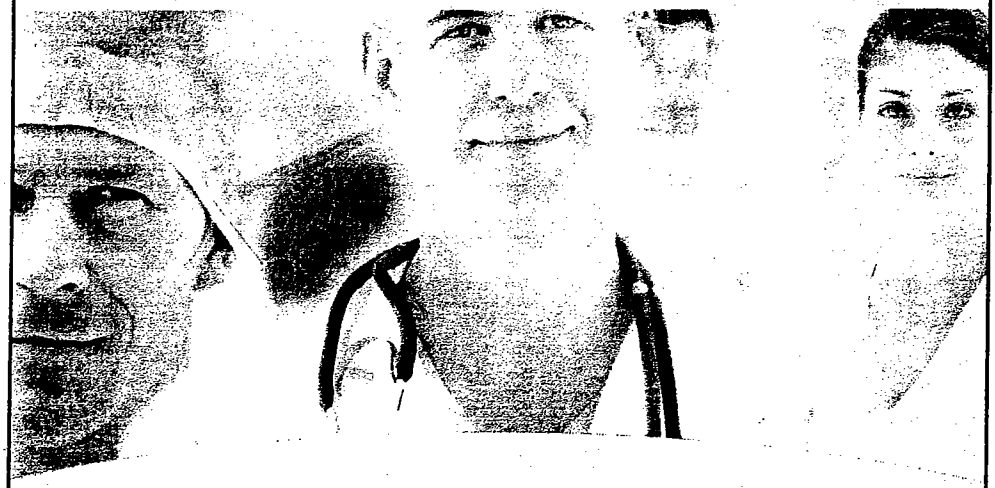
Leaders → Project Coordinator → President → Board

## 4/17/06 Rochester General Fam. Med. Dept.

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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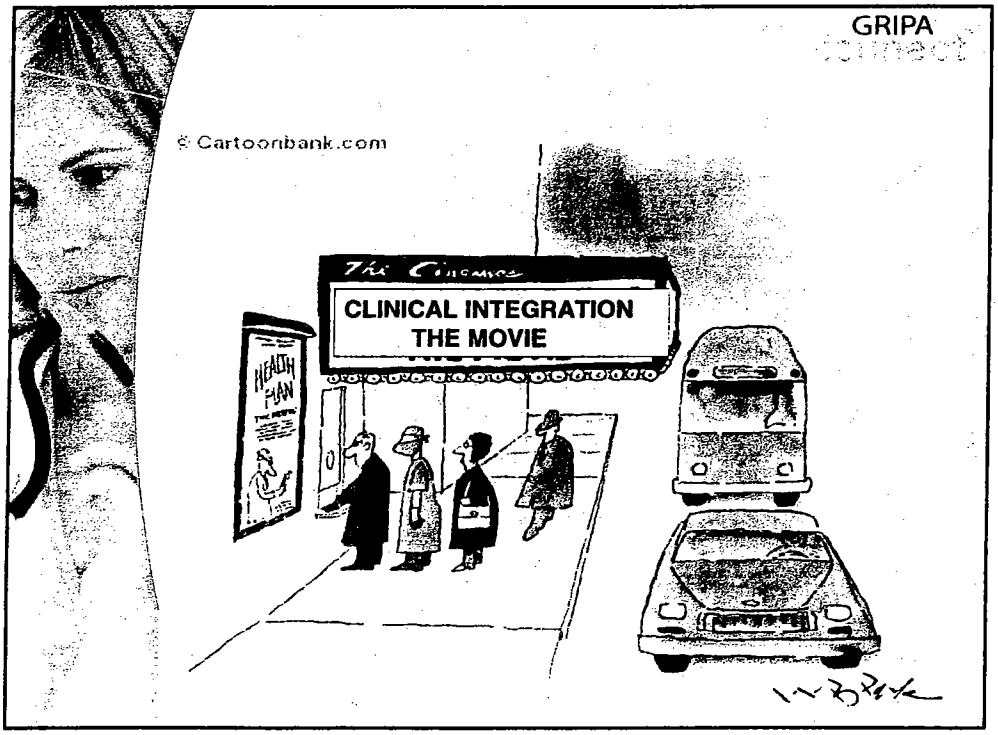




## Clinical Integration

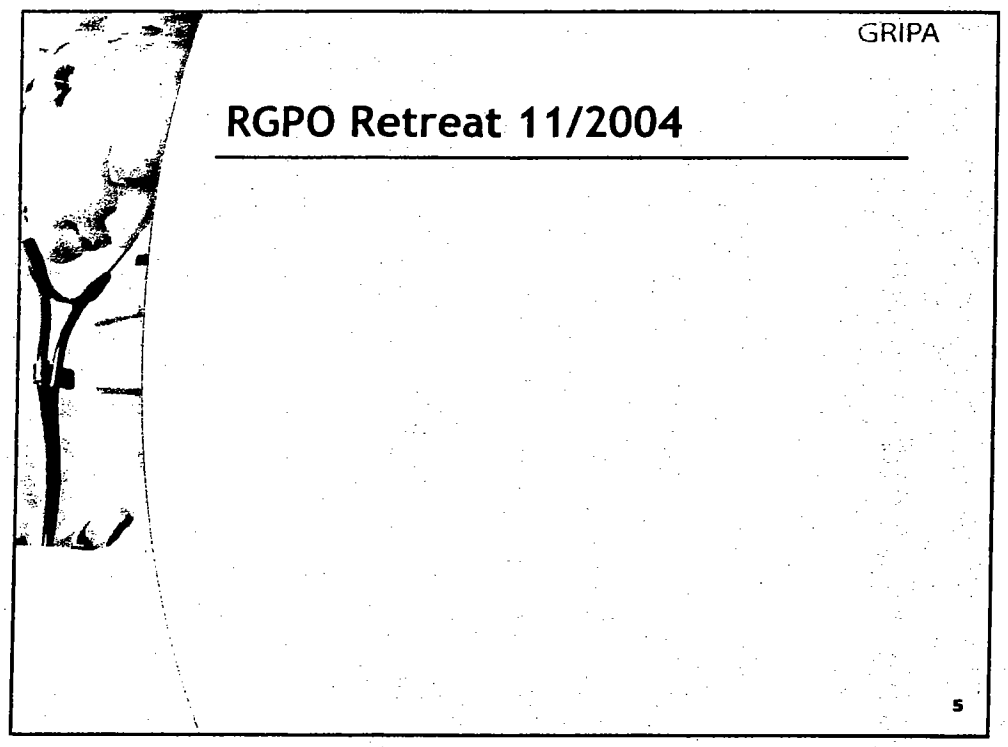
- ☐ Natural outgrowth—pioneering step
- ☐ Short presentation followed by Q&A
- ☐ The presenters
- ☐ Collaborative spirit - input and feedback
- ☐ Why the change?

3



## GRIPA Retreat 8/2004

4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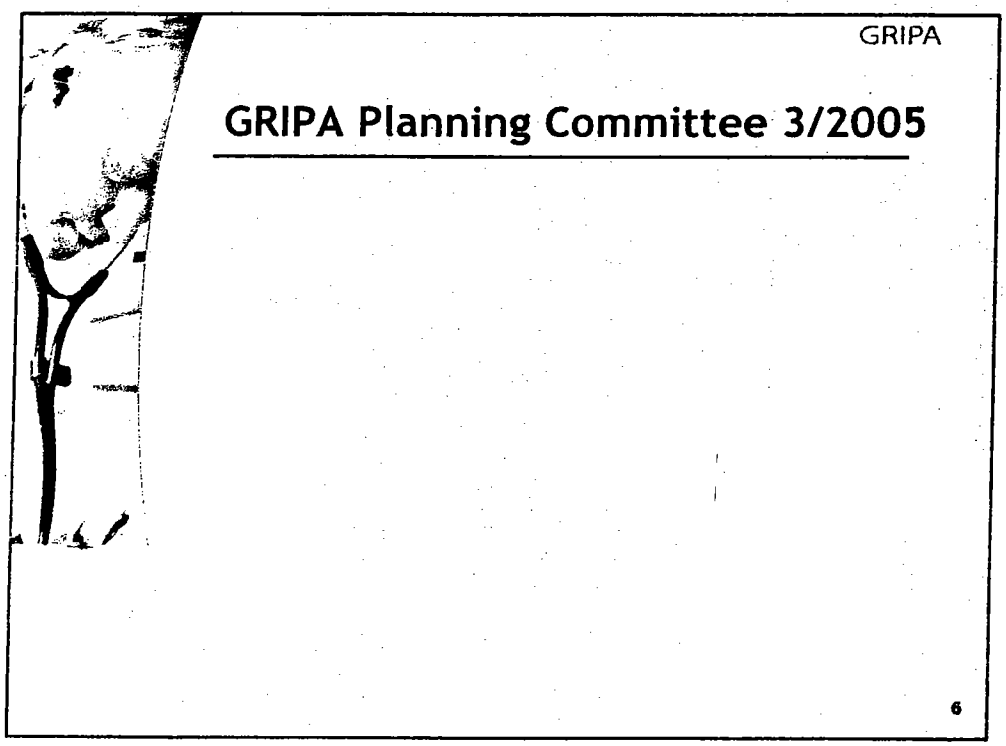
RGPO Retreat 11/2004
5


GRIPA
GRIPA Planning Committee 3/2005
6



## GRIPA Retreat 6/2005

- ☐ Clinical Integration ratified as goal
- ☐ Consultants and legal team identified

**12/2005**

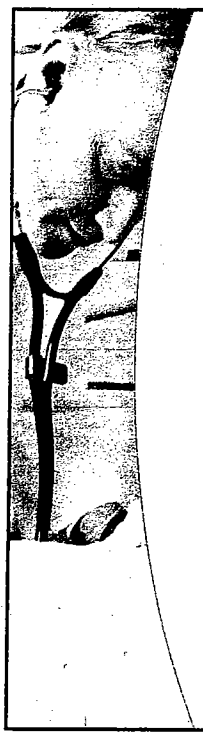
- ☐ GRIPA BOD approves C.I. business plan





## Physician contracting

- ☐ Per FTC & DOJ, illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
- ☐ Waiver only for
  - Financial Integration
    - employed group
    - group accepting capitated risk & withhold
  - Clinical Integration
    - Hard to do – MedSouth is only group in the country to get prior approval of FTC





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- ☐ Insurers want direct contract with each MD
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- ☐ Antitrust constraints on physician organization fee-for-service contracting
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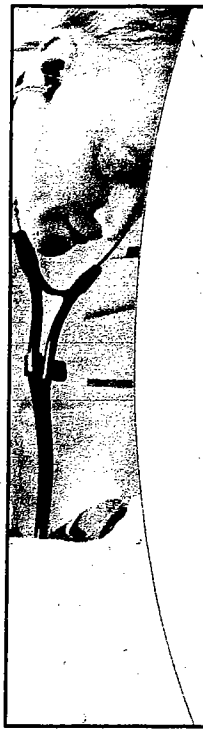
10



GRIPA

## Yes, with three key components

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11

GRIPA

## Benefits of Clinical Integration

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- ☐ Shared commitment to clinical improvement using guidelines, care management, and IT
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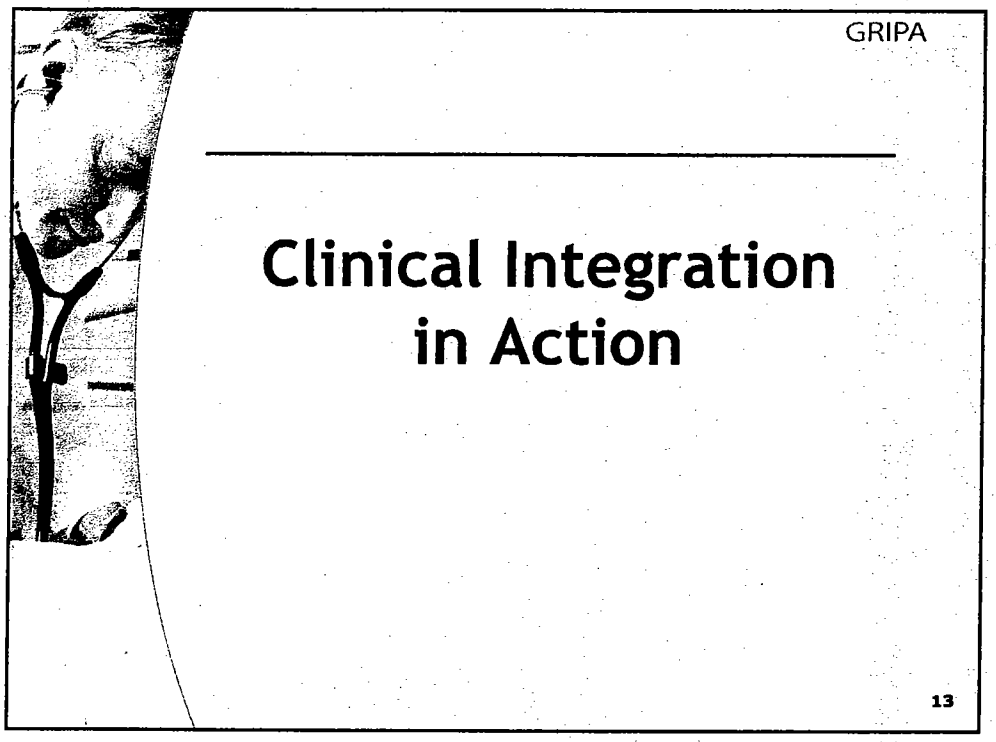
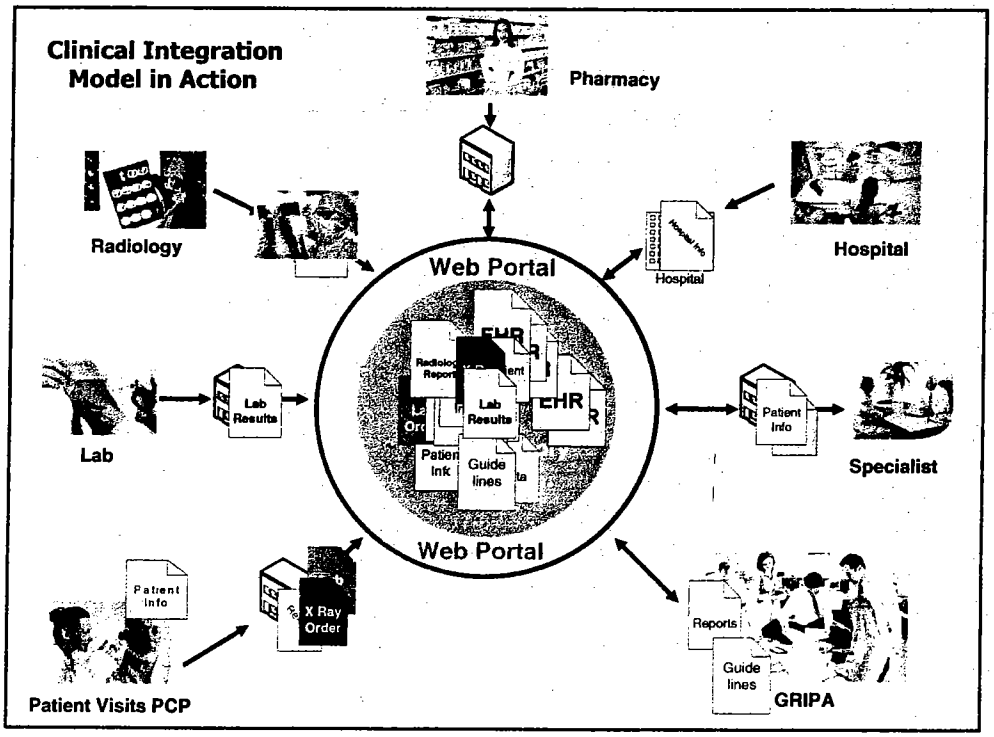

GRIPA
Clinical Integration
in Action
13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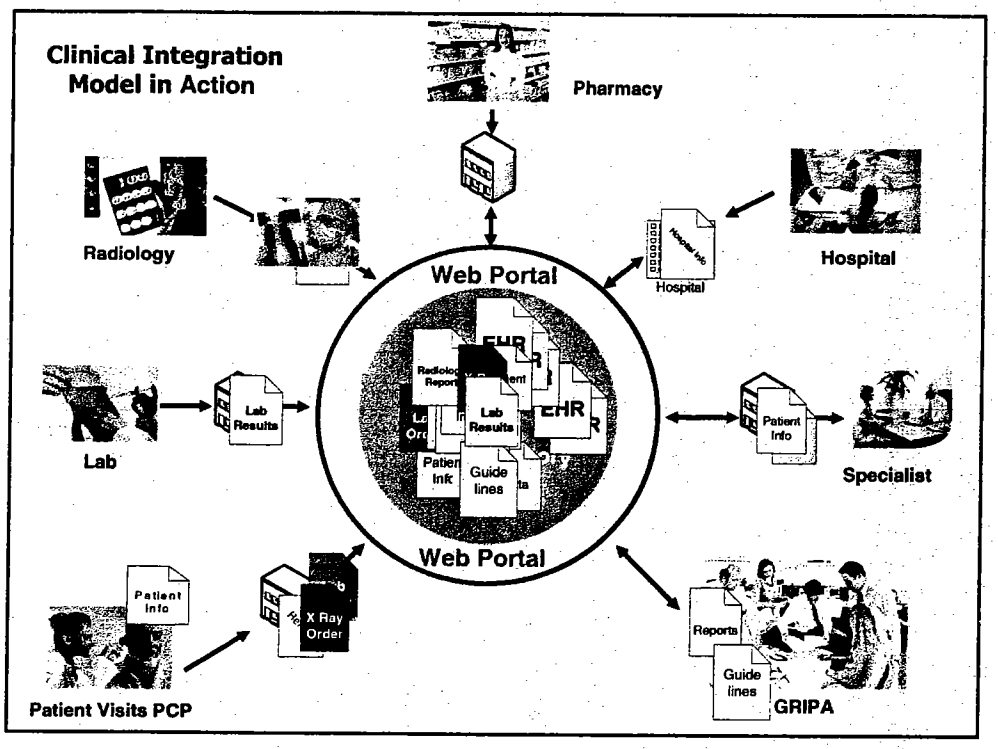
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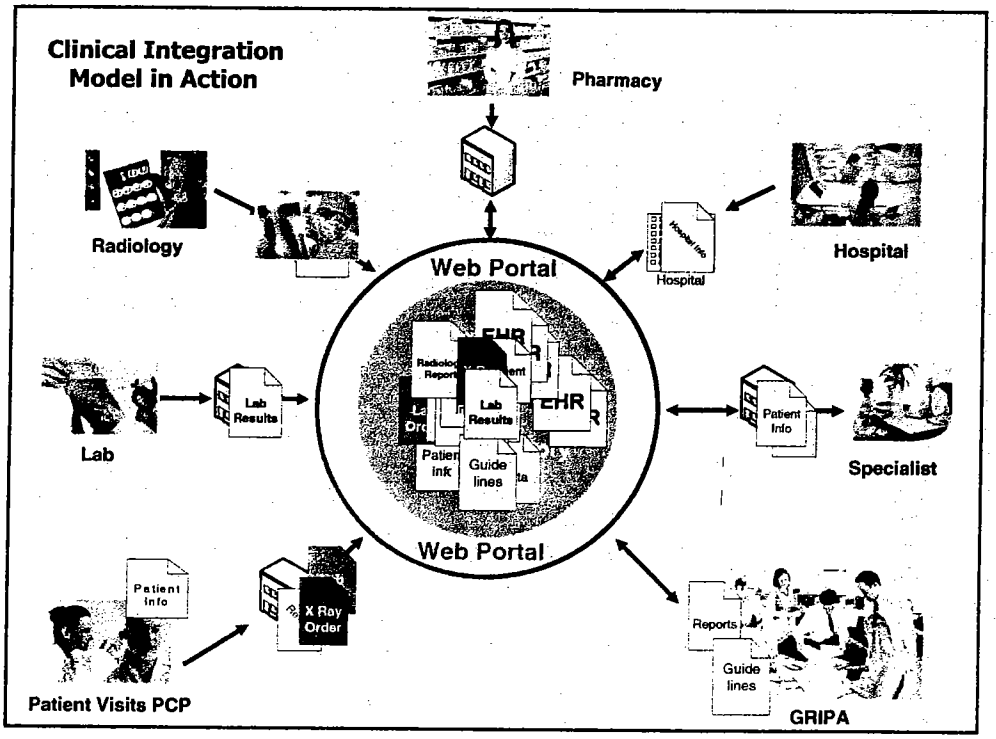
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## GRIPA Connect – our version

- ☐ Clinical Integration Committee
  - Quality Assurance Committee
  - Advisory Committees by specialty
- ☐ Evidence-based guidelines, measures, & goals prepared and updated by committees and expanded to multiple specialties
- ☐ Processes for disseminating guidelines, monitoring adherence, feedback to MDs, and reporting to IPA
- ☐ Care Mgmt. assisting MDs with compliance
- ☐ Laptop for each MD, wireless router each office

17



## GRIPA Connect – first steps

**View and print lab and x-ray reports**

- Have staff print lab, x-ray reports during patient appointment
- Office staff prints ahead of appointment for patient paper file
- Least impact to office workflow

**Next step: view report on PC or wireless laptop in exam rooms**

**Next step: use portal to send patient notes to other physicians**

**Next step: migrate all patient records to portal or EMR**

18

GRIPA

## From simplest to fully integrated

- ☐ Flexibility
- ☐ Works with offices that are completely paper and those that already have EMR
- ☐ Optional e-prescribing & lab order entry
- ☐ Adding data from physician's offices will be helpful but not mandatory

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GRIPA

## Goals of GRIPA Connect

- ☐ Provide physicians with most complete medical history at time of care
- ☐ Provide physicians with e-tools to replace manual processes
- ☐ Provide IPA with comprehensive clinical data to develop incentive and quality programs
- ☐ Employed and private physicians in contracts
- ☐ Be accountable to insurers, employers, community, regulators
- ☐ Differentiate the network based on technology and quality of care

20



## GRIPA's plans & timelines

- ☐ 12/05 - contracted with Healthvision for IT infrastructure
- ☐ Early 2006 - data source interfaces & portal design
- ☐ Late 2006 - roll-out web portal to physician offices
- ☐ 2006 - FTC advisory opinion
- ☐ 2007 - negotiate / charge premium for better product
- ☐ Continue risk contracting for 640, FFS for 400?

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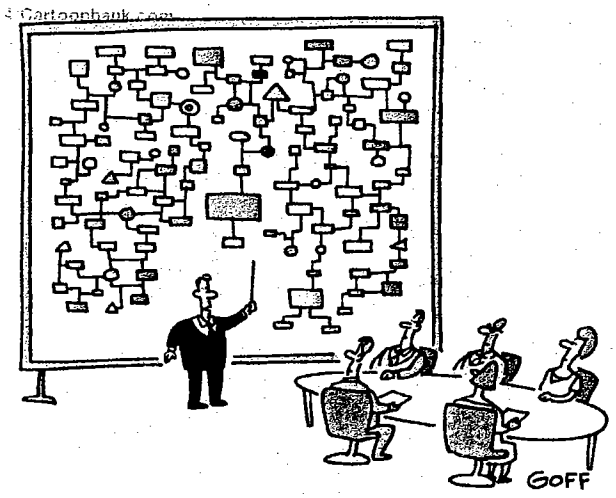
## GRIPA Connect Stretch Goals

- ☐ Obtain a copy of all electronic billing from practice management systems, clearinghouses, or billing services to augment clinical data
- ☐ Encourage, but not require, MD offices to adopt EMRs interoperable with Healthvision
- ☐ Co-development with Healthvision:
  - Guideline availability on the portal (phase 1)
  - Patient-specific prompts at point of care (phase 2)
  - Monitoring & reporting on compliance (phase 2)

22



## Simplify technology




"And that's why we need a computer."





## ViaHealth perspective

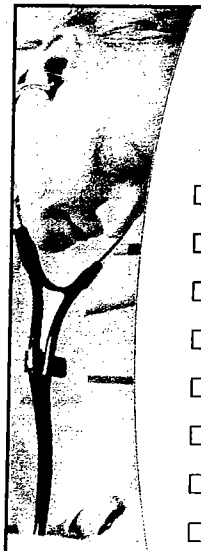
- ☐ Physician recruitment & retention very important to RGH & VOW
- ☐ Connectivity key to future success
- ☐ Relationship to GRIPA and POs highly valued
- ☐ Risk contracting appears to be disappearing
- ☐ Loss of the risk model leaves physicians bare & with few options
- ☐ Some aspects of CI may be mandated in next 5 years
- ☐ Makes sense to pursue now if it is to be mandated
- ☐ ViaHealth commitment to Clinical Integration

GRIPA

## Physician perspective

- ❑initially skeptical
- ❑essential to the future of physicians and RGH
- ❑no longer "business as usual"
- ❑allows you to be an independent practitioner
- ❑retaining the benefits of a large group
- ❑not ready for a full EMR
- ❑begin the transition to use computers
- ❑input into clinical guidelines & portal
- ❑Pay-for-performance programs are coming
- ❑rather set them up with "friends and family"
- ❑maintain the bond of GRIPA physicians
- ❑recognized for the excellent care we deliver

25



GRIPA

## RGPO Board Members

- ☐ Joseph DiPoala – Pres.
- ☐ John Genier – Treas.
- ☐ Michael Jacobs
- ☐ Michael Kukfa
- ☐ Paul Mikus
- ☐ David Schlageter
- ☐ Christine Stewart
- ☐ Robert Thomson
- ☐ David Cheeran
- ☐ Mark Chodoff
- ☐ Karin Dunnigan
- ☐ Lyle Praire
- ☐ Patrick Riggs – V.Pres.
- ☐ Andrew Swinburne
- ☐ Edward Tanner

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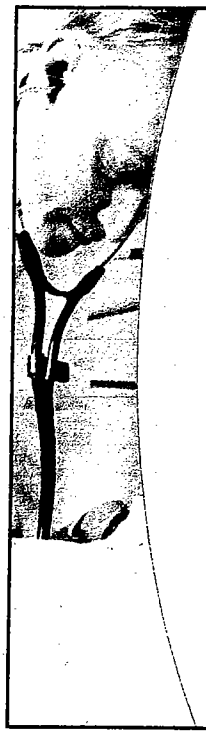



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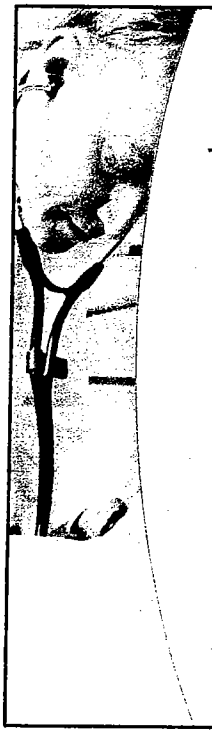
WCPO

- ☐ Richard Endres
- ☐ David Hannan

ViaHealth

- ☐ John Biemiller – Treas.
- ☐ Richard Gangemi
- ☐ Richard Hogg
- ☐ Samuel Huston
- ☐ Daniel Meyers – V.Chair
- ☐ Robert Wayland-Smith





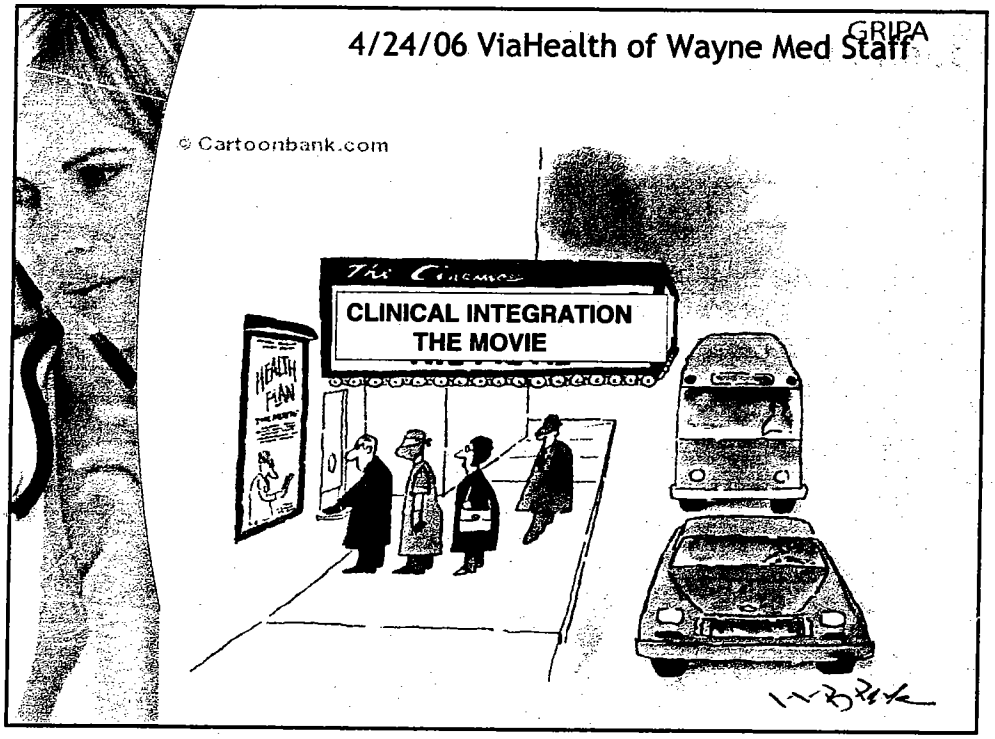


## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

4/24/06 ViaHealth of Wayne Med Staff



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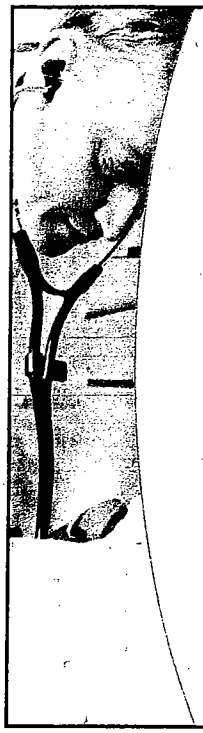

GRIPA

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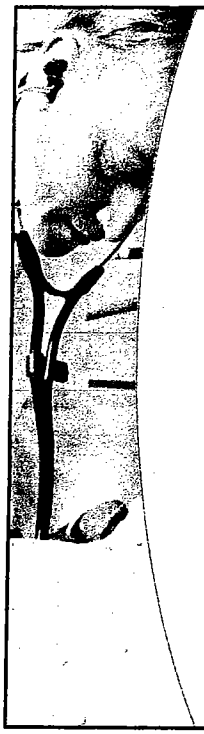

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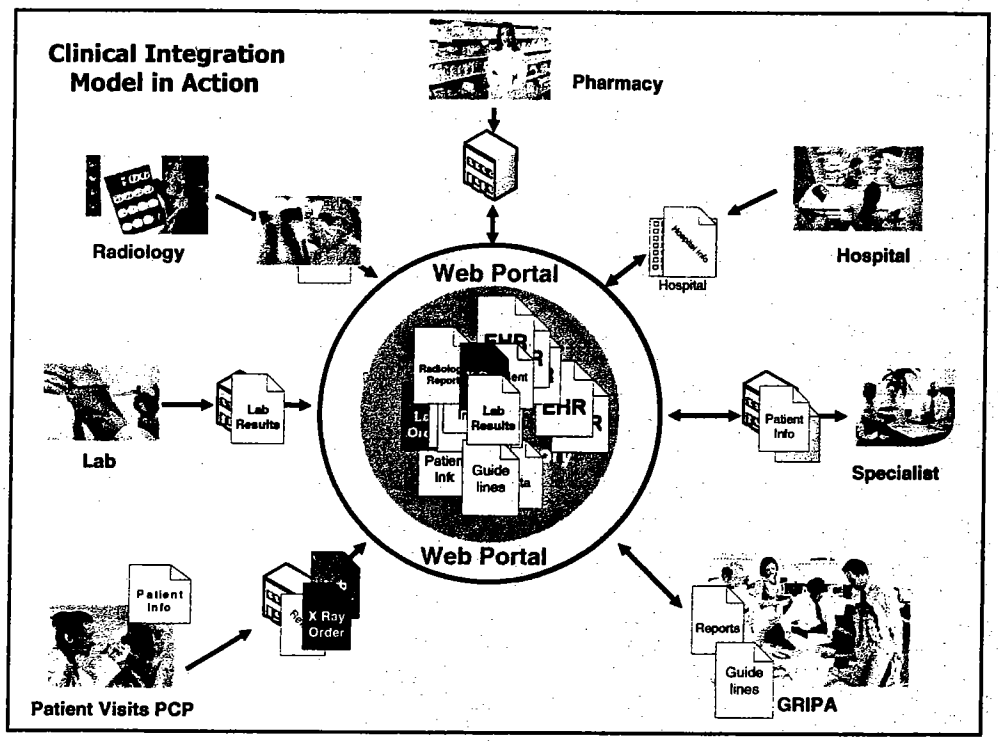
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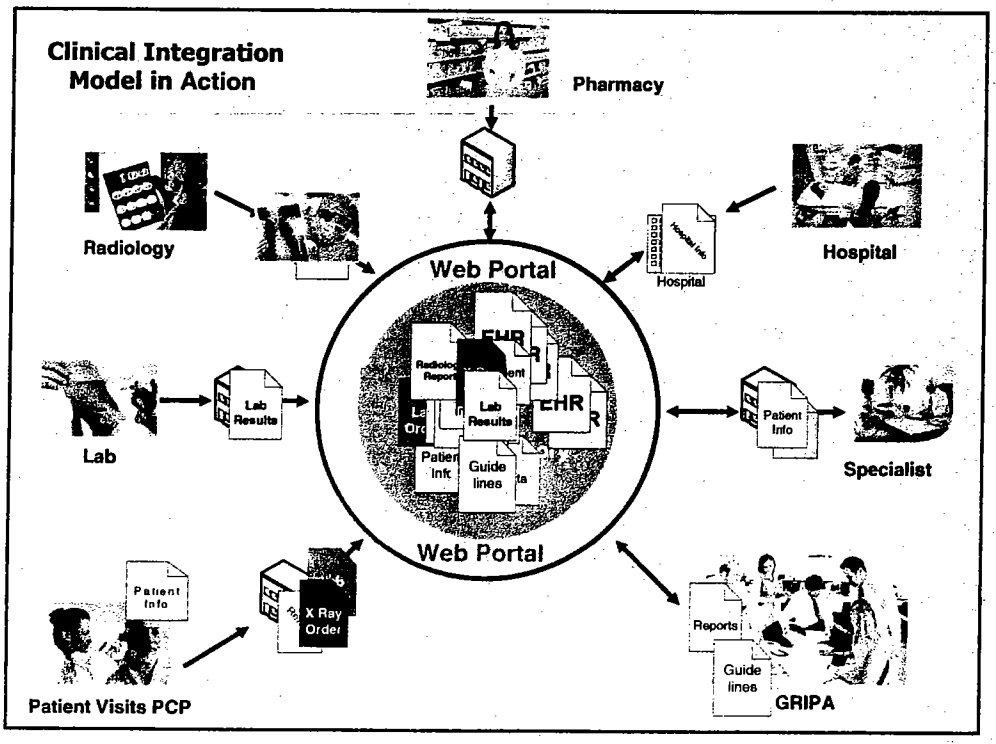
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GRIPA

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GRIPA

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14



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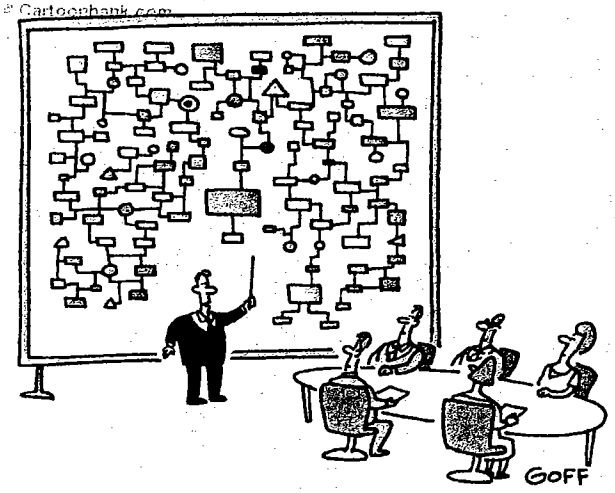


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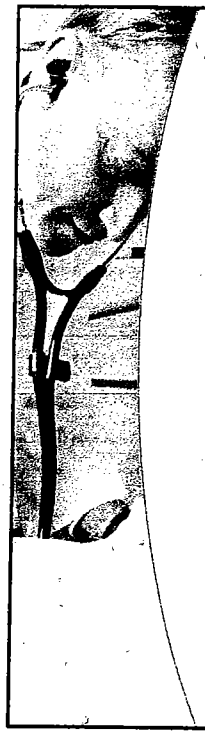

GRIPA

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- ❑maintains the bond of GRIPA physicians
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17

GRIPA

## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

18

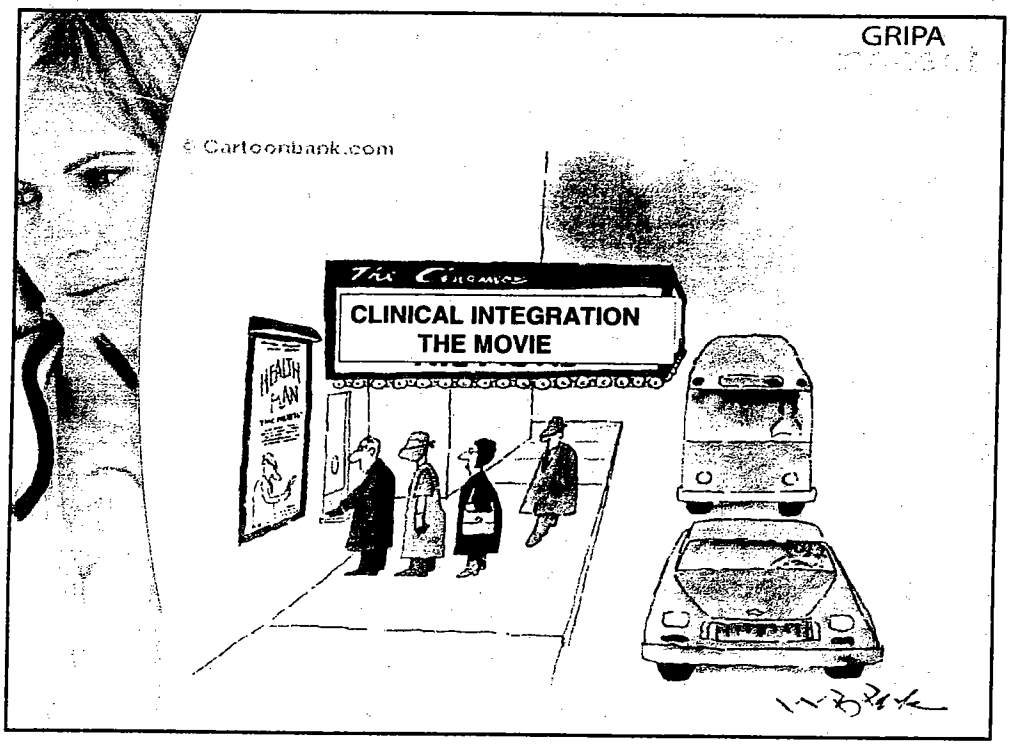
## 5/19/06 Physician Dinner meeting

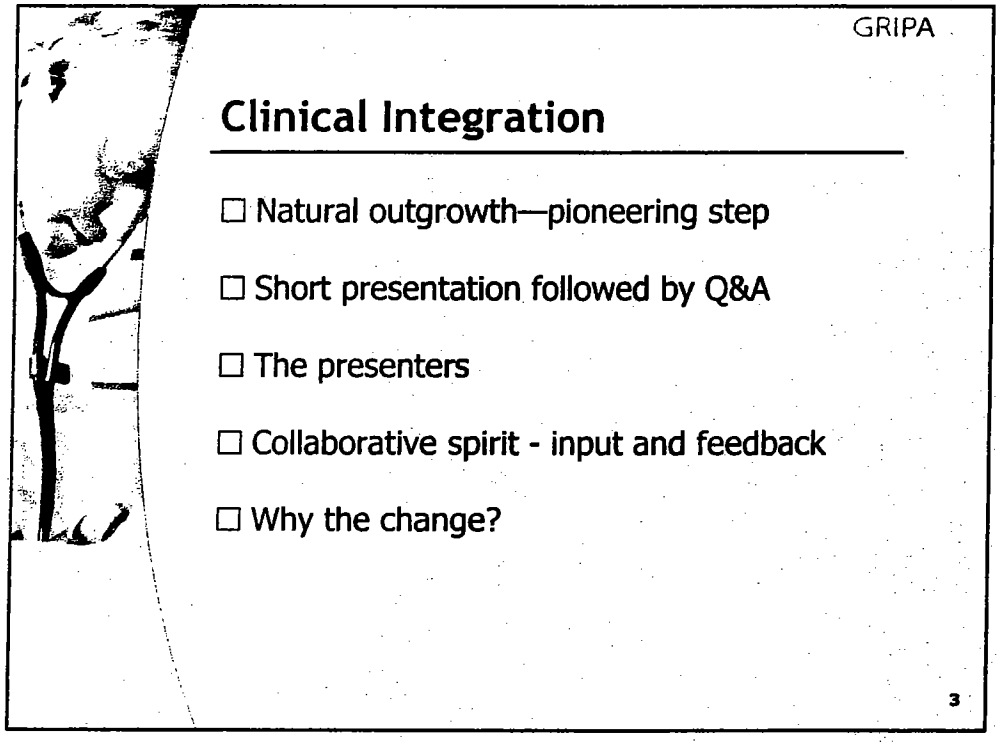
CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS

GRIPA

GRIPA

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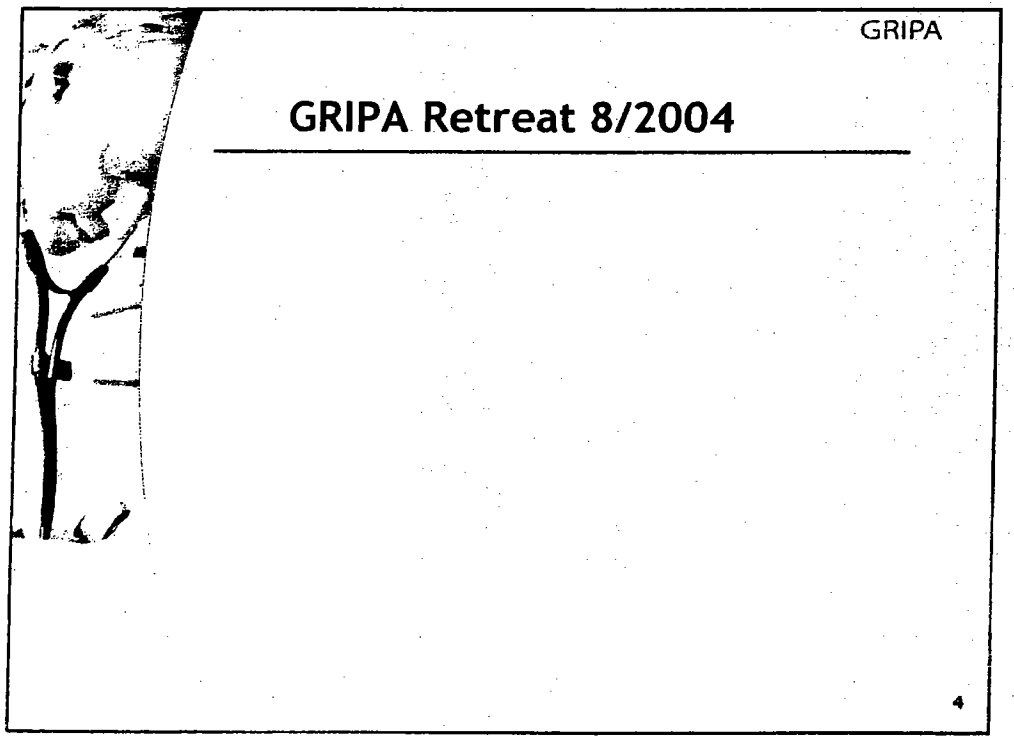
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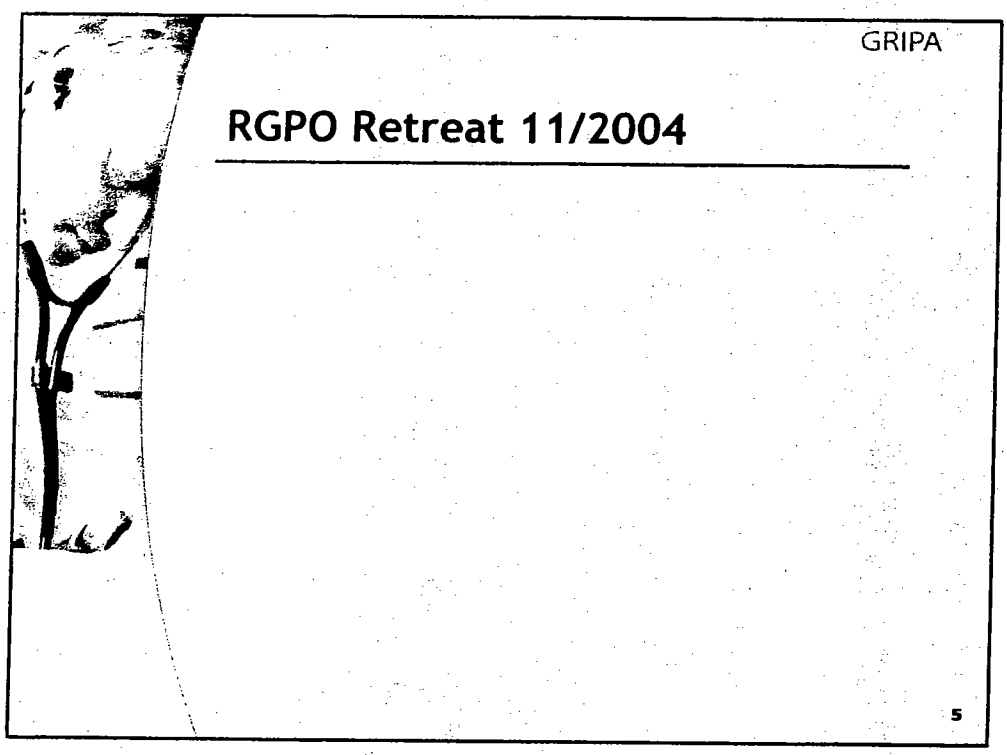
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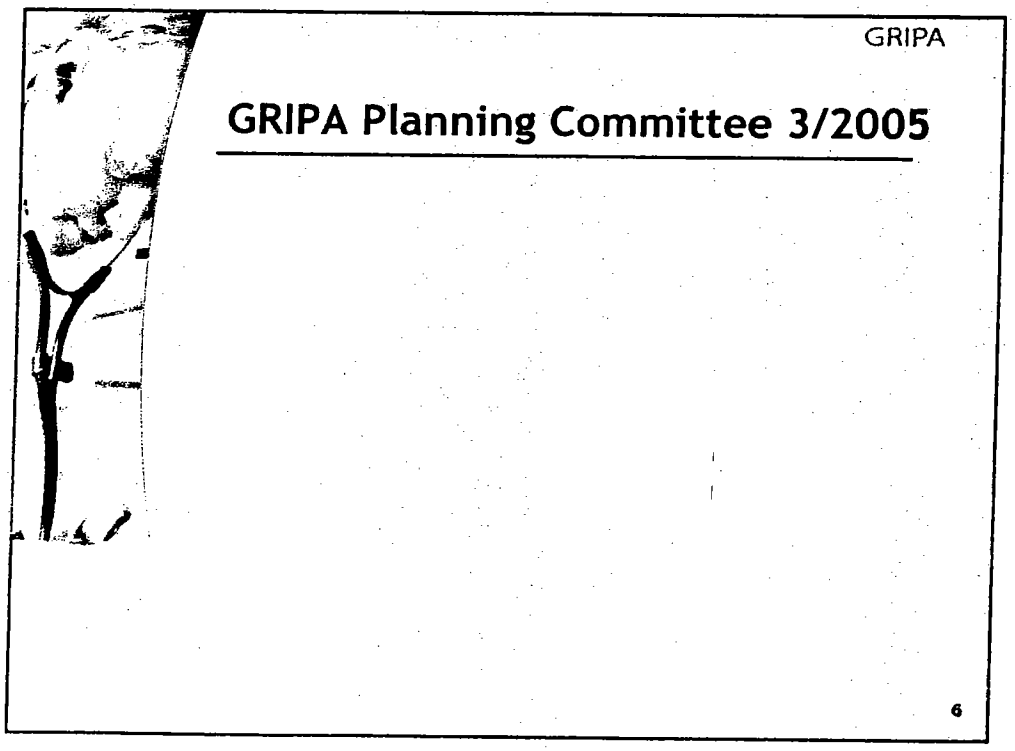
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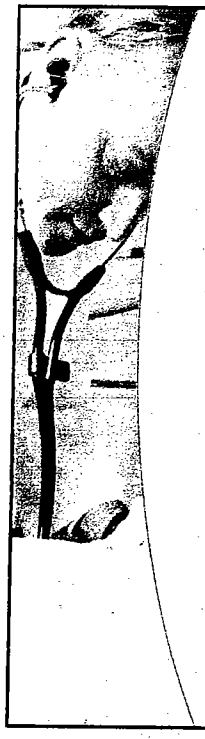

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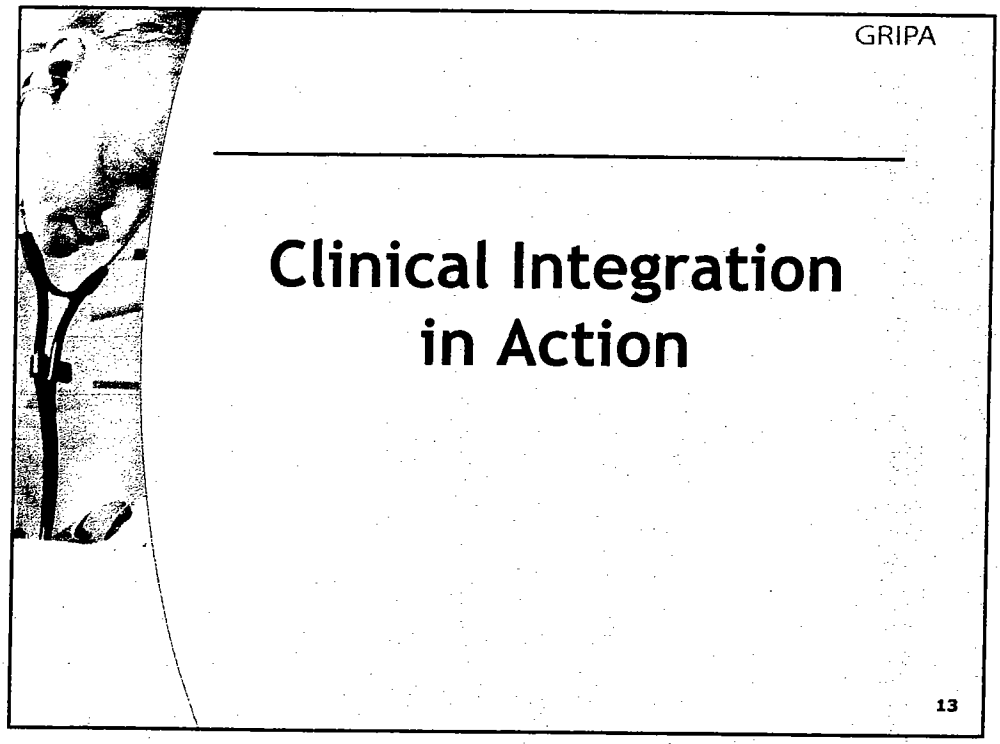
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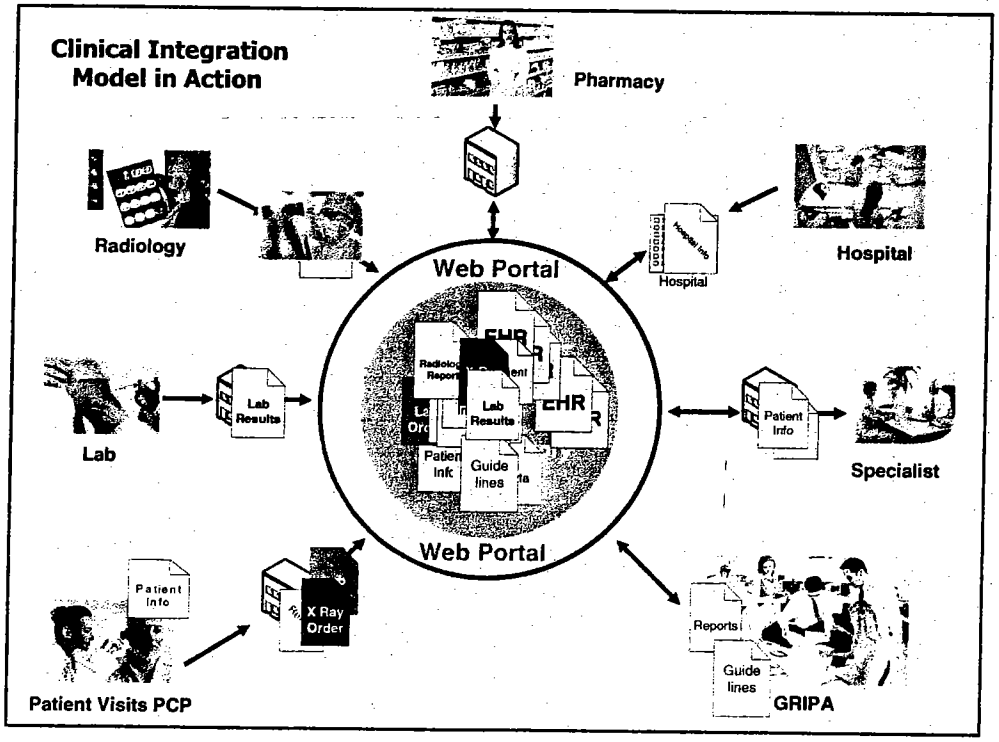
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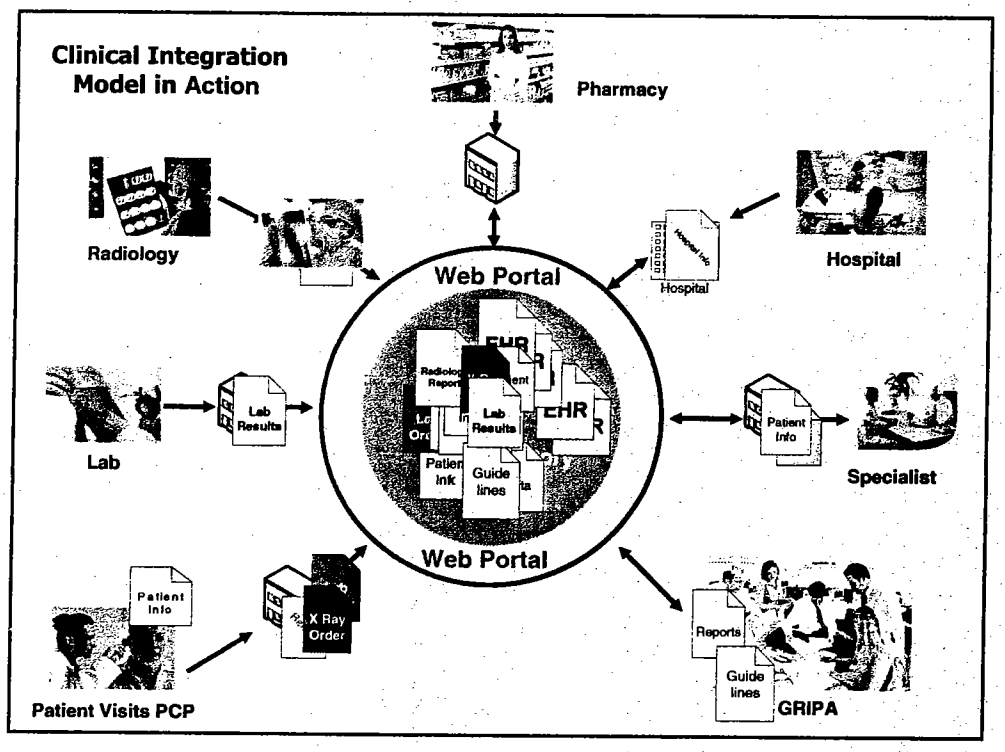
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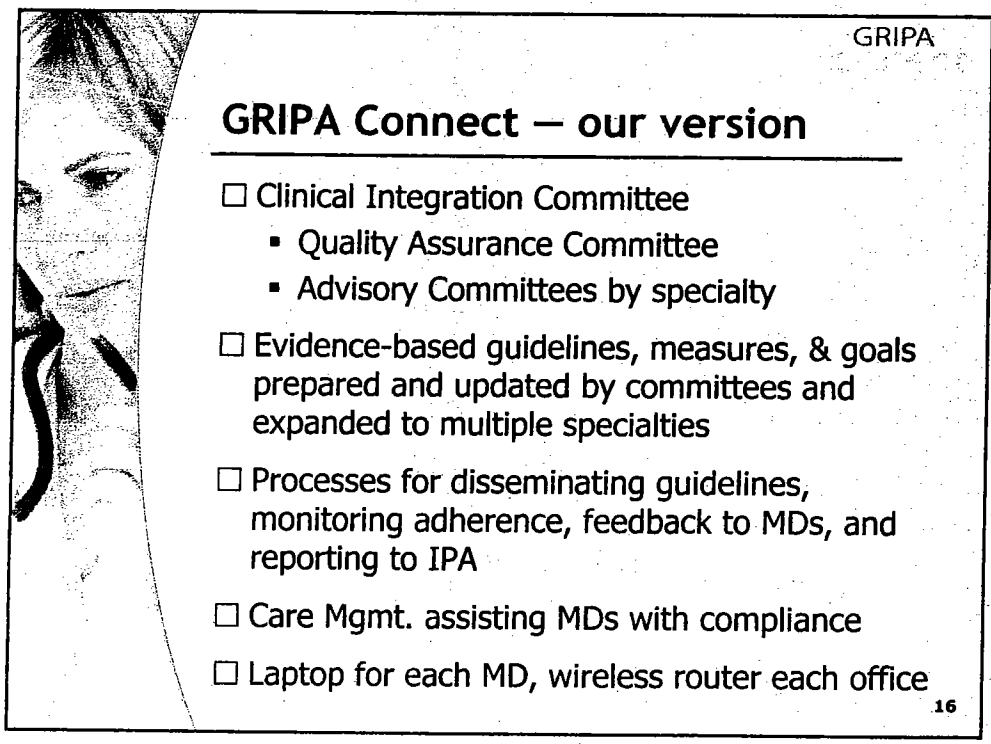
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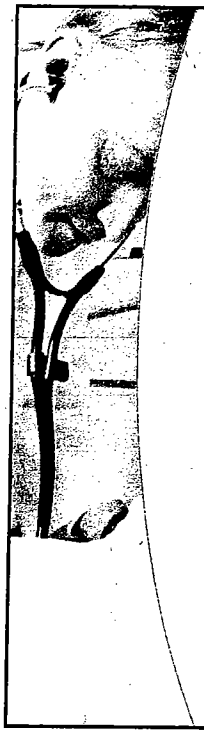



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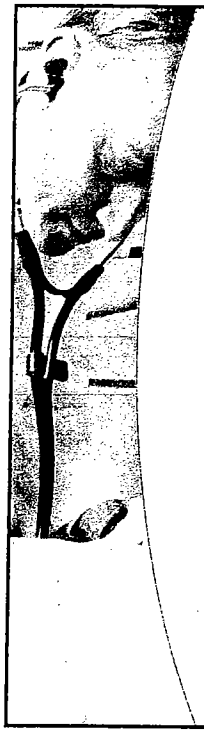



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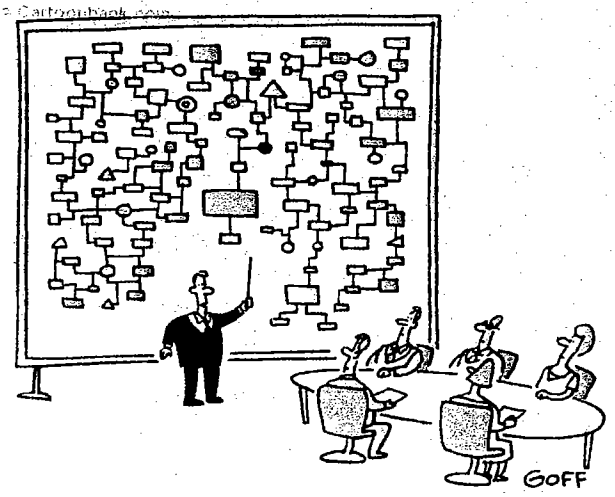


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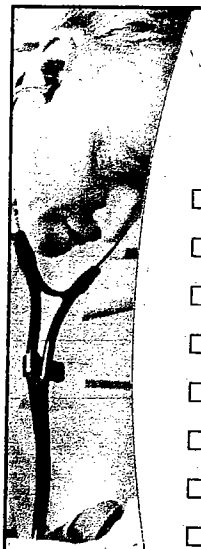



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- ☐ John Genier – Treas.
- ☐ Michael Jacobs
- ☐ Michael Kukfa
- ☐ Paul Mikus
- ☐ David Schlageter
- ☐ Christine Stewart
- ☐ Robert Thomson
- ☐ David Cheeran
- ☐ Mark Chodoff
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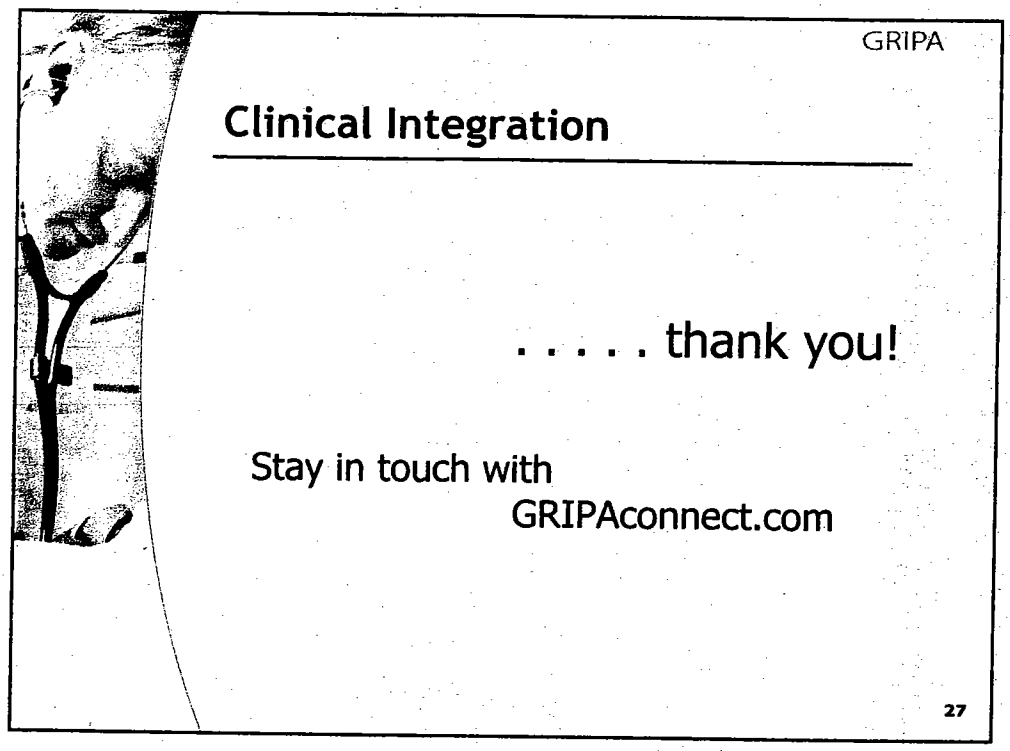
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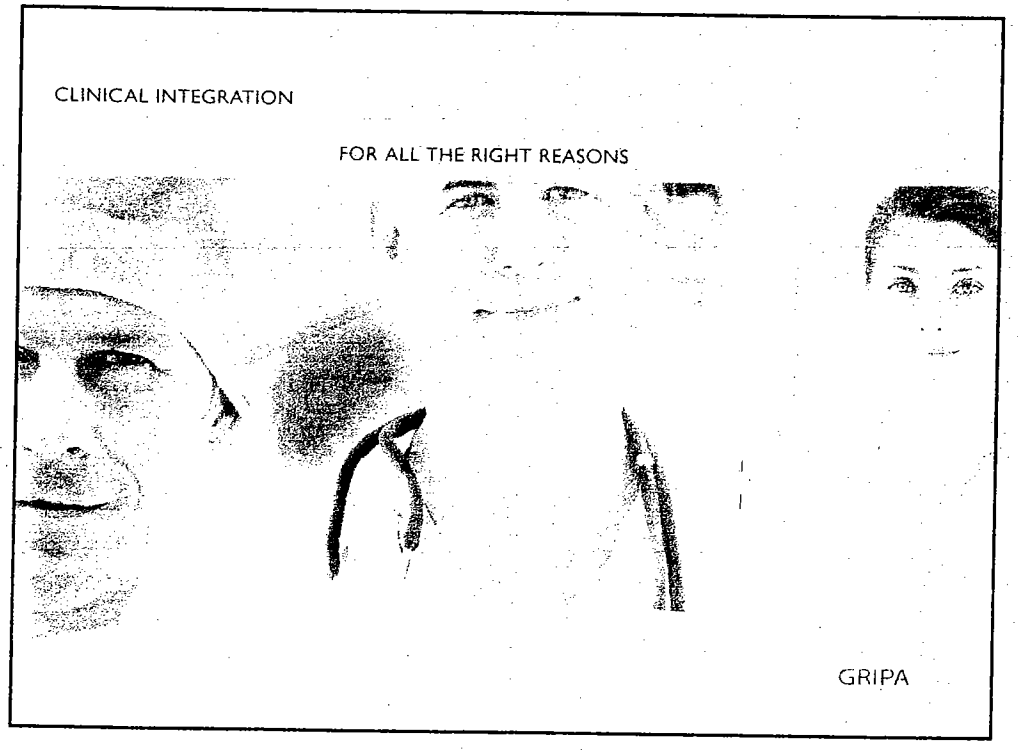
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## 5/23/06 Physician dinner meeting

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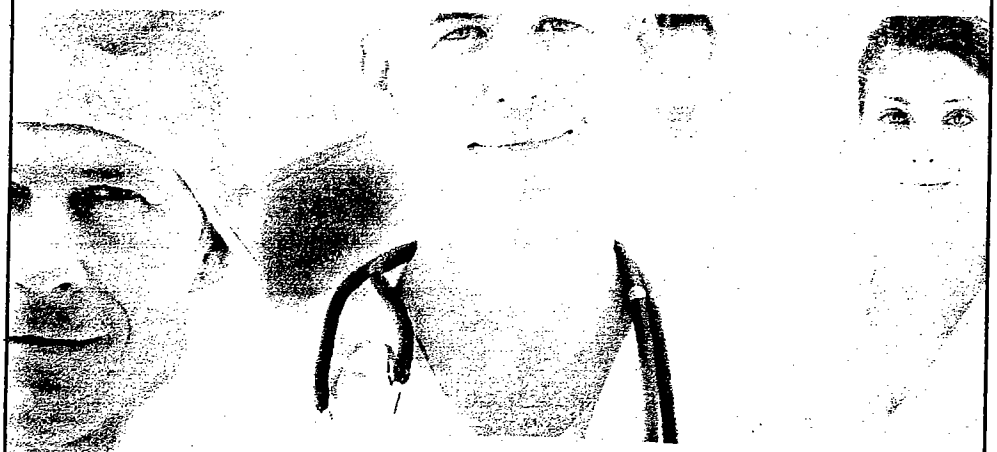

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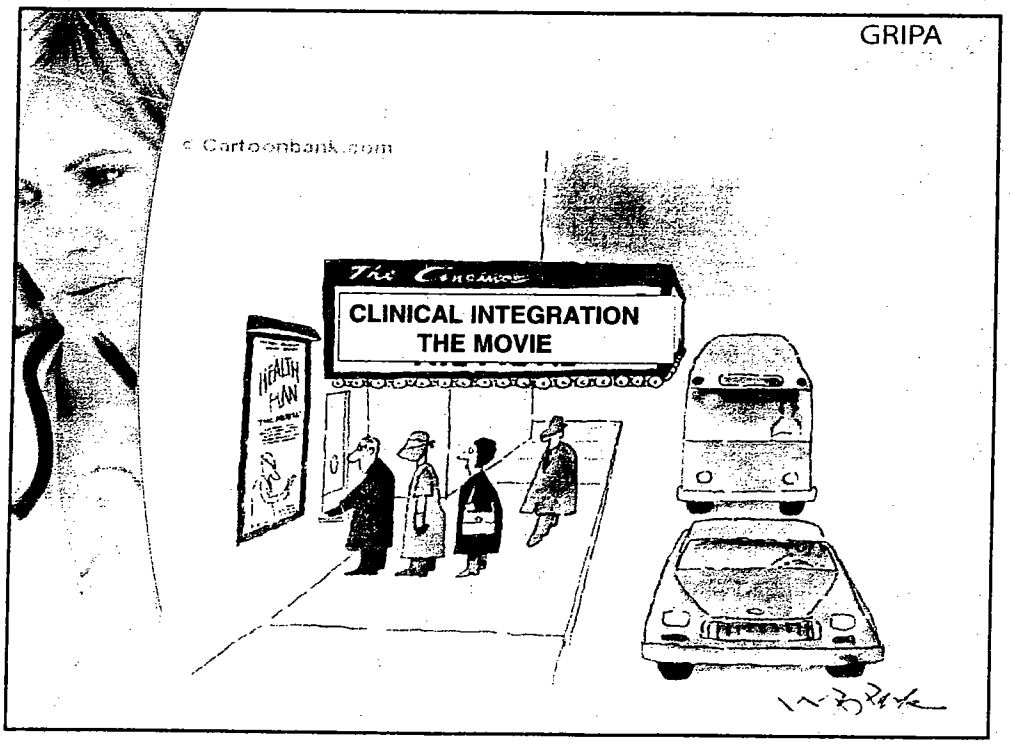

GRIPA

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GRIPA

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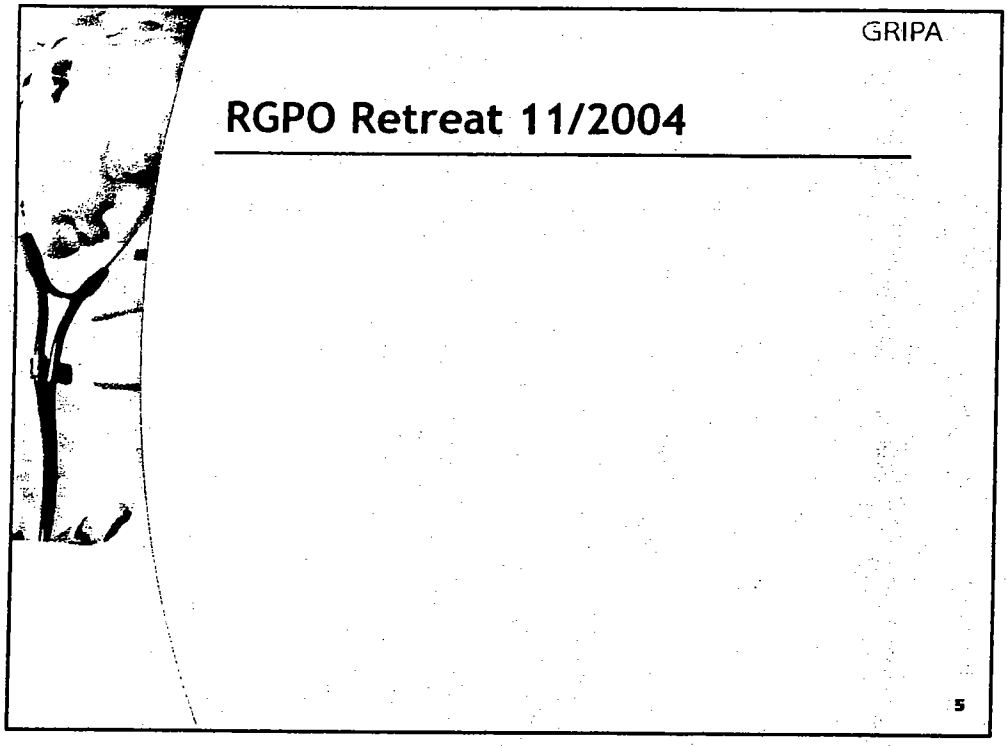
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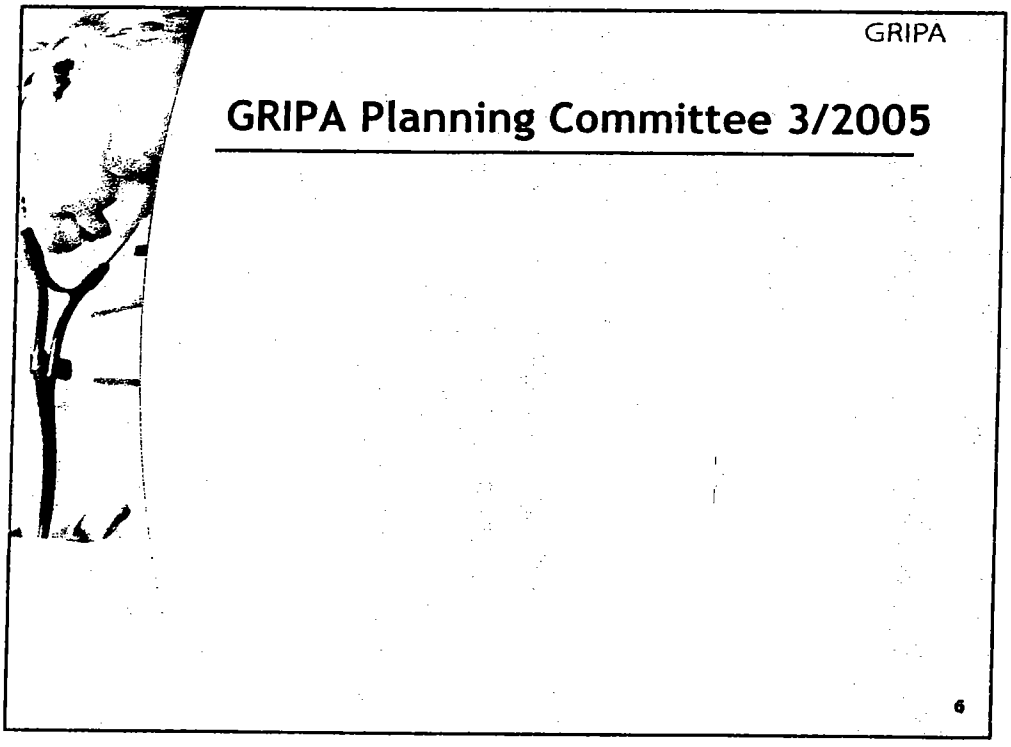
GRIPA
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## Clinical Integration defined

Clinical integration delivers **higher quality patient care** by creating a **connected community** of physicians, hospitals, labs and imaging facilities with **electronic access to complete patient information, support from patient care managers** and assistance to fulfill a commitment to **evidence-based clinical care.**





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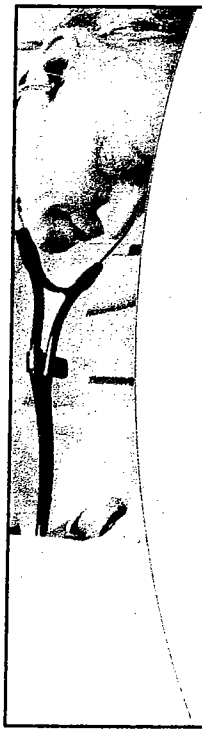

GRIPA

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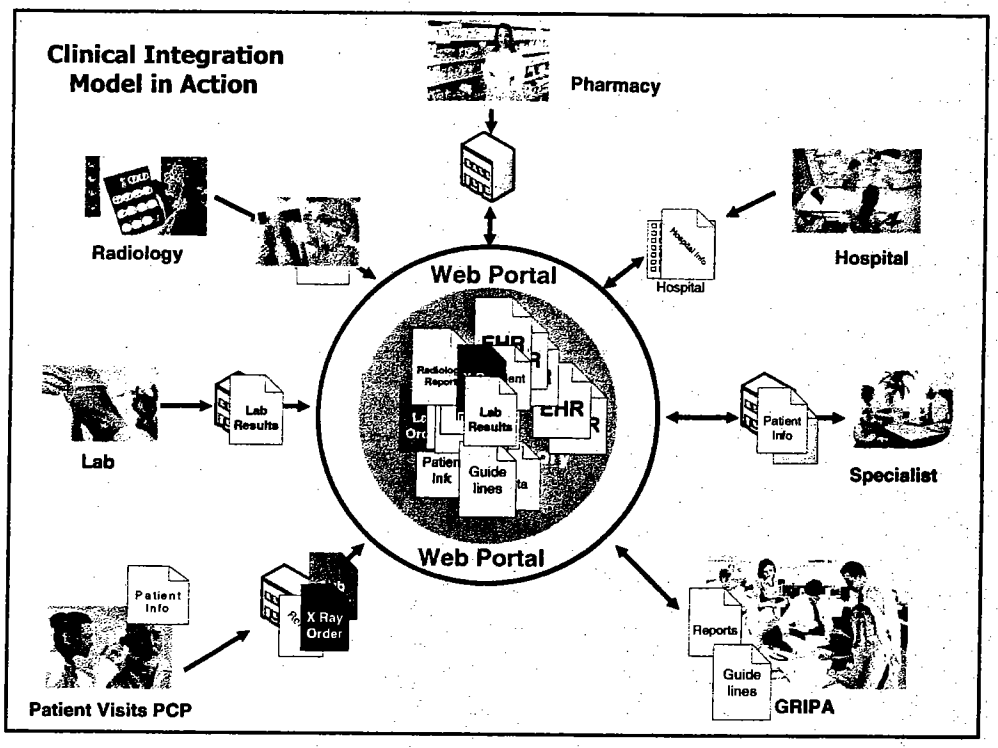
14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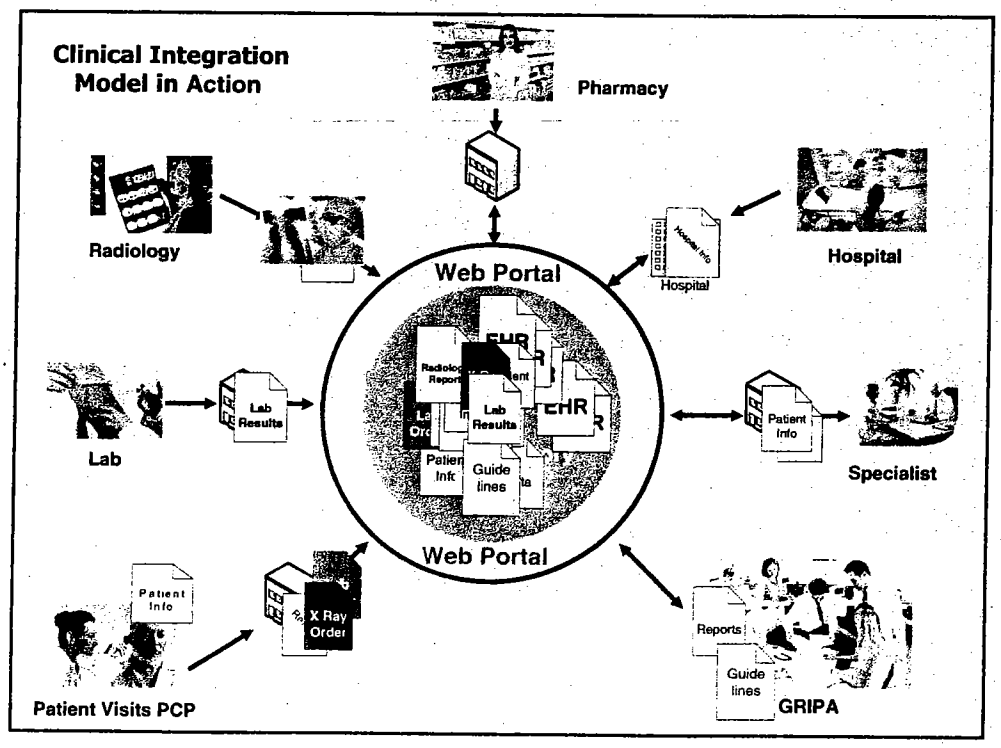
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20



## GRIPA's plans & timelines

- ☐ 12/05 - contracted with Healthvision for IT infrastructure
- ☐ Early 2006 - data source interfaces & portal design
- ☐ Late 2006 - roll-out web portal to physician offices
- ☐ 2006 - FTC advisory opinion
- ☐ 2007 - negotiate / charge premium for better product
- ☐ Continue risk contracting for 640, FFS for 400?

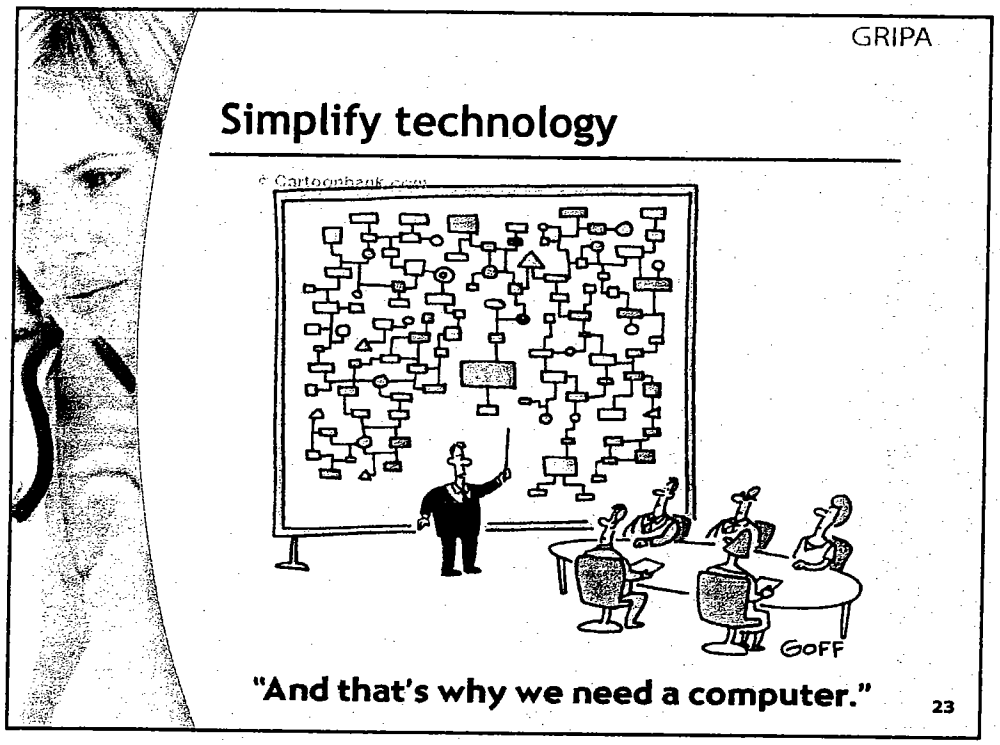
21

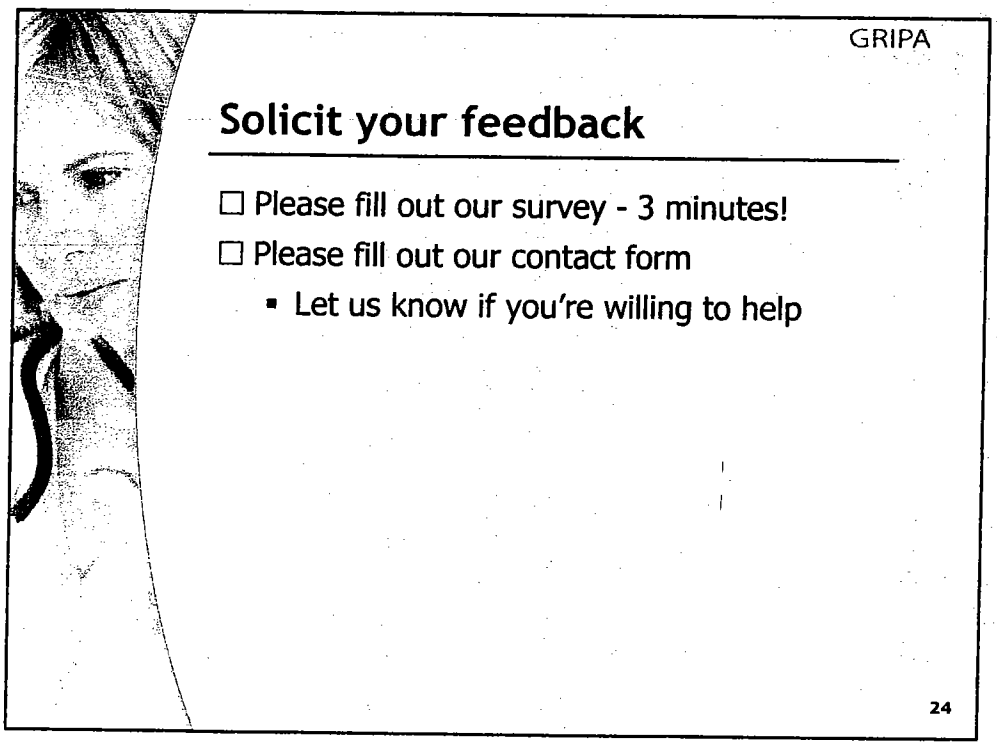


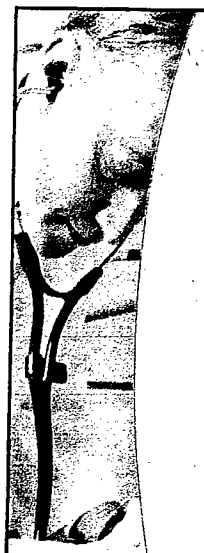
## GRIPA Connect Stretch Goals

- ☐ Obtain a copy of all electronic billing from practice management systems, clearinghouses, or billing services to augment clinical data
- ☐ Encourage, but not require, MD offices to adopt EMRs interoperable with Healthvision
- ☐ Co-development with Healthvision:
  - Guideline availability on the portal (phase 1)
  - Patient-specific prompts at point of care (phase 2)
  - Monitoring & reporting on compliance (phase 2)

22


GRIPA
Simplify technology
© Cartoonbank.com
GOFF
"And that's why we need a computer."
23


GRIPA
Solicit your feedback
☐ Please fill out our survey - 3 minutes!
☐ Please fill out our contact form
▪ Let us know if you're willing to help
24



GRIPA

## ViaHealth perspective

- ☐ Physician recruitment & retention very important to RGH & VOW
- ☐ Connectivity key to future success
- ☐ Relationship to GRIPA and POs highly valued
- ☐ Risk contracting appears to be disappearing
- ☐ Loss of the risk model leaves physicians bare & with few options
- ☐ Some aspects of CI may be mandated in next 5 years
- ☐ Makes sense to pursue now if it is to be mandated
- ☐ ViaHealth commitment to Clinical Integration

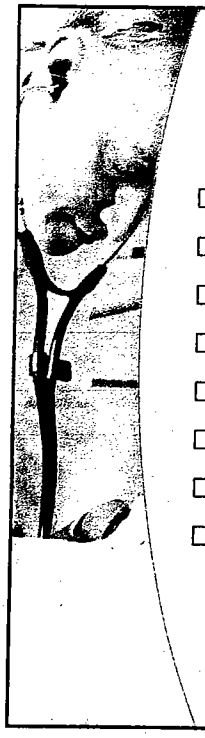
25

GRIPA

## Physician perspective

- ☐ initially skeptical
- ☐ essential to the future of physicians and RGH
- ☐ no longer "business as usual"
- ☐ allows you to be an independent practitioner
- ☐ retaining the benefits of a large group
- ☐ not ready for a full EMR
- ☐ begin the transition to use computers
- ☐ input into clinical guidelines & portal
- ☐ Pay-for-performance programs are coming
- ☐ rather set them up with "friends and family"
- ☐ maintain the bond of GRIPA physicians
- ☐ recognized for the excellent care we deliver

26

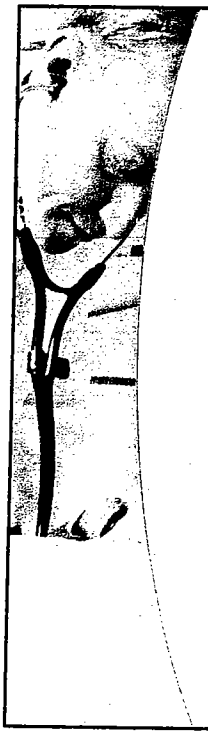




## RGPO Board Members

- ☐ Joseph DiPoala – Pres.
- ☐ John Genier – Treas.
- ☐ Michael Jacobs
- ☐ Michael Kukfa
- ☐ Paul Mikus
- ☐ David Schlageter
- ☐ Christine Stewart
- ☐ Robert Thomson
- ☐ David Cheeran
- ☐ Mark Chodoff
- ☐ Karin Dunnigan
- ☐ Lyle Praire
- ☐ Patrick Riggs – V.Pres.
- ☐ Andrew Swinburne
- ☐ Edward Tanner







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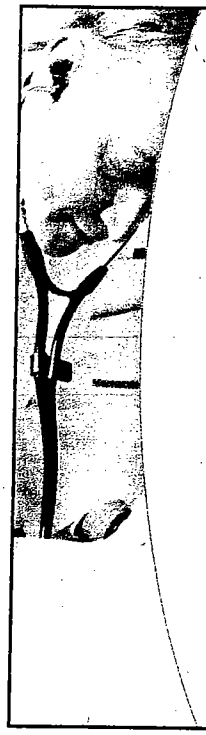
- ☐ Joseph DiPoala
- ☐ John Genier
- ☐ Michael Kukfa – Chair
- ☐ Patrick Riggs

WCPO

- ☐ Richard Endres
- ☐ David Hannan

ViaHealth

- ☐ John Biemiller – Treas.
- ☐ Richard Gangemi
- ☐ Richard Hogg
- ☐ Samuel Huston
- ☐ Daniel Meyers – V.Chair
- ☐ Robert Wayland-Smith



GRIPA

## Clinical Integration

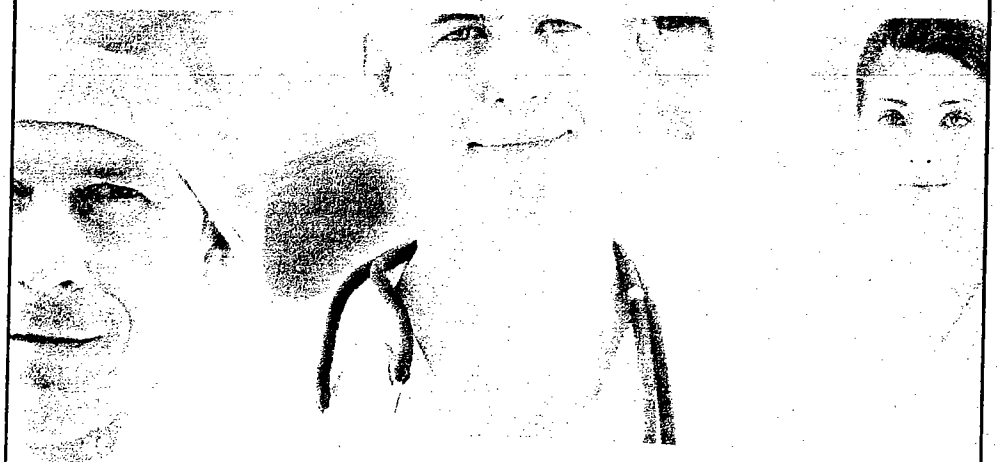
. . . . . thank you!

Stay in touch with
GRIPAconnect.com

29

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS

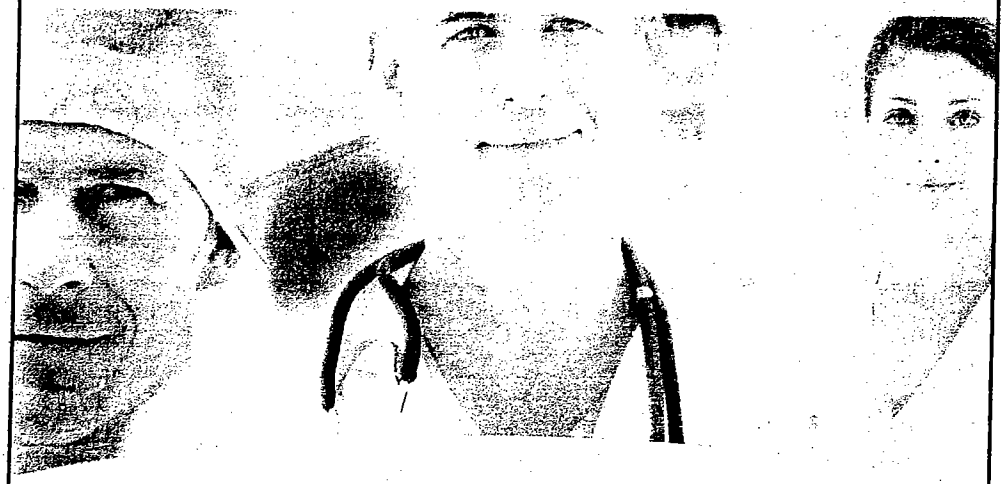


GRIPA

## 6/20/06 ViaHealth Finance Committee

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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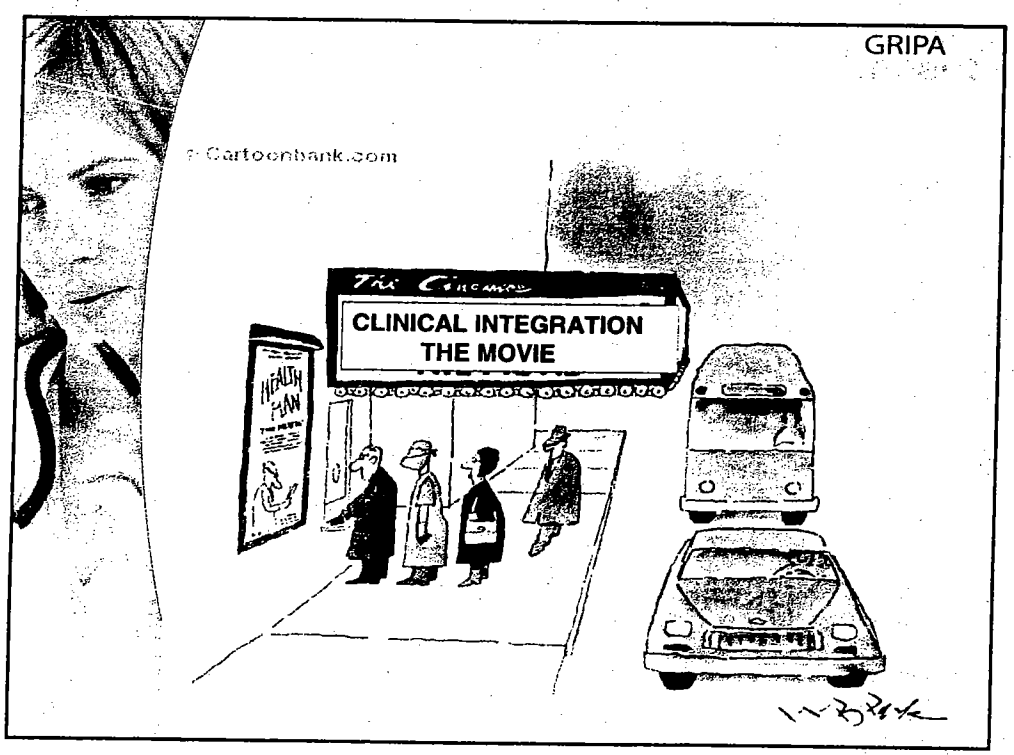
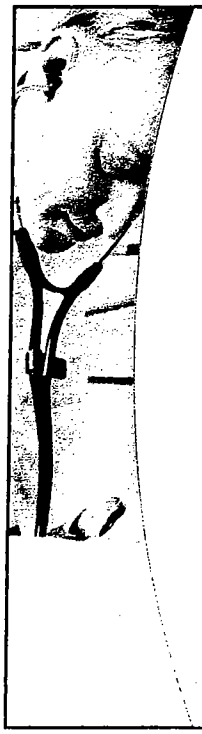




## GRIPA Retreat 8/2004

- ☐ Flat conversion factors
- ☐ Payors' movement towards direct contracting
- ☐ URMC's success at increasing payments to its employed physicians

3





## RGPO Retreat 11/2004

4

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## GRIPA Planning Committee 3/2005

5

GRIPA

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6



## GRIPA Retreat 6/2005

- ☐ Clinical Integration ratified as goal
- ☐ Consultants and legal team identified

**12/2005**

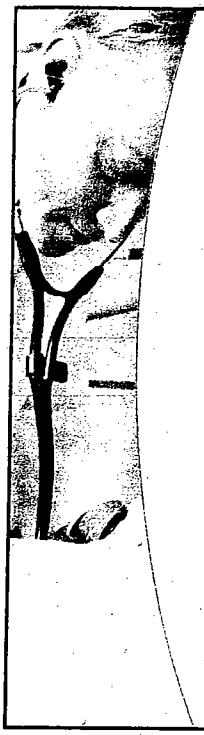
- ☐ GRIPA BOD approves C.I. business plan





## Physician contracting

- ☐ Per FTC & DOJ, illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
- ☐ Waiver only for
  - Financial Integration
    - employed group
    - group accepting capitated risk & withhold
  - Clinical Integration
    - Hard to do – MedSouth is only group in the country to get prior approval of FTC





## Why IPAs have to change

- ☐ HMOs unpopular, capitation decreasing
- ☐ Insurers want direct contract with each MD
- ☐ Insurers want to set up their own P4Ps
- ☐ Employers want "0" premium increases
- ☐ Antitrust constraints on physician organization fee-for-service contracting
- ☐ Most private MDs in groups <5 by choice





## Clinical Integration not a medical term

Can we as an IPA continue to contract for our physicians without taking capitation or another type of financial risk?

. . . without running afoul of FTC/DOJ?

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## Yes, with three key components

1) Evidence-based guidelines to control costs and assure quality of care, agreed upon by the physicians

2) Monitor guideline-related performance with sanctions for poor performance

3) Common EMR system or another way to electronically share access to patient records

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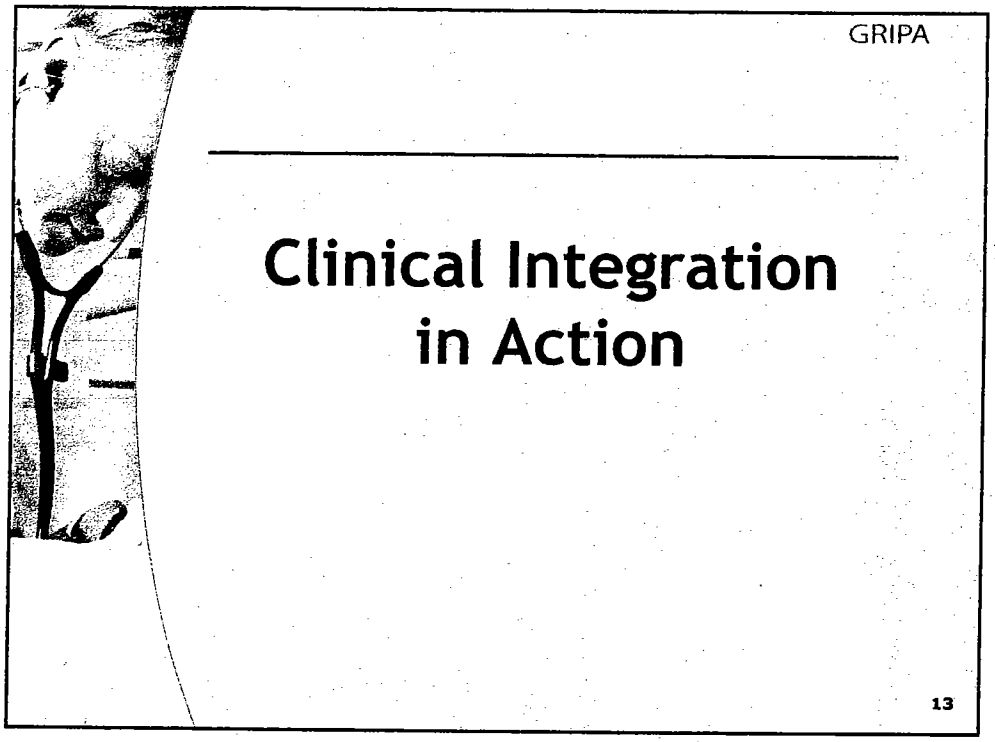
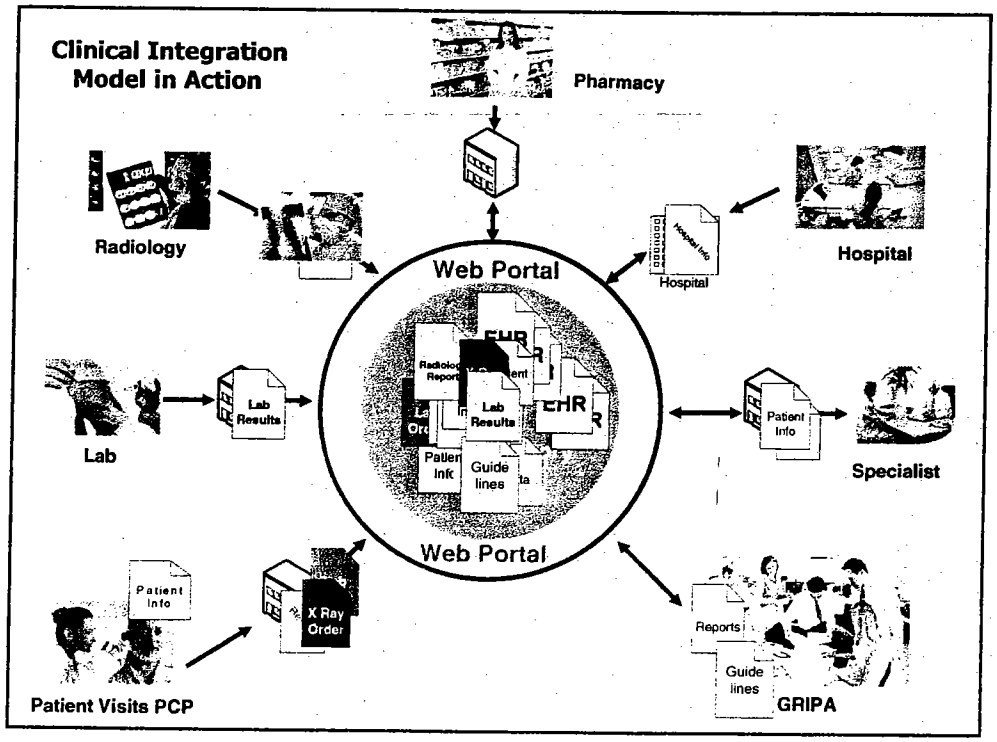
## Benefits of Clinical Integration

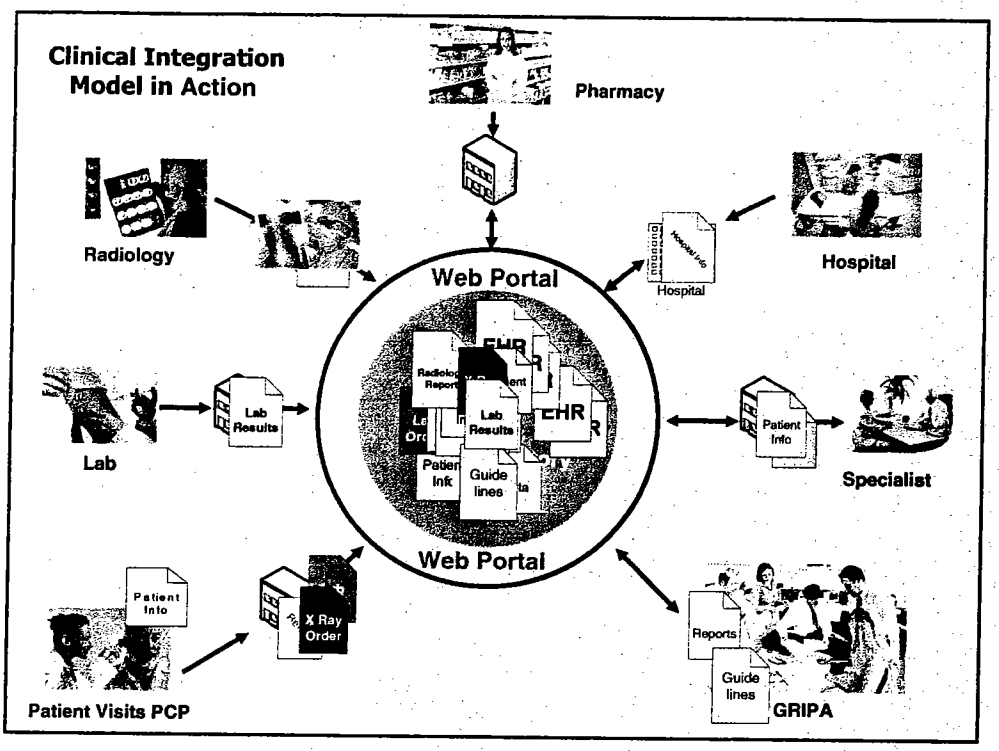
- ☐ Improved quality
- ☐ Lower costs
- ☐ Maintain stable network of physicians contracting together for risk & fee-for-service business
- ☐ Shared commitment to clinical improvement using guidelines, care management, and IT
- ☐ Present a common product to the community
- ☐ Better reimbursement to physicians for a better product (4% for MedSouth in 2005)

NOT MARKET POWER – must be <35% of providers in the service area

12


GRIPA
Clinical Integration
in Action
13


Clinical Integration
Model in Action
Pharmacy
Radiology
Hospital
Web Portal
Hospital
Lab
Lab Results
Lab Results
EHR
Patient Info
Specialist
Guide lines
Web Portal
Patient Info
X Ray Order
Reports
Guide lines
Patient Visits PCP
GRIPA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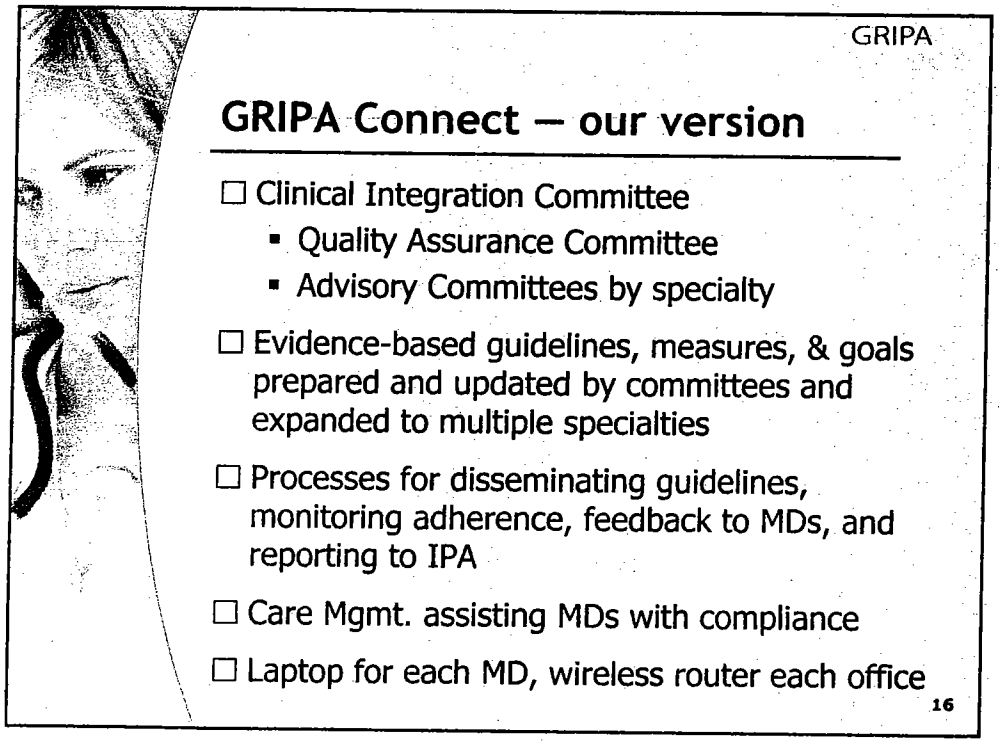
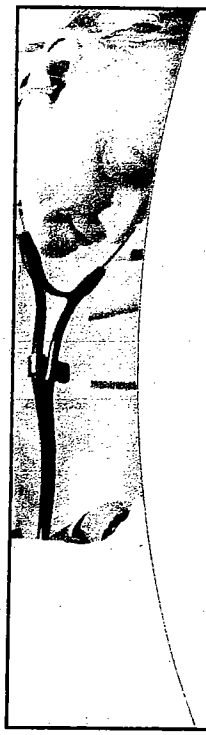
GRIPA


GRIPA
GRIPA Connect – our version
☐ Clinical Integration Committee
▪ Quality Assurance Committee
▪ Advisory Committees by specialty
☐ Evidence-based guidelines, measures, & goals prepared and updated by committees and expanded to multiple specialties
☐ Processes for disseminating guidelines, monitoring adherence, feedback to MDs, and reporting to IPA
☐ Care Mgmt. assisting MDs with compliance
☐ Laptop for each MD, wireless router each office
16





## GRIPA Connect – first steps

**View and print lab and x-ray reports**

- Have staff print lab, x-ray reports during patient appointment
- Office staff prints ahead of appointment for patient paper file
- Least impact to office workflow

**Next step: view report on PC or wireless laptop in exam rooms**

**Next step: use portal to send patient notes to other physicians**

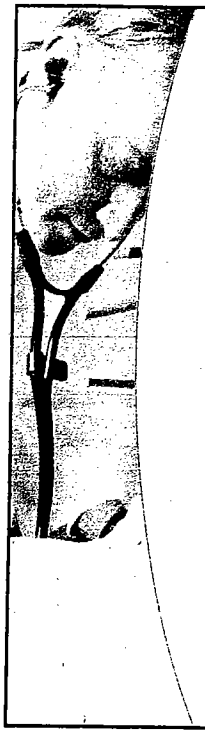
**Next step: migrate all patient records to portal/EMR[lite]**





## From simplest to fully integrated

- ☐ Flexibility
- ☐ Works with offices that are completely paper and those that already have EMR
- ☐ Optional e-prescribing & lab order entry
- ☐ Adding data from physician's offices will be helpful but not mandatory





## Goals of GRIPA Connect

- ☐ Provide physicians with most complete medical history at time of care
- ☐ Provide physicians with e-tools to replace manual processes
- ☐ Provide IPA with comprehensive clinical data to develop incentive and quality programs
- ☐ Employed and private physicians in contracts
- ☐ Be accountable to insurers, employers, community, regulators
- ☐ Differentiate the network based on technology and quality of care

19



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  - Patient-specific prompts at point of care (phase 2)
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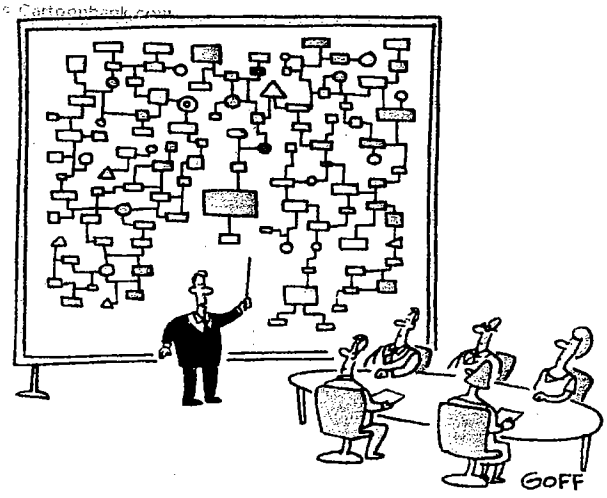
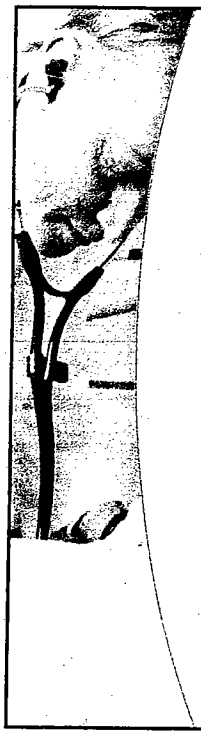
## Simplify technology




"And that's why we need a computer."



GRIPA

## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

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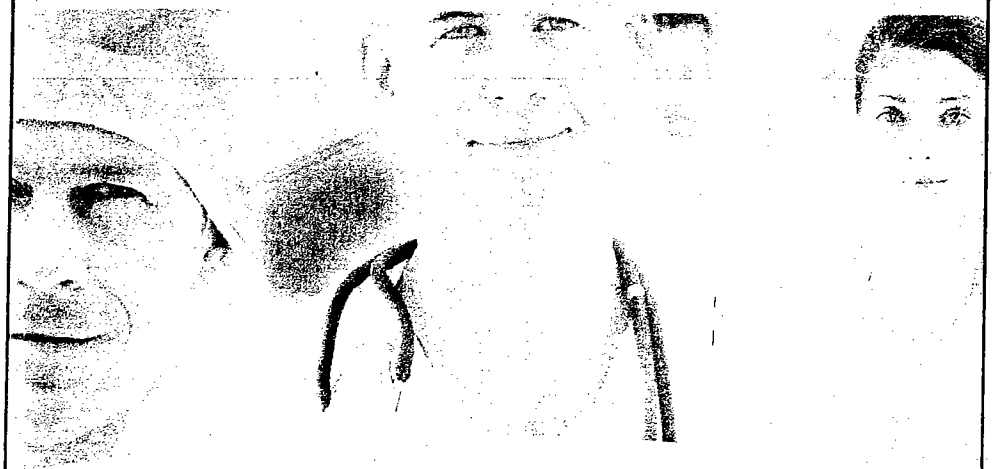
CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA



GRIPA

## Clinical Integration defined

Clinical integration delivers **higher quality patient care** by creating a **connected community** of physicians, hospitals, labs and imaging facilities with **electronic access to complete patient information, support from patient care managers** and assistance to fulfill a commitment to **evidence-based clinical care.**

GRIPA

## Physician Participation Contracts
## Executive Summary

- ☐ Brief overview of notable features—in particular, some that may be unusual compared to previous contracts
- ☐ By signing these contracts you agree to the following:

GRIPA

## 1

GRIPA

## 2

**Whenever it is medically appropriate, refer patients participating in GRIPA health plans to other physicians participating in GRIPA Connect Clinical Integration**

- ☐ We want patients to remain within the Network where they will be taken care of by physicians who are clinically integrated via the web portal, clinical guidelines, and case management
- ☐ To ensure that patients reap the benefits of our integration: safer, more effective care, with fewer gaps in care and duplicated efforts
- ☐ Whenever a patient receives care outside the Network, GRIPA will be unable to collect data, resulting in a gap in the collective understanding of that patient's history and treatment
- ☐ There will be times when necessary services can only be obtained outside of GRIPA Connect

GRIPA

3

**Make available to GRIPA information necessary to implement Clinical Integration: patient clinical data, medical records, and billing data**

GRIPA

4

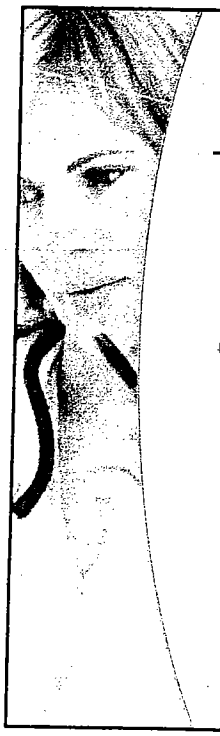
**Accept, and use, a tablet computer provided by GRIPA**

GRIPA

## 5

**You will provide high-speed Internet access and a computer able to access the Internet at each office location where patients are seen**

- ☐ Your GRIPA Connect tablet computer may be one of these computers
- ☐ If you don't already have high-speed access, contact us for information on providers and rates
- ☐ These will be your only out-of-pocket costs associated with participating in GRIPA Connect



GRIPA

## 6

**You and your office staff will attend training sessions on using the web portal**

- ☐ To be sure that you and your patients are reaping the greatest possible benefit from all the features the portal will offer
- ☐ As advanced features come online, we will offer subsequent training sessions

GRIPA

## 7

**You will not opt out of any health benefit plans contracted through GRIPA under these new contracts**

- Our purpose is to maintain the integrity of the Clinically Integrated Network so as to provide the most choices and continuity of care for patients

GRIPA

## 8

GRIPA

## 9

**Serve on our Quality Assurance Council if asked**

- ☐ Role is to assess performance with respect to Clinical Guidelines, agreed upon by the physicians, that all physicians will be asked to implement
- ☐ Rotating membership chosen through a lottery system
- ☐ We may also ask you to serve on other GRIPA committees but will not require you to serve on more than one committee at a time

GRIPA

## A testimonial

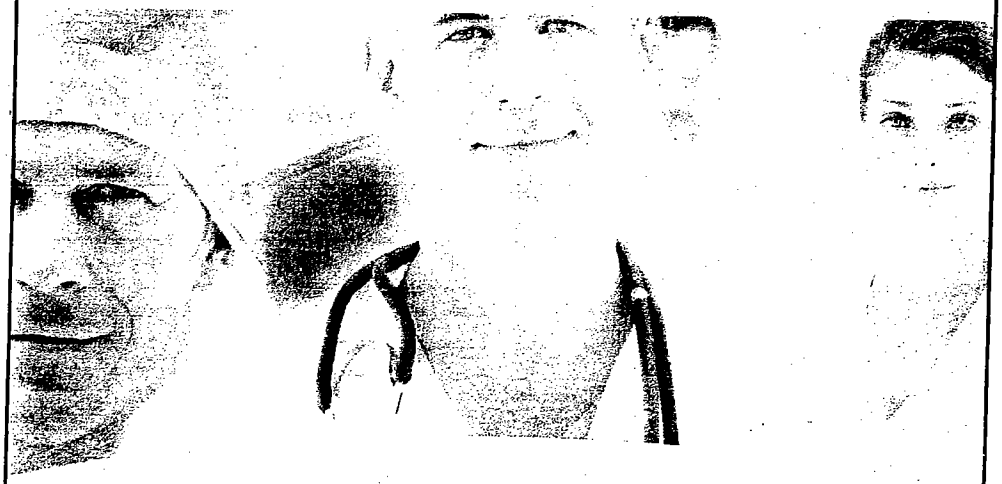
"Clinical Integration allows you to be an independent practitioner, while retaining the benefits of a large group. Clinical guidelines and pay-for-performance programs are coming soon, and I would rather set them up with "friends and family" than have them dictated to me by outside sources. I think Clinical Integration is an exciting opportunity to maintain the bond of GRIPA physicians and hopefully be appropriately recognized for the excellent care we deliver every day."

—John Genier, M.D.

## 7/14/06 Presentation & audio recording for web publishing

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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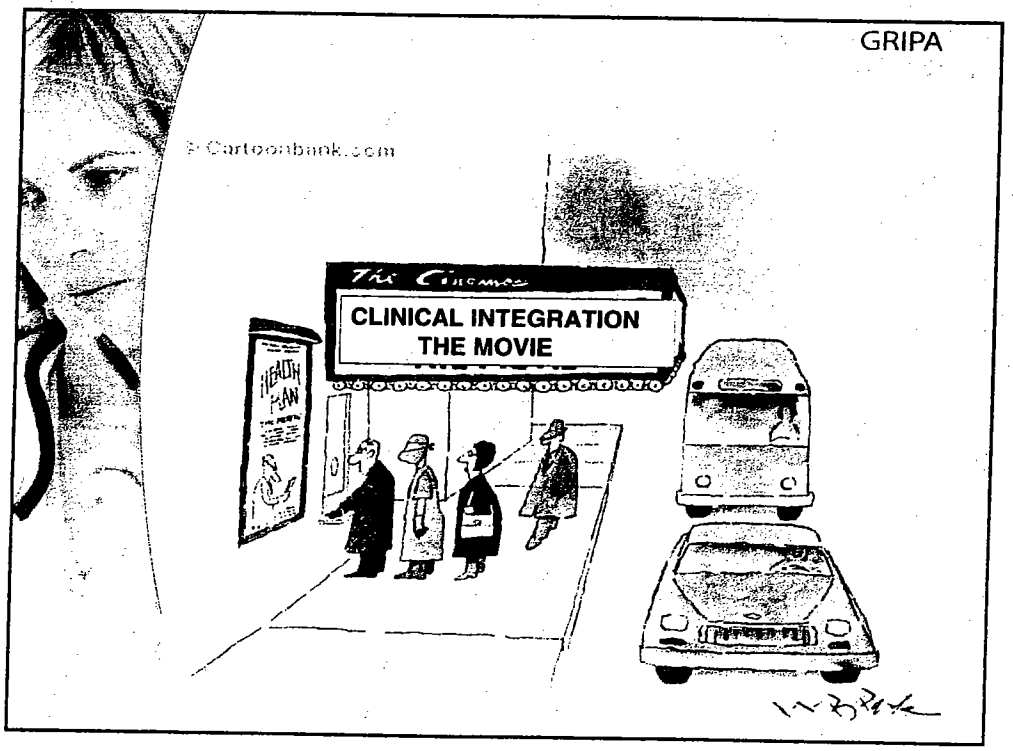

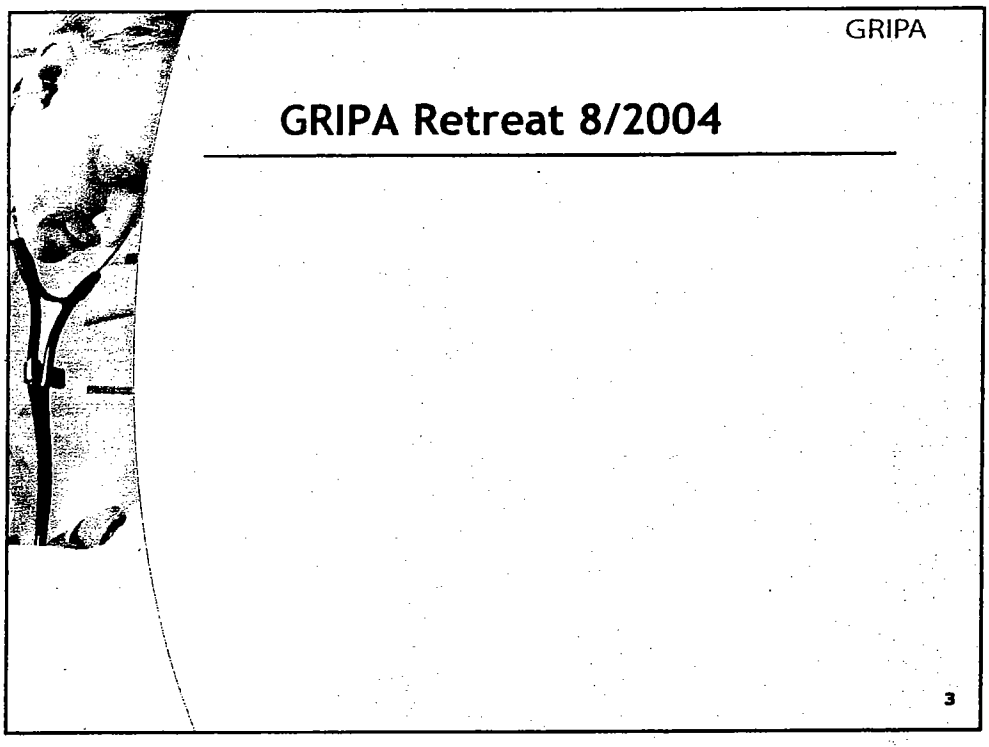
GRIPA
GRIPA Retreat 8/2004
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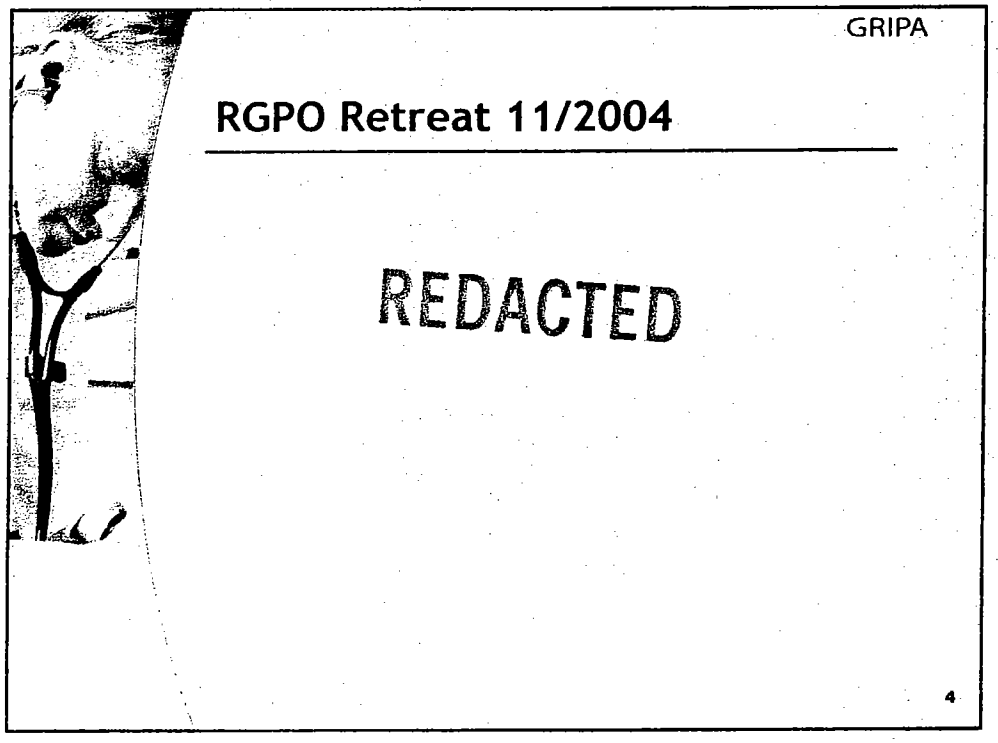
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RGPO Retreat 11/2004
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4



## GRIPA Planning Committee 3/2005





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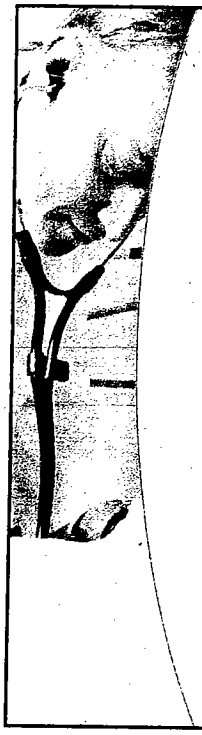



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**12/2005**

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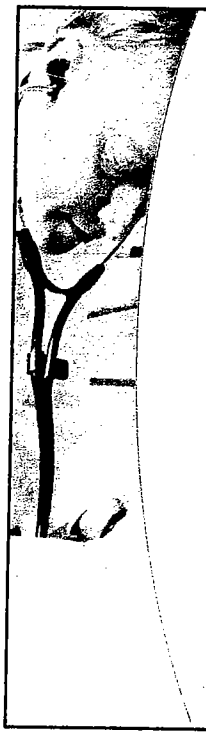



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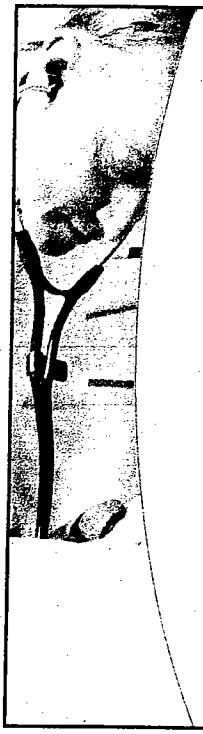

GRIPA

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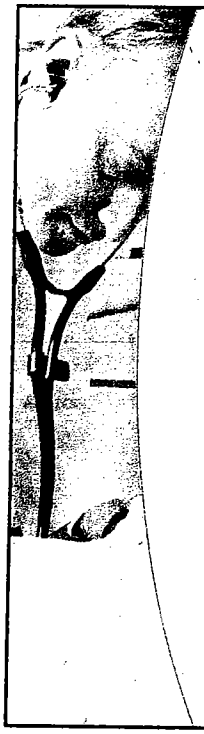

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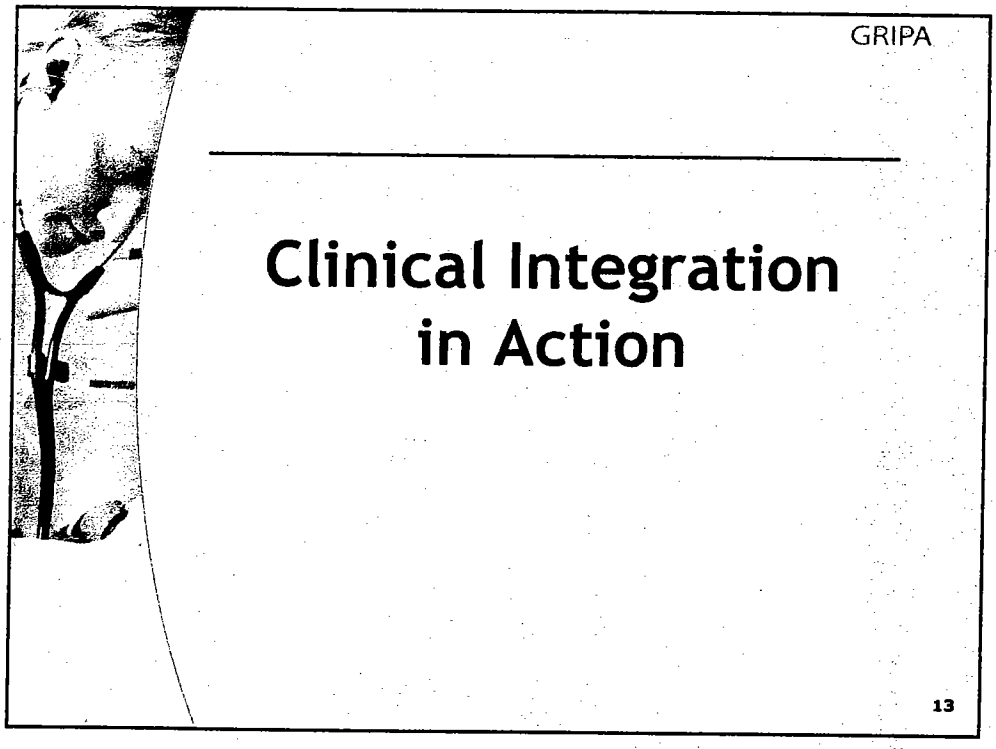
GRIPA
Clinical Integration
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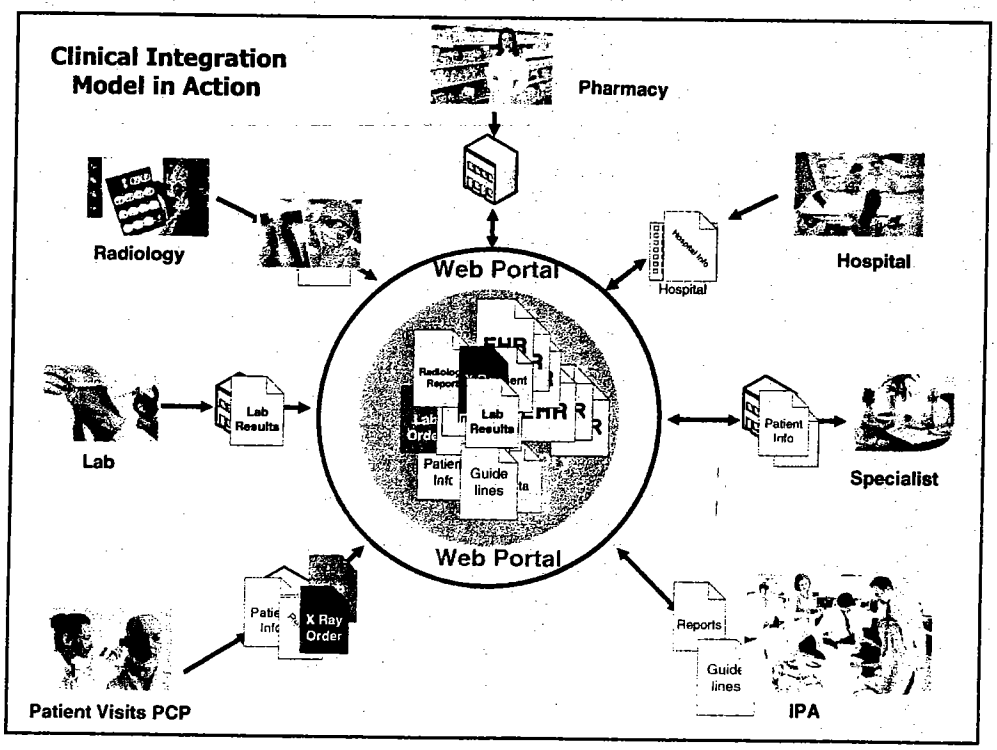
13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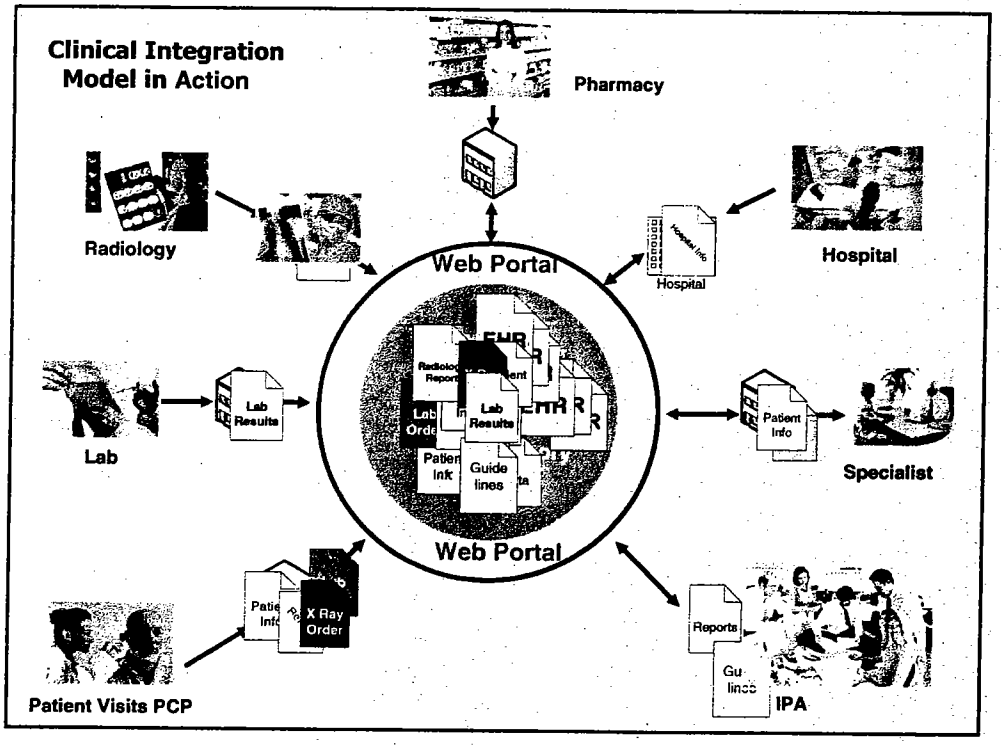
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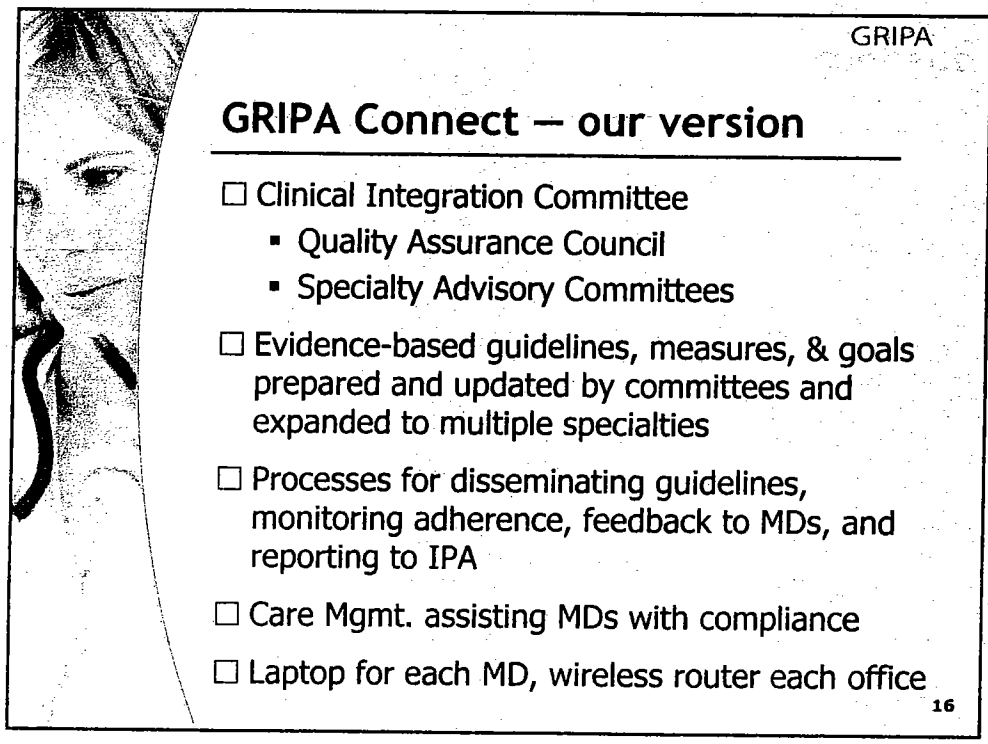
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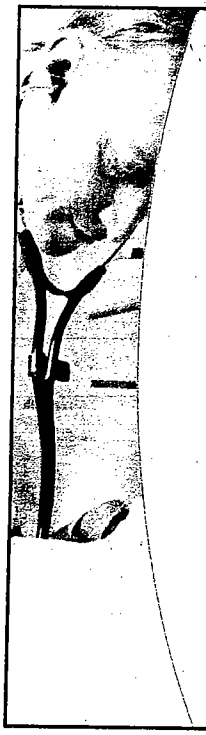

GRIPA

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GRIPA

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- ☐ Optional e-prescribing & lab order entry
- ☐ Adding data from physician's offices will be helpful but not mandatory

18



## Goals of GRIPA Connect

- ☐ Provide physicians with most complete medical history at time of care
- ☐ Provide physicians with e-tools to replace manual processes
- ☐ Provide IPA with comprehensive clinical data to develop incentive and quality programs
- ☐ Employed and private physicians in contracts
- ☐ Be accountable to insurers, employers, community, regulators
- ☐ Differentiate the network based on technology and quality of care

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## GRIPA's plans & timelines

- ☐ 12/05 - contracted with Healthvision for IT infrastructure
- ☐ Early 2006 - data source interfaces & portal design
- ☐ Late 2006 - roll-out web portal to physician offices
- ☐ 2006 - FTC advisory opinion
- ☐ 2007 - negotiate / charge premium for better product
- ☐ Continue risk contracting for 640, FFS 400-500

20



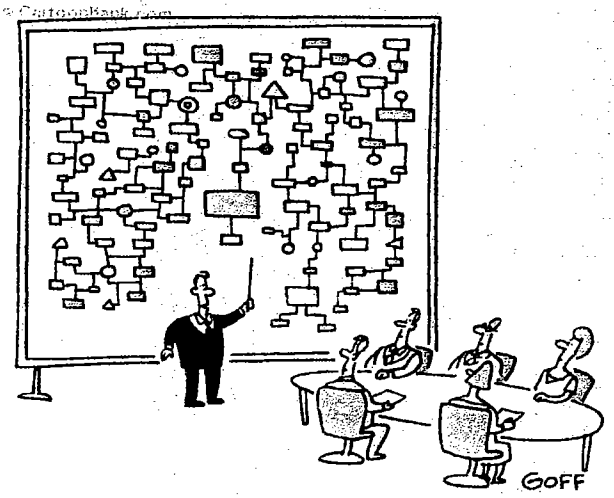
## GRIPA Connect Stretch Goals

- ☐ Obtain a copy of all electronic billing from practice management systems, clearinghouses, or billing services to augment clinical data
- ☐ Encourage, but not require, MD offices to adopt EMRs interoperable with Healthvision
- ☐ Co-development with Healthvision:
  - Guideline availability on the portal (phase 1)
  - Patient-specific prompts at point of care (phase 2)
  - Monitoring & reporting on compliance (phase 2)





## Simplify technology

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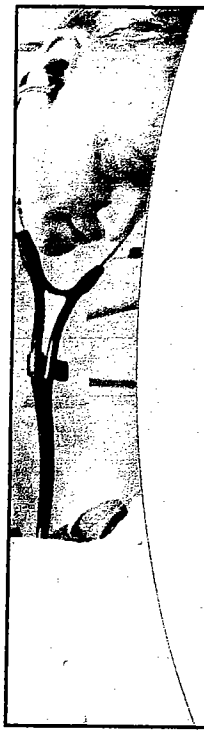

GRIPA

## ViaHealth perspective

- ☐ Physician recruitment & retention very important to RGH & VOW
- ☐ Connectivity key to future success
- ☐ Relationship to GRIPA and POs highly valued
- ☐ Risk contracting appears to be disappearing
- ☐ Loss of the risk model leaves physicians bare & with few options
- ☐ Some aspects of CI may be mandated in next 5 years
- ☐ Makes sense to pursue now if it is to be mandated
- ☐ ViaHealth commitment to Clinical Integration

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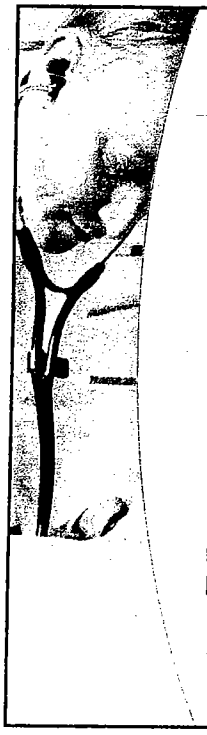
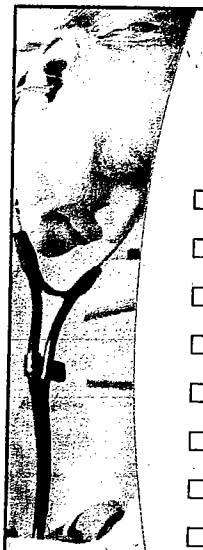


GRIPA

## Physician perspective

- ☐ initially skeptical
- ☐ essential to the future of physicians and RGH
- ☐ no longer "business as usual"
- ☐ allows you to be an independent practitioner
- ☐ retaining the benefits of a large group
- ☐ not ready for a full EMR
- ☐ begin the transition to use computers
- ☐ input into clinical guidelines & portal
- ☐ Pay-for-performance programs are coming
- ☐ rather set them up with "friends and family"
- ☐ maintain the bond of GRIPA physicians
- ☐ recognized for the excellent care we deliver

24



GRIPA

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- ☐ Joseph DiPoala – Pres.
- ☐ John Genier – Treas.
- ☐ Eric Ingerowski
- ☐ Michael Jacobs
- ☐ Michael Kukfa
- ☐ Paul Mikus
- ☐ David Schlageter
- ☐ Robert Thomson
- ☐ David Cheeran
- ☐ Ronald Kirshner
- ☐ Lyle Praire
- ☐ Patrick Riggs – V.Pres.
- ☐ Andrew Swinburne
- ☐ Edward Tanner
- ☐ Gordon Whitbeck

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GRIPA

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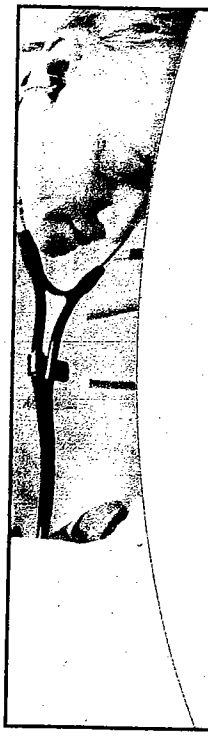
WCPO

- ☐ David Hannan
- ☐ Greg Heeb

ViaHealth

- ☐ John Biemiller – Treas.
- ☐ Richard Gangemi
- ☐ Richard Hogg
- ☐ Samuel Huston
- ☐ Daniel Meyers – V.Chair
- ☐ Robert Wayland-Smith

26



GRIPA

## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

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GRIPA

## Solicit your feedback

- ☐ Please fill out our survey - 3 minutes!
- ☐ Please fill out our contact form
  - Let us know if you're willing to help

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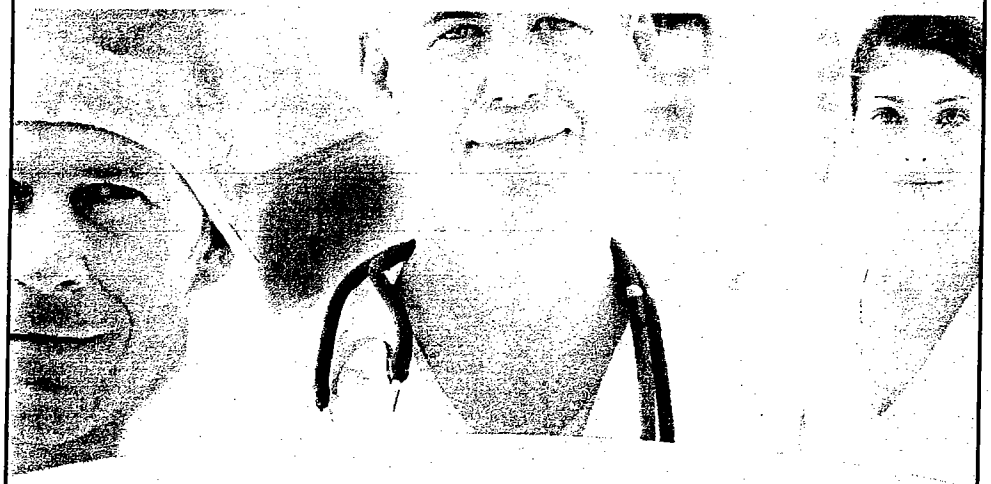
## 7/20/06 Physician contracting meeting

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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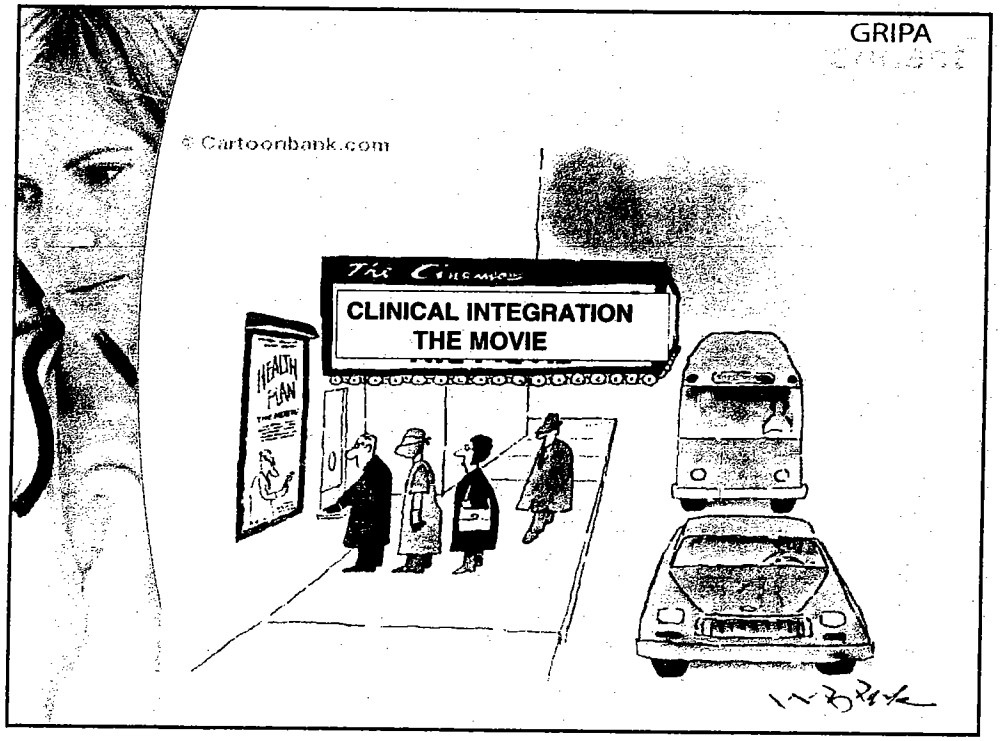

GRIPA

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3

GRIPA

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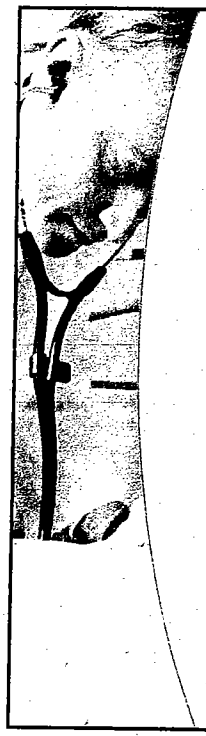

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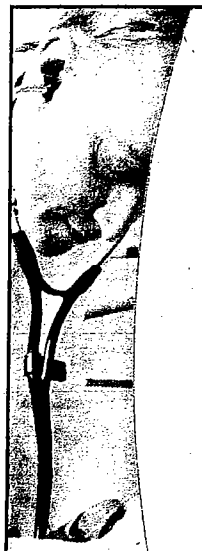

GRIPA

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GRIPA

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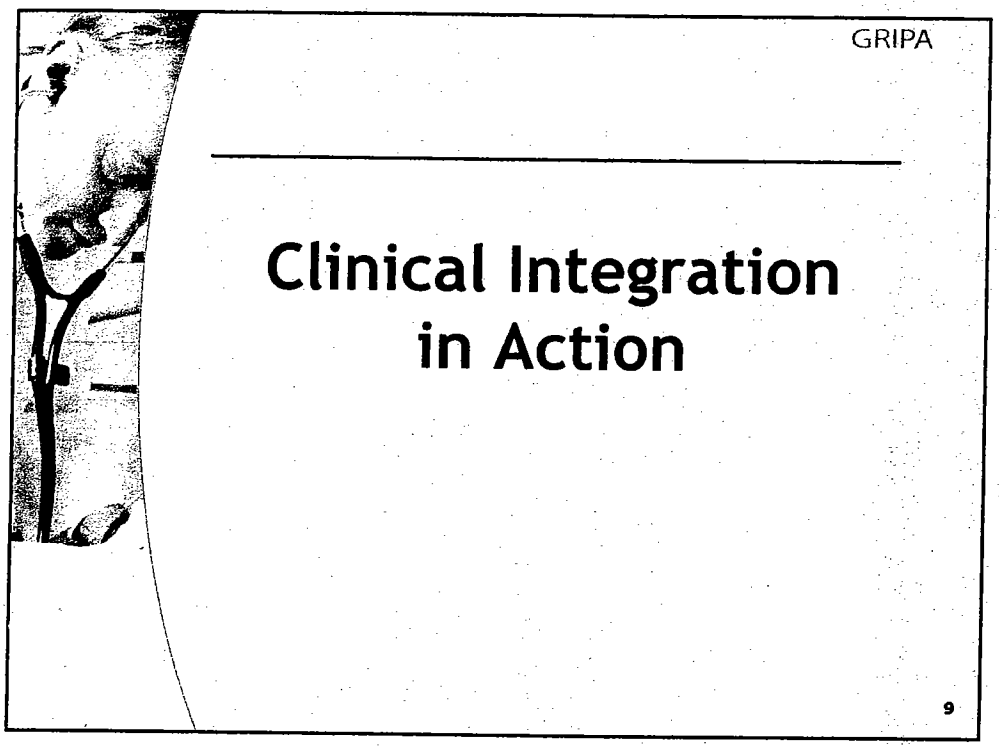
NOT MARKET POWER – must be <35% of providers in the service area

8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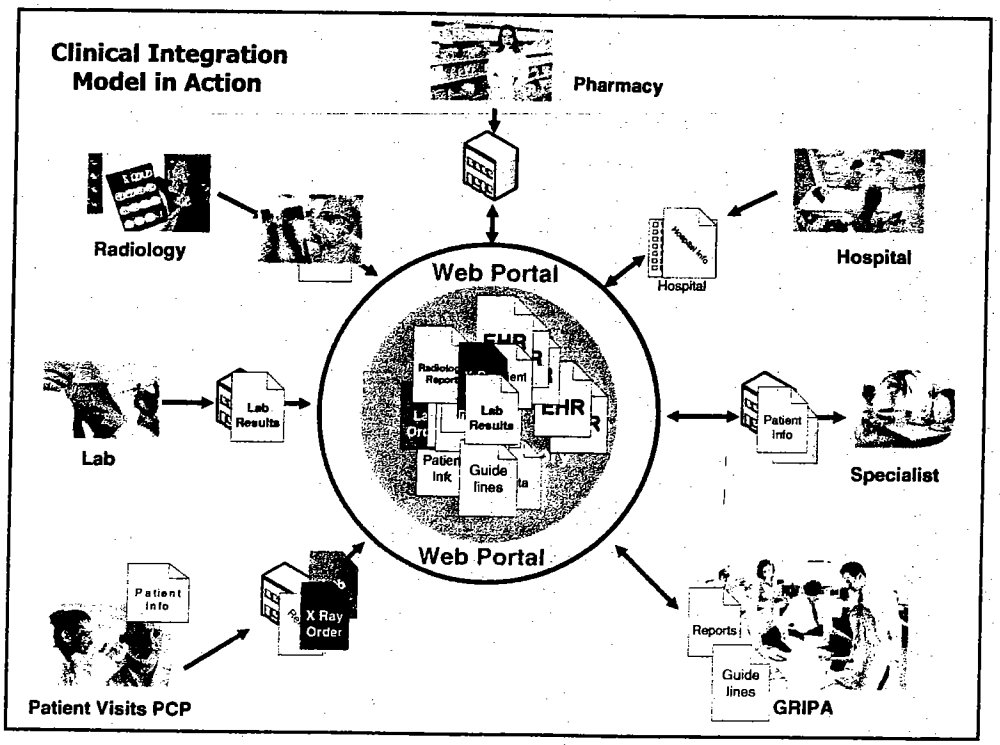
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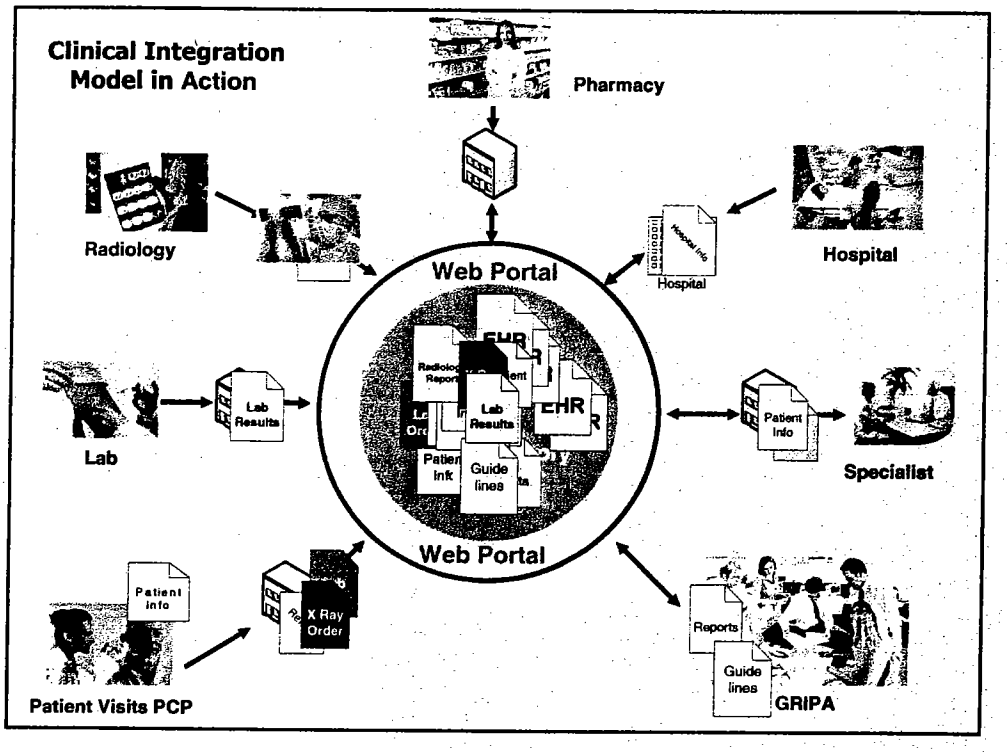
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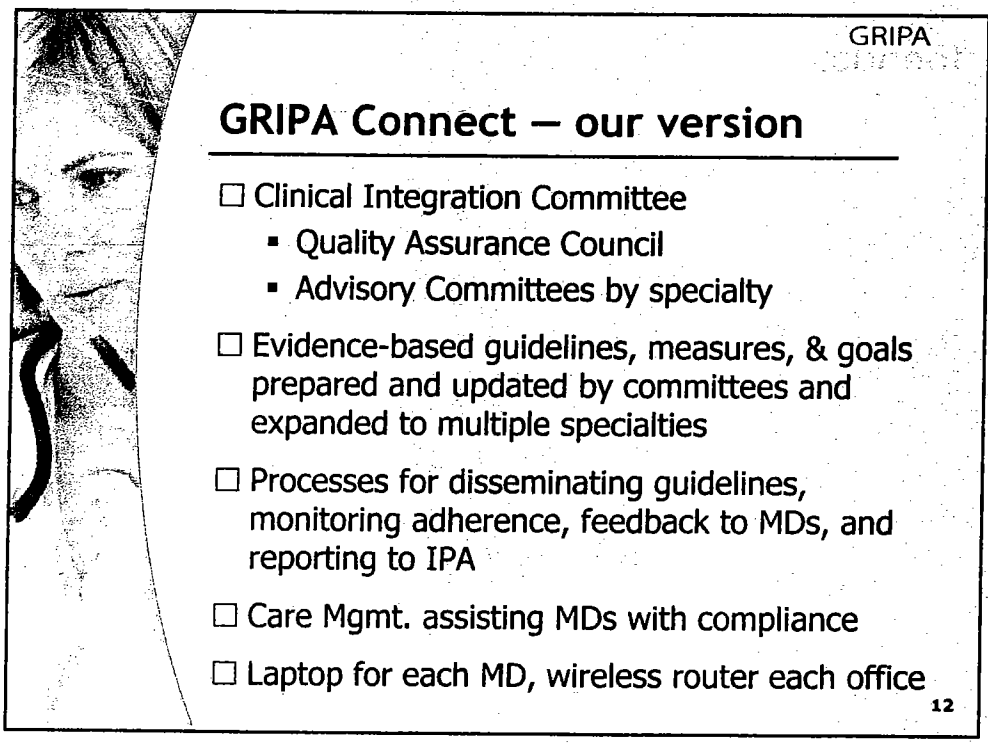
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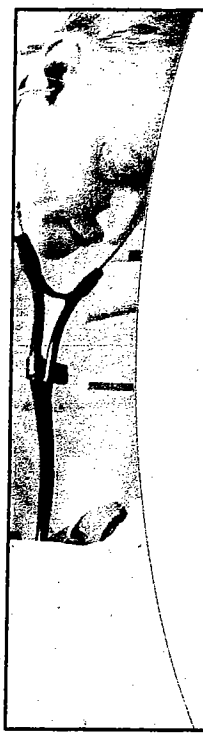



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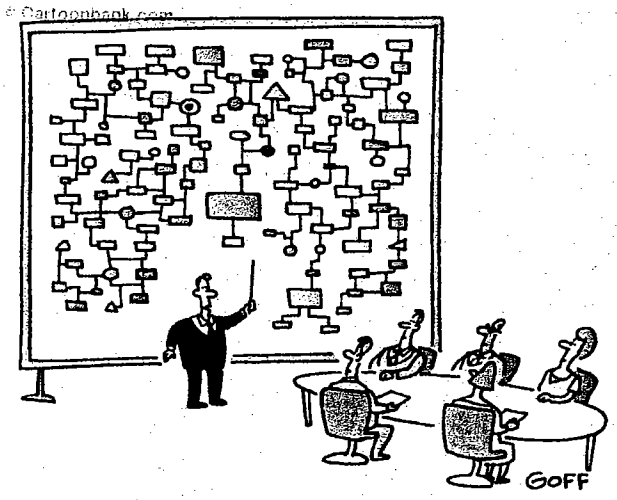


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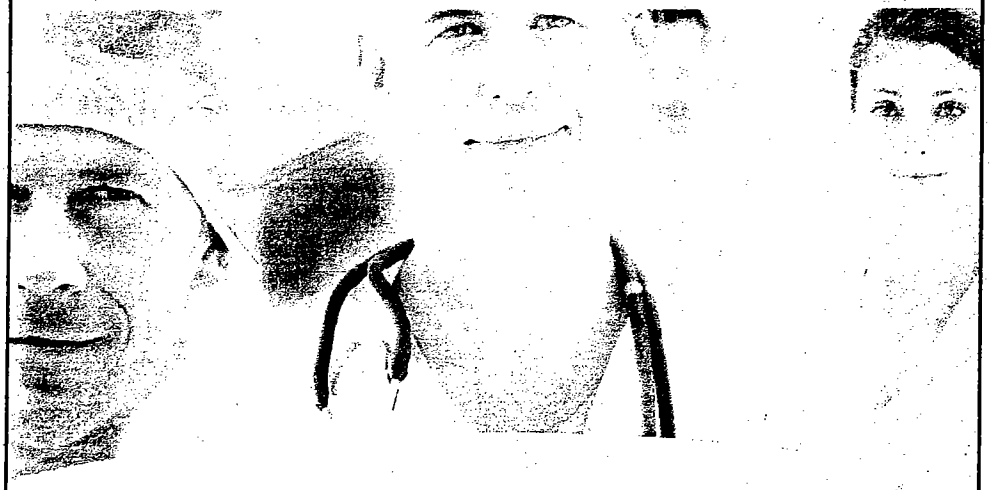

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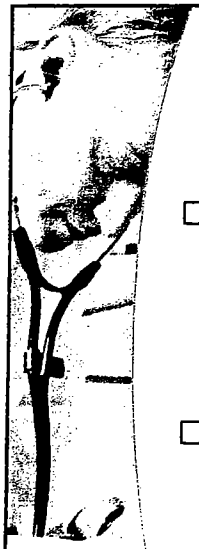
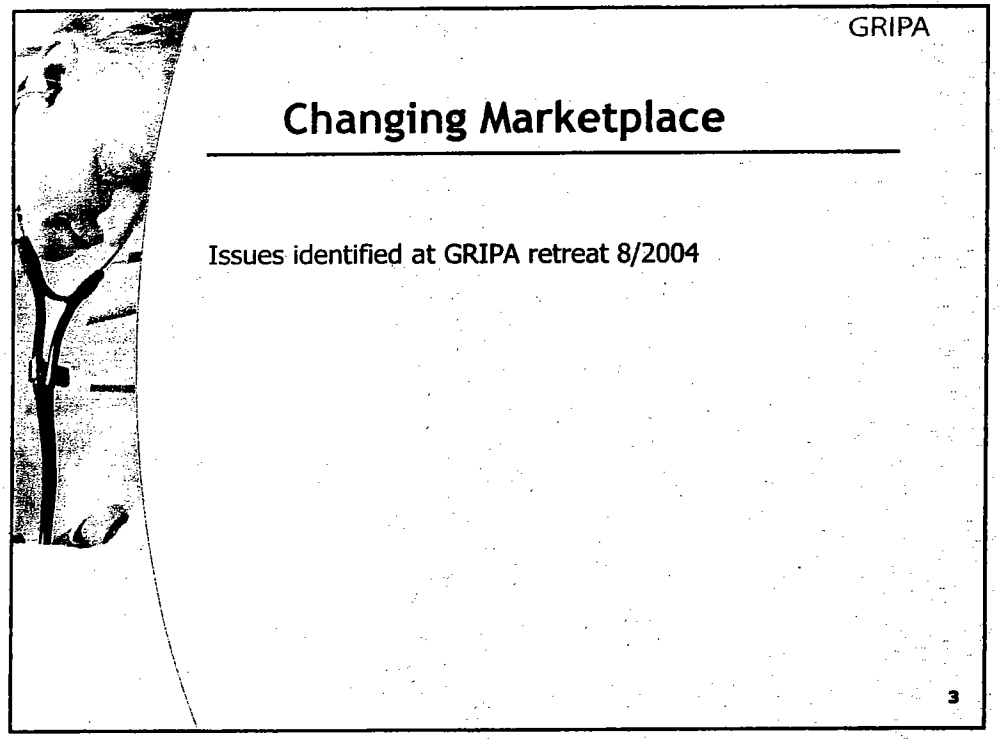




## GRIPA

**Greater Rochester Independent Practice Association**

- ☐ 50/50 partnership (PHO) of the ViaHealth hospital system and the physicians organizations formed in 1996 from the medical staffs of ViaHealth hospitals
  - RGPO, GPO, WCPO
- ☐ Joint venture to take capitated risk and negotiate contracts for its shareholders with HMO's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Changing Marketplace
Issues identified at GRIPA retreat 8/2004
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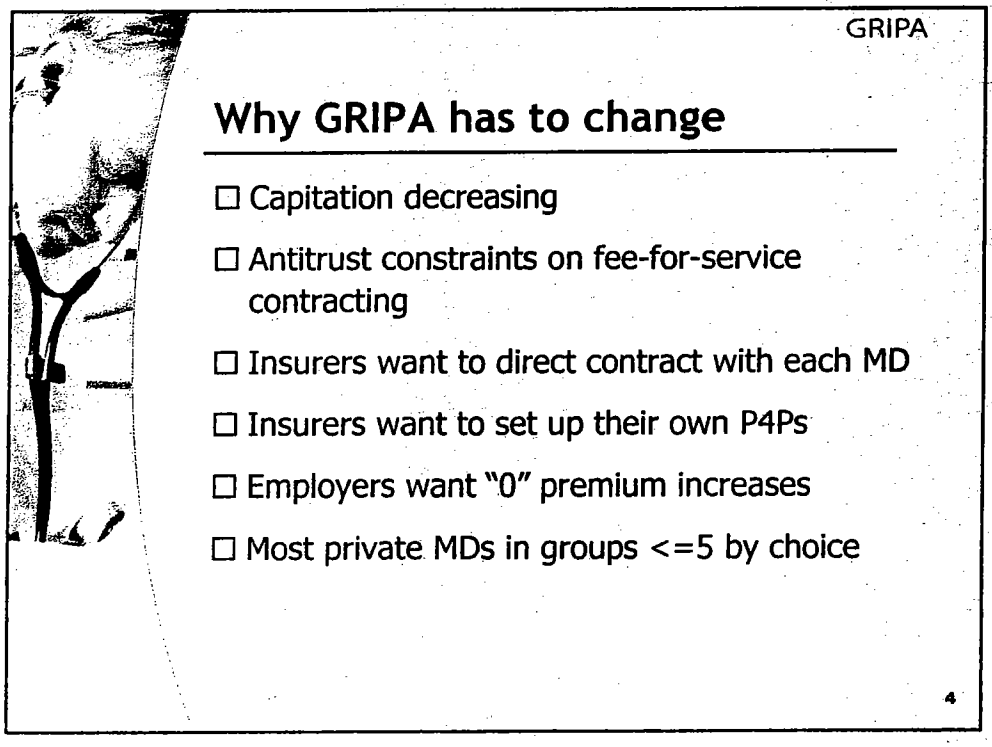
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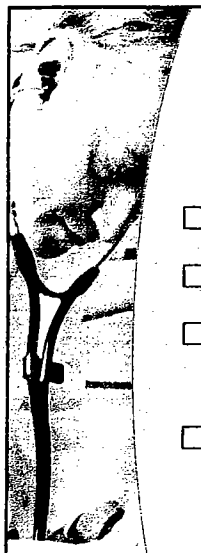



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- ☐ RGPO Retreat 11/2004
- ☐ GRIPA Retreat 6/2005
- ☐
- ☐

5



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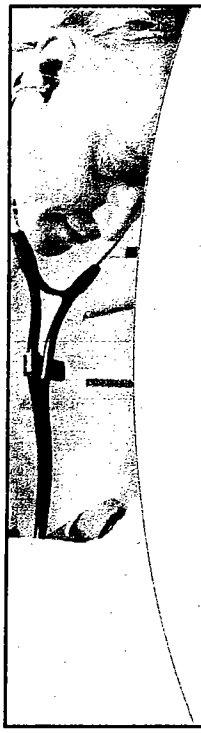

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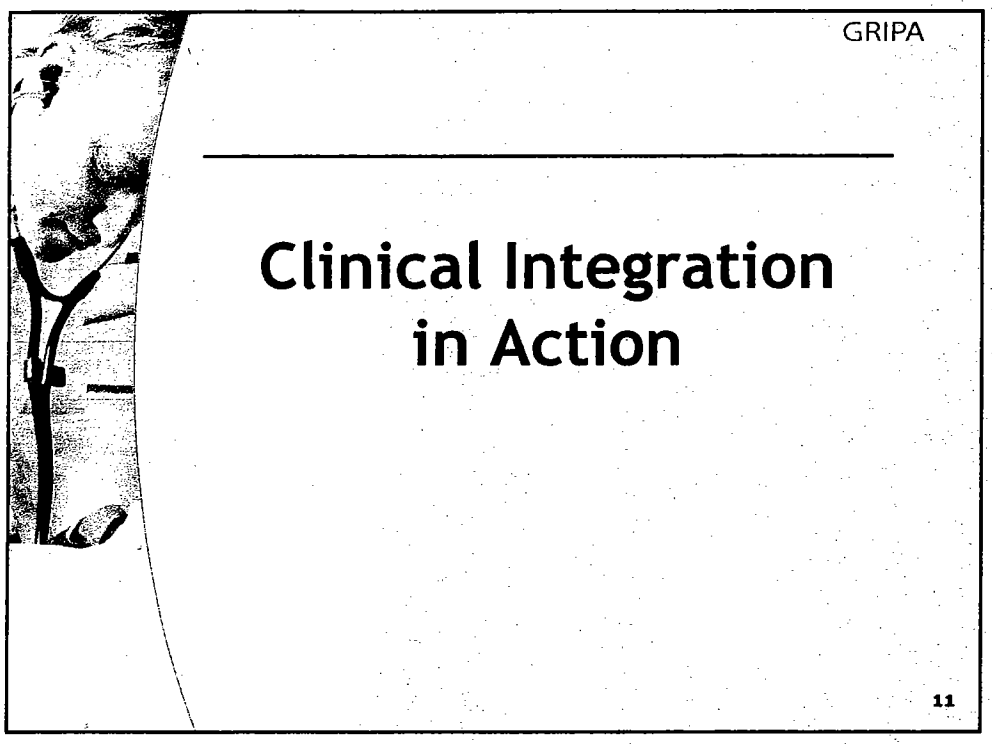
NOT MARKET POWER – must be <35% of providers in the service area

10


GRIPA
Clinical Integration
in Action
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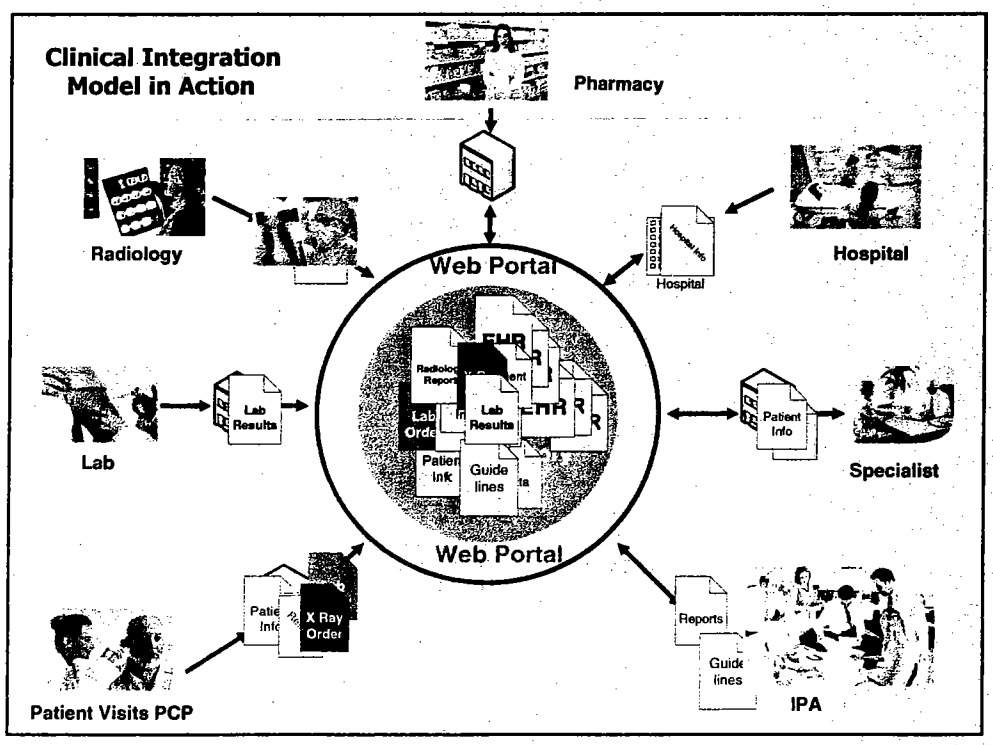
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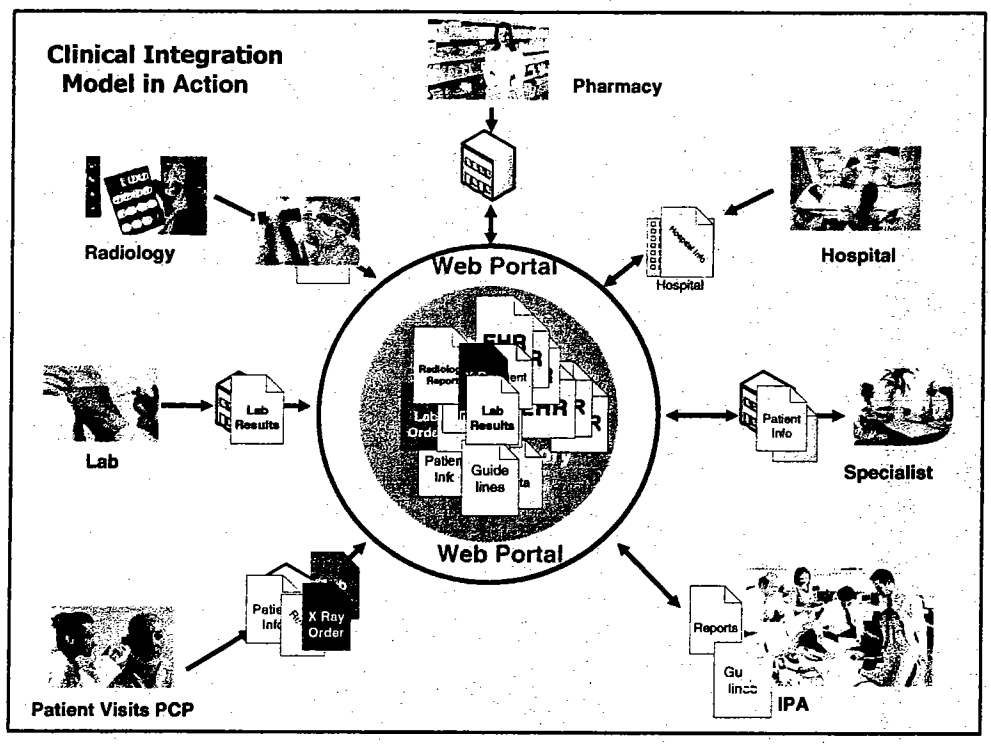
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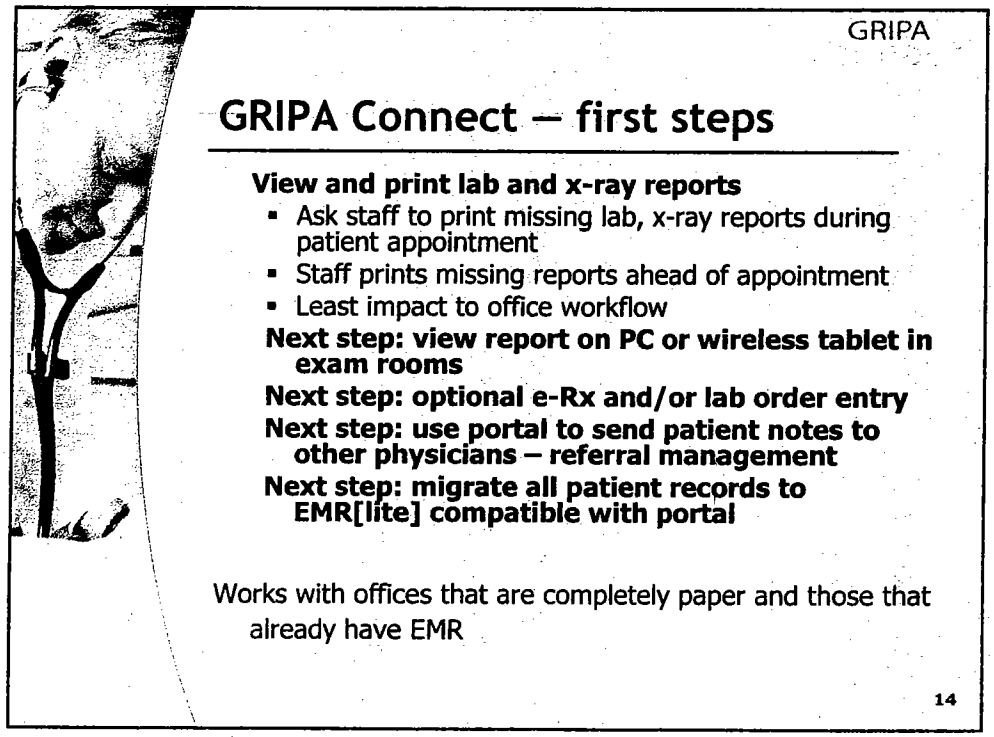
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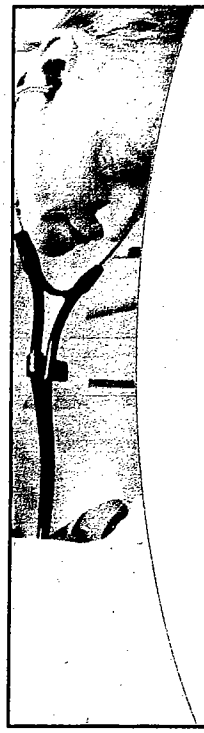
## Requests of ViaHealth Board



GRIPA

## Clinical Integration

. . . . . thank you!

Please check out:
www.GRIPAconnect.com

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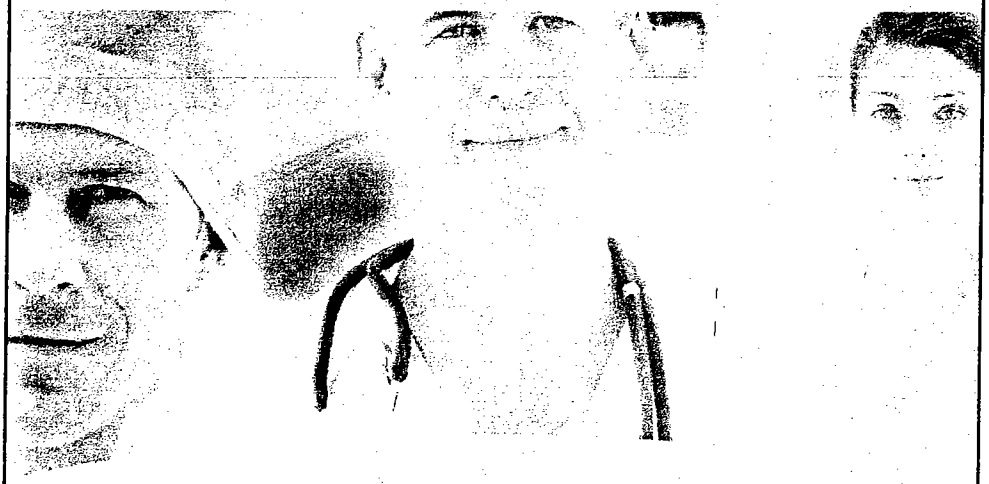
CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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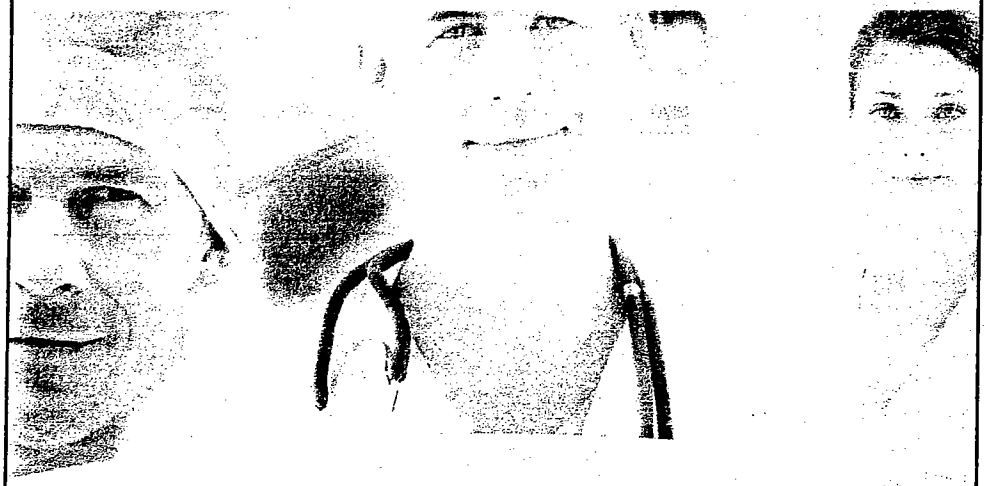
## 8/10/06 ViaHealth Quality Committee

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



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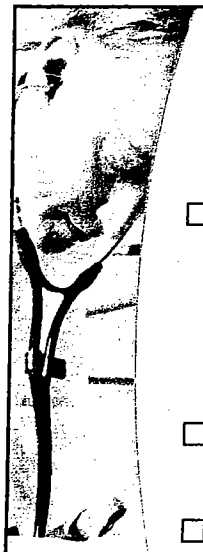

GRIPA

## GRIPA

**Greater Rochester Independent Practice Association**

- ☐ 50/50 partnership (PHO) of the ViaHealth hospital system and the physicians organizations formed in 1996 from the medical staffs of ViaHealth hospitals
  - RGPO, GPO, WCPO
- ☐ Joint venture to take capitated risk and negotiate contracts for its shareholders with HMO's
- ☐

2

GRIPA

## Changing Marketplace

Issues identified at GRIPA retreat 8/2004

3

GRIPA

## Why GRIPA has to change

- ☐ Capitation decreasing
- ☐ Antitrust constraints on fee-for-service contracting
- ☐ Insurers want to direct contract with each MD
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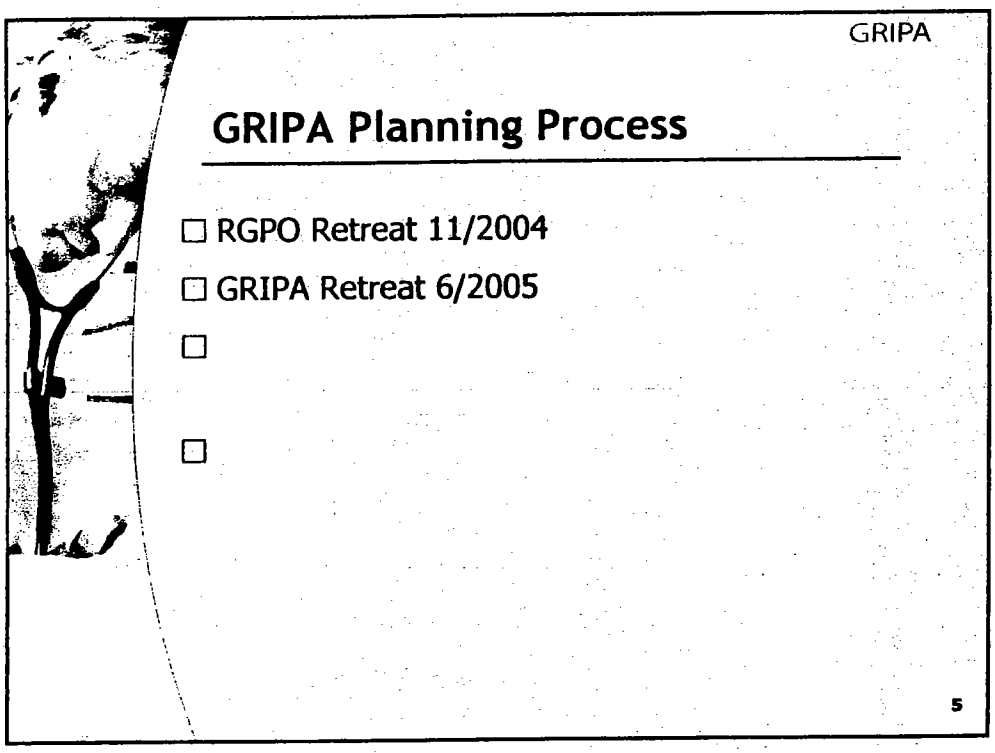
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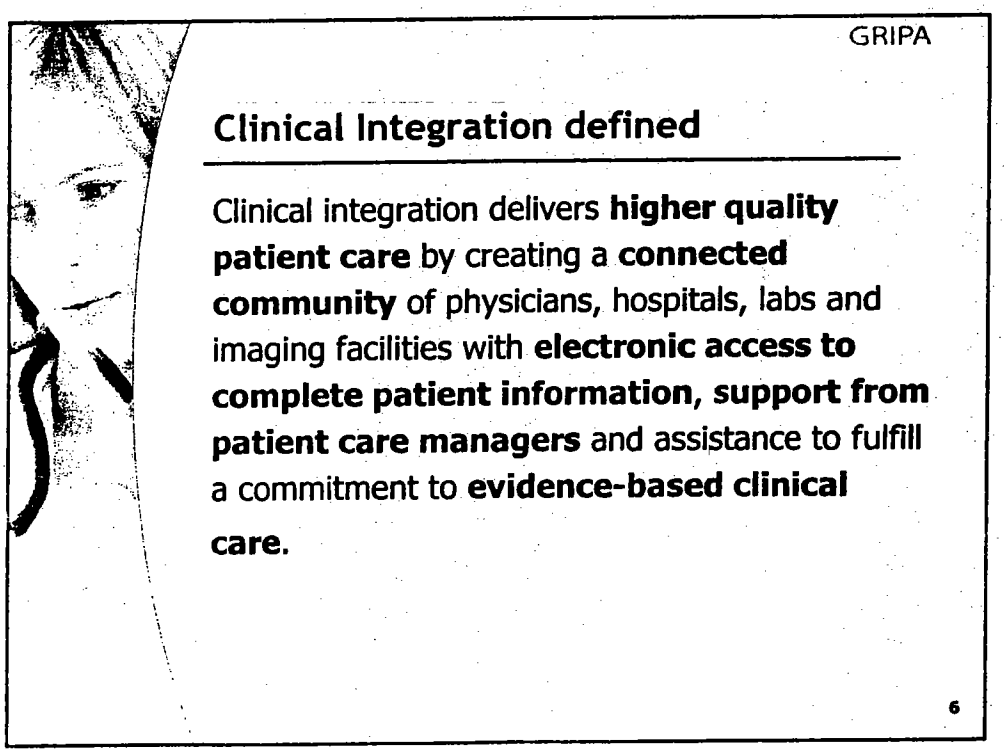
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    - Hard to do – MedSouth is only group in the country to get prior approval of FTC





## Clinical Integration" is *not* a medical term

Can we as an IPA continue to contract for our physicians without taking capitation or another type of financial risk?

. . . without running afoul of FTC/DOJ?

GRIPA

## Yes, with three key components

1. Evidence-based guidelines on utilization – agreed upon by physicians – to control costs and assure quality of care
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GRIPA

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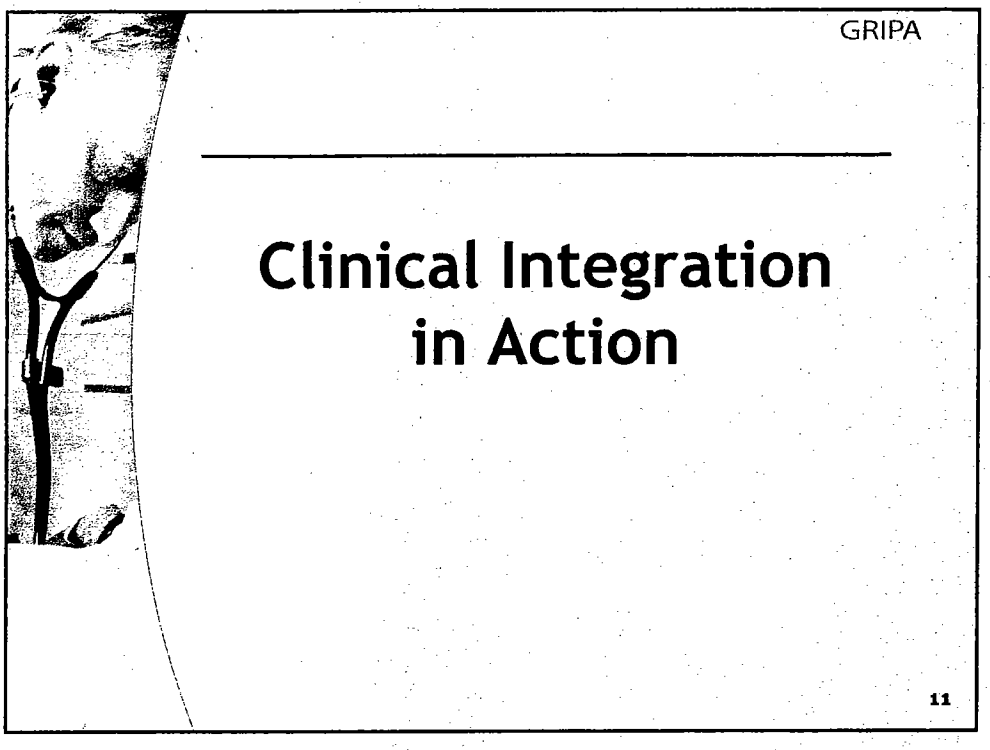
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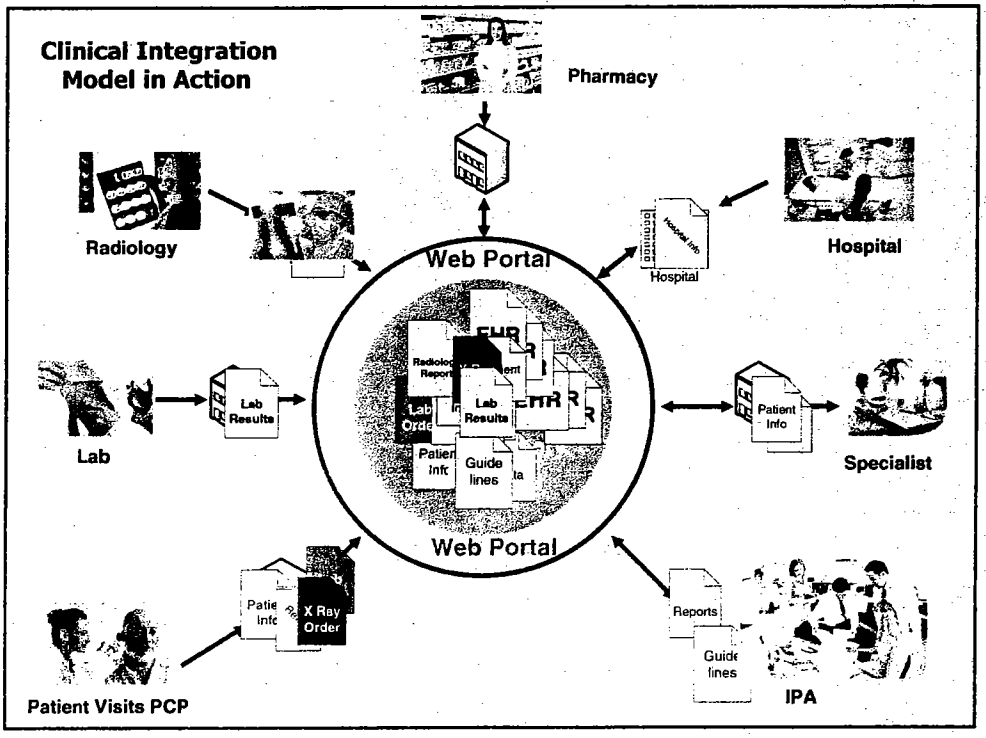
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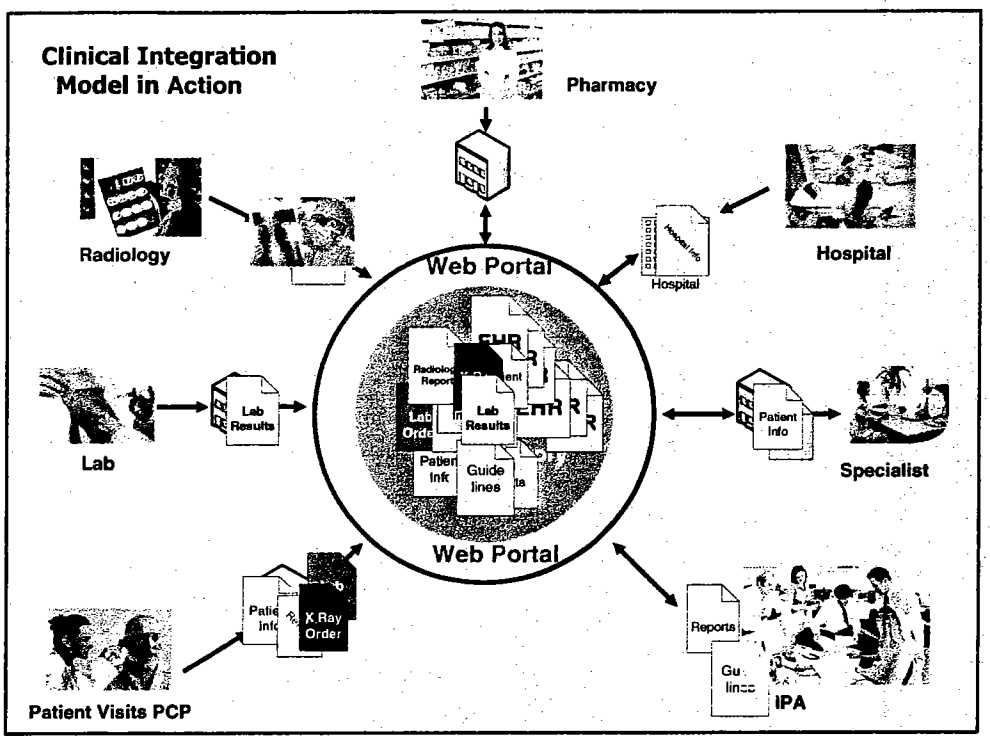
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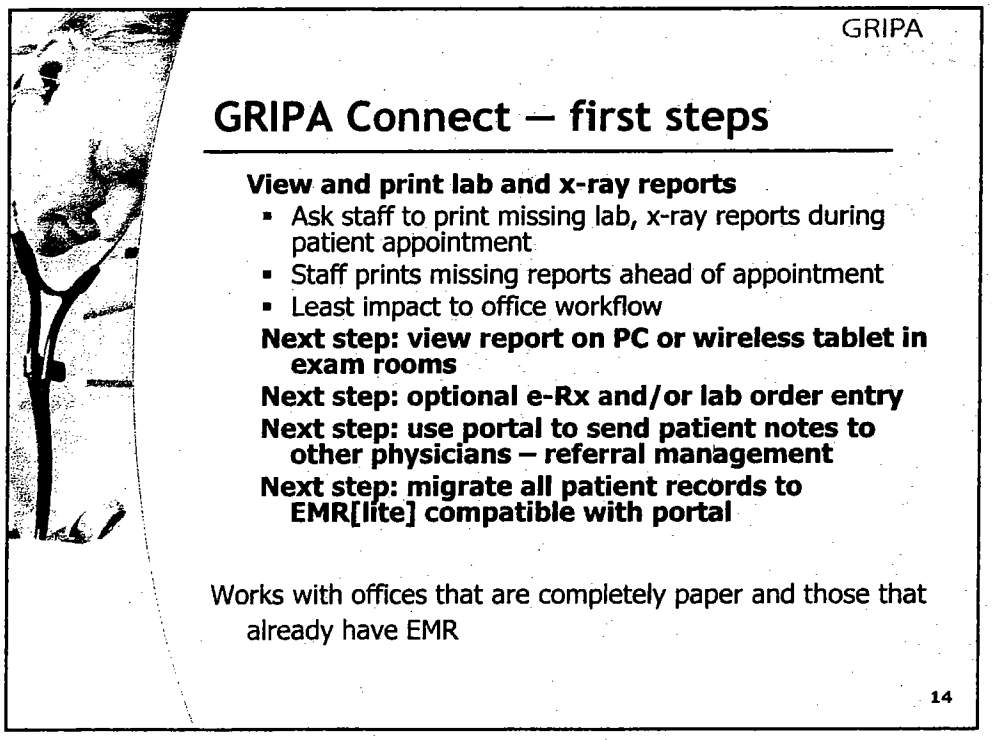
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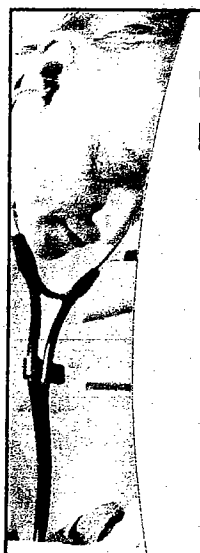



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GRIPA

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17

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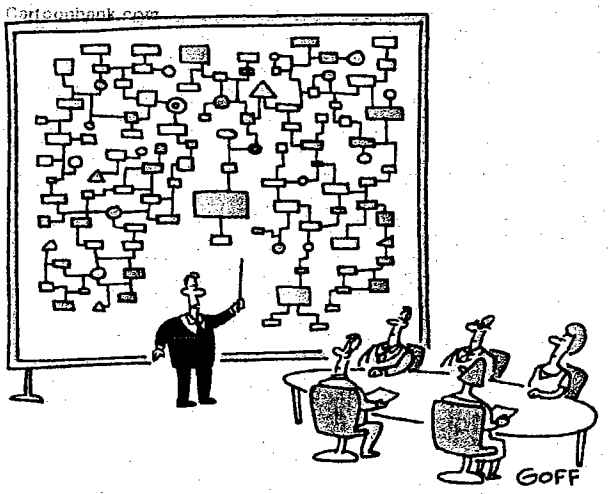
## Requests of ViaHealth Board

18

GRIPA

## Simplify technology




**"And that's why we need a computer."**

19

GRIPA

## Clinical Integration

. . . . . thank you!

Please check out:
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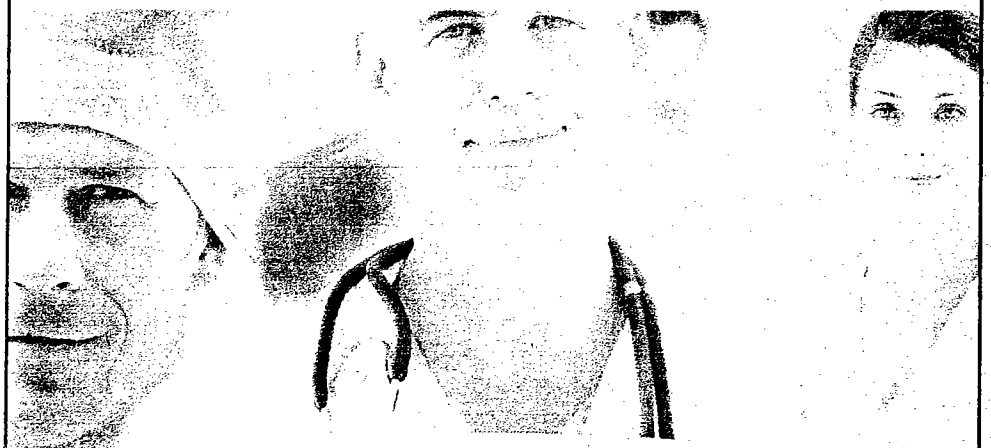
CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA

# Physician Advisory Group Mtg. 9/5/06

## Agenda

- Introduction
- Physician Contracts Update
- Hardware Assessment
- Portal Features/Rollout Timeline
- Practice Management Data
- Portal Demonstration

## Introduction

- Kelly Taddeo – GRIPA Dir. Network Services
- Ben Smith – GRIPA Physician Tech. Cons.
- Kelly Brady – GRIPA Manager Technical Dev.
- Brad Lawrence – Healthvision Project Mgr.

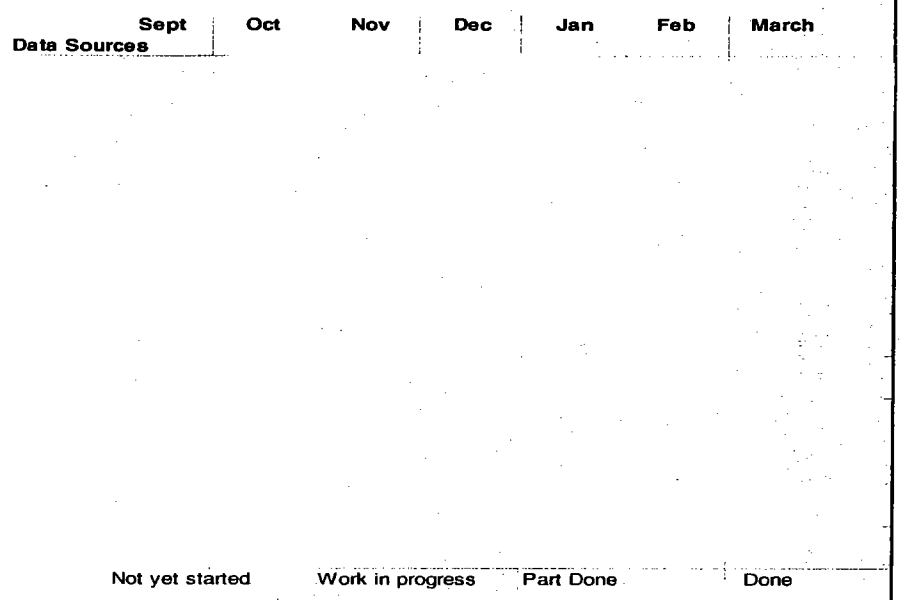
## Physician Contracts Update

- Private Physicians
  - 141 signed contracts
- ViaHealth Employed Physicians
  - Single signature by CEO
- Contract Summary sent with contracts
- MCMS Review
  - Response from our lawyers

## Office Hardware Assessments

- High-speed Internet Access
- Router/Wireless Access point
  - Installation
- Setup/connection of wireless tablet
- # & type of existing computers
- Other existing hardware
- Support of existing hardware

## GRIPAconnect Portal Feature/Rollout Timeline




# Practice Management Data

- Vendors who are working with us:
  - MEDENT
  - Perfect Care
  - Practice Made Perfect
  - Specialist
  - IDX

# Healthvision Roles/Rules

- Clinician
- Office Staff Admin
- Front Office
- Physician
- Security Administrator
- Merge Admin
- HCO Site Configurator
- Interface Administrator
- Test Administrator
- Feed Administrator
- Report – Audit
- Patient Reg - Level 1
- Patient Reg - Level 2
- Patient Reg - Level 3
- Referral Config. Admin.
- Clinical Data – Summary
- Referral Administrator
- Utilization Manager
- Consulting Provider

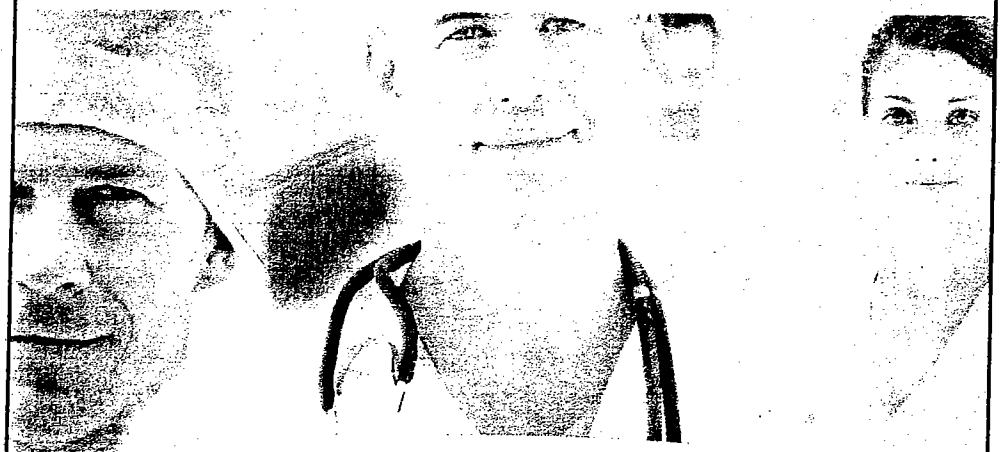
# Portal Demonstration

Questions/comments
from group

## 9/26/06 Physician dinner meeting

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA

GRIPA

## Clinical Integration

- ☐ Natural outgrowth—pioneering step
- ☐ Short presentation followed by Q&A:
  - History and why the change?
  - Clinical integration defined
  - GRIPA Connect web portal
  - Physician Contracts
- ☐ The presenters
- ☐ Collaborative spirit - input and feedback

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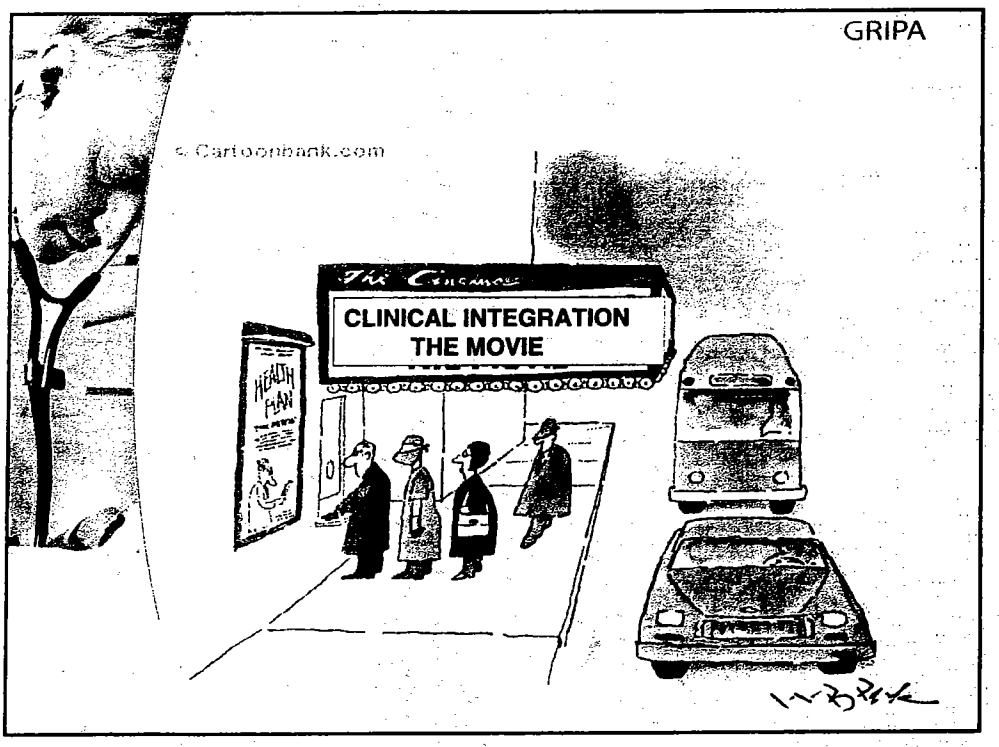


GRIPA

## GRIPA retreat 8/2004

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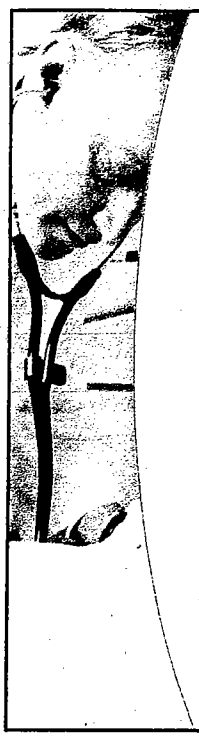

GRIPA

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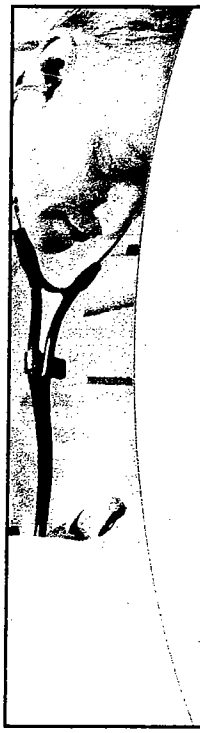

GRIPA

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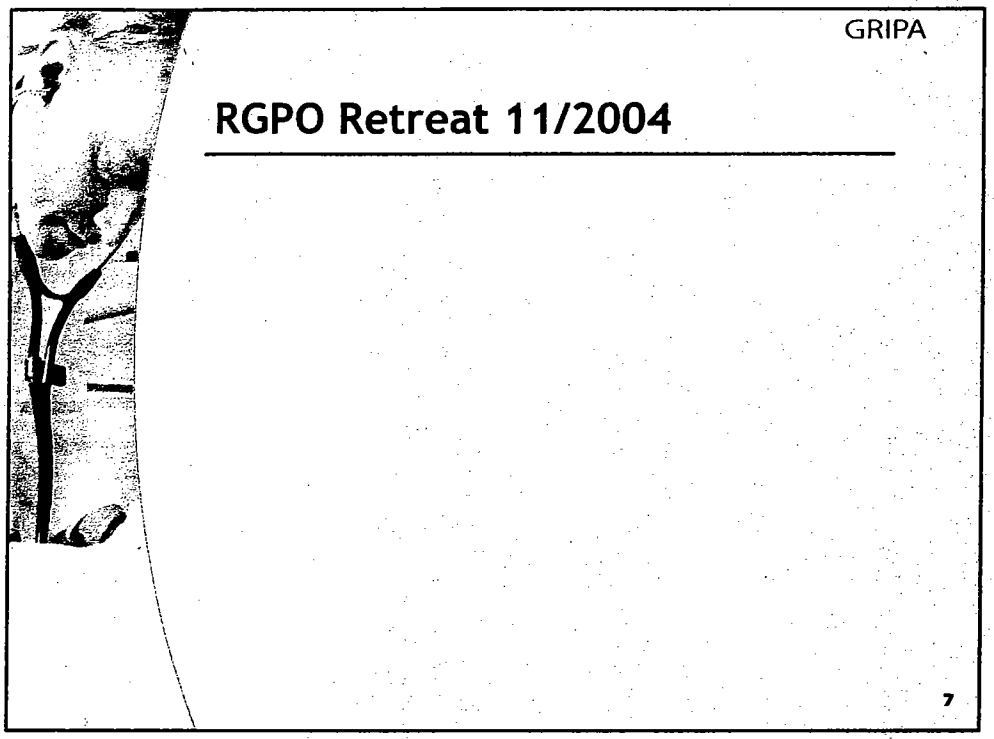
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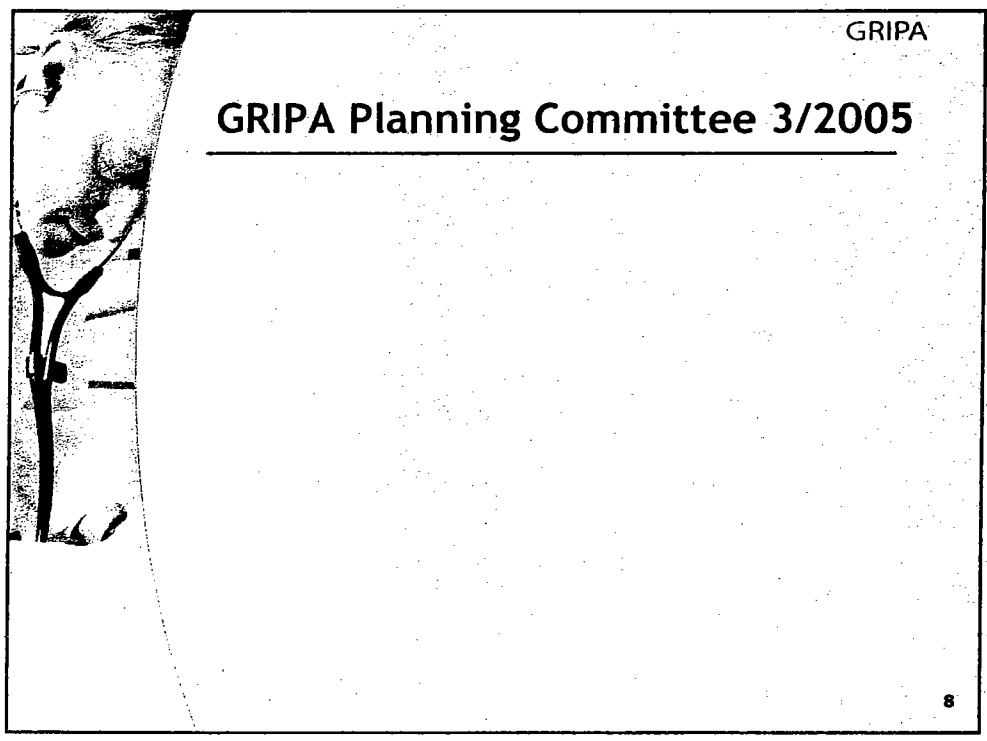
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GRIPA

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GRIPA

## Three key components of C.I.

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GRIPA

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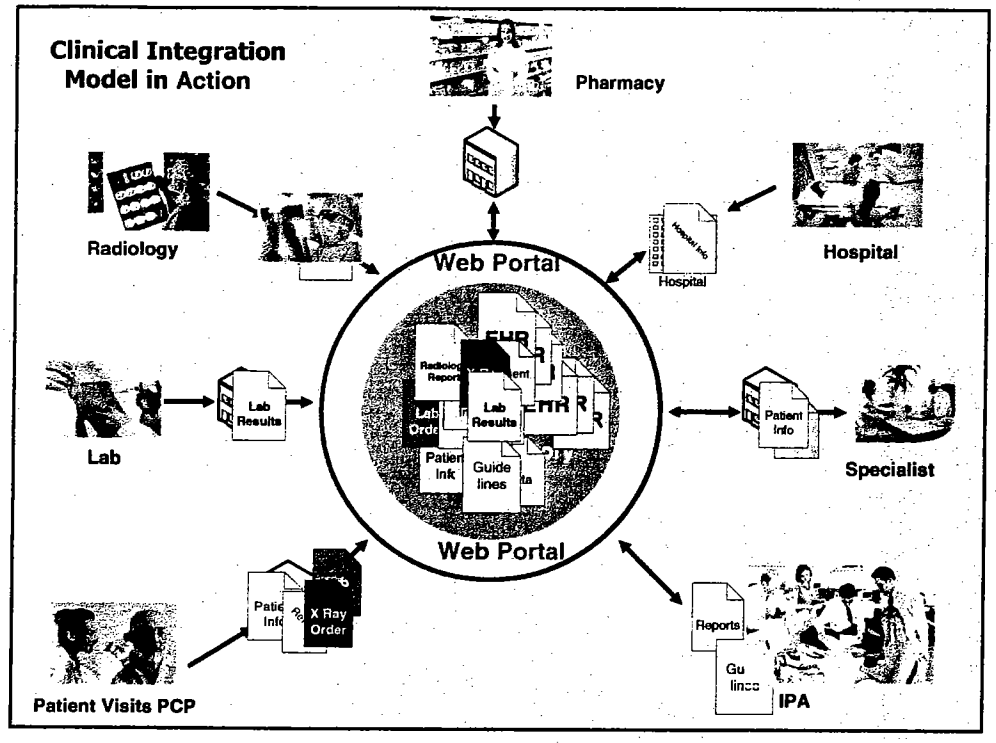
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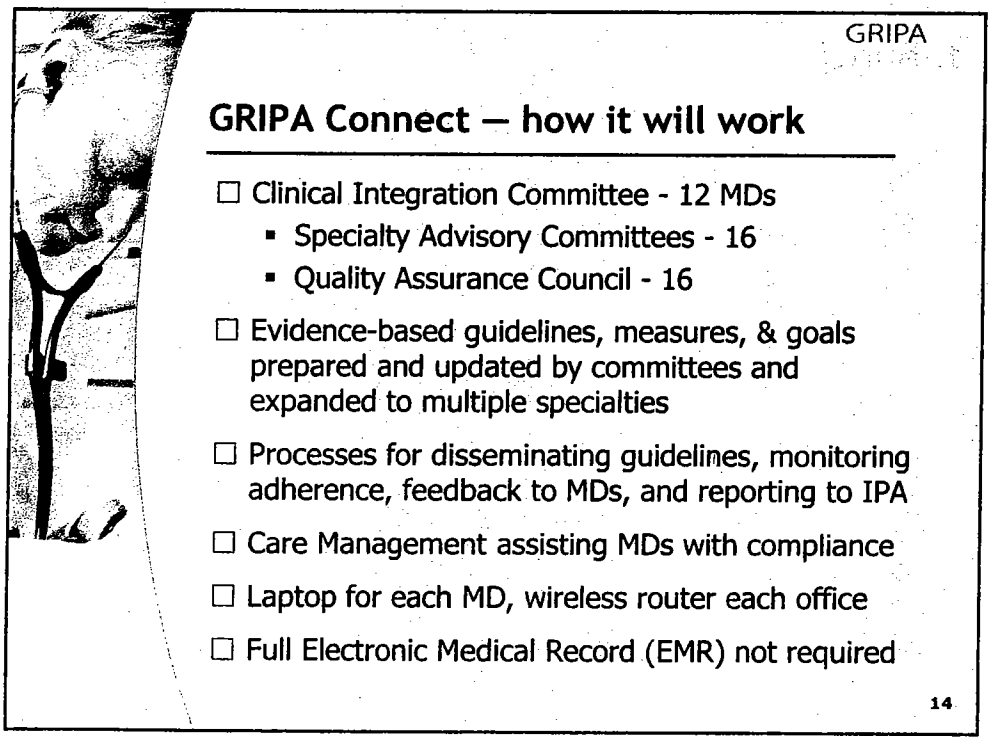
GRIPA
GRIPA Connect – how it will work
☐ Clinical Integration Committee - 12 MDs
▪ Specialty Advisory Committees - 16
▪ Quality Assurance Council - 16
☐ Evidence-based guidelines, measures, & goals prepared and updated by committees and expanded to multiple specialties
☐ Processes for disseminating guidelines, monitoring adherence, feedback to MDs, and reporting to IPA
☐ Care Management assisting MDs with compliance
☐ Laptop for each MD, wireless router each office
☐ Full Electronic Medical Record (EMR) not required
14



## GRIPA Connect – first steps

**View and print lab and x-ray reports**

- Ask staff to print missing lab, x-ray reports during patient appointment
- Staff prints missing reports ahead of appointment
- Least impact to office workflow

**Next step: use portal to send information to other physicians – referral management**

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Works with offices that are paper-based and those that already have EMR

15



## Goals of GRIPA Connect

- ☐ Provide physicians with most complete medical history at time of care
- ☐ Provide physicians with e-tools to replace manual processes
- ☐ Provide IPA with comprehensive clinical data to develop incentive and quality programs
- ☐ Employed and private physicians in contracts
- ☐ Be accountable to insurers, employers, community, regulators
- ☐ Differentiate the network based on technology and quality of care

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## GRIPA's progress/current status

- ☐ 6/2005 Clinical Integration ratified as goal, consultants and legal team identified
- ☐ 12/2005 – BOD approved CI business plan, contracted with Healthvision for IT infrastructure
- ☐ Early 2006 – portal design
- ☐ 6/2006 - FTC advisory opinion request
- ☐ 7/2006 contracts to private physicians & ViaHealth
- ☐ 2006 - data source contracts & interfaces
- ☐ Practice Mgmt system interfaces
- ☐ IBM review of IT readiness

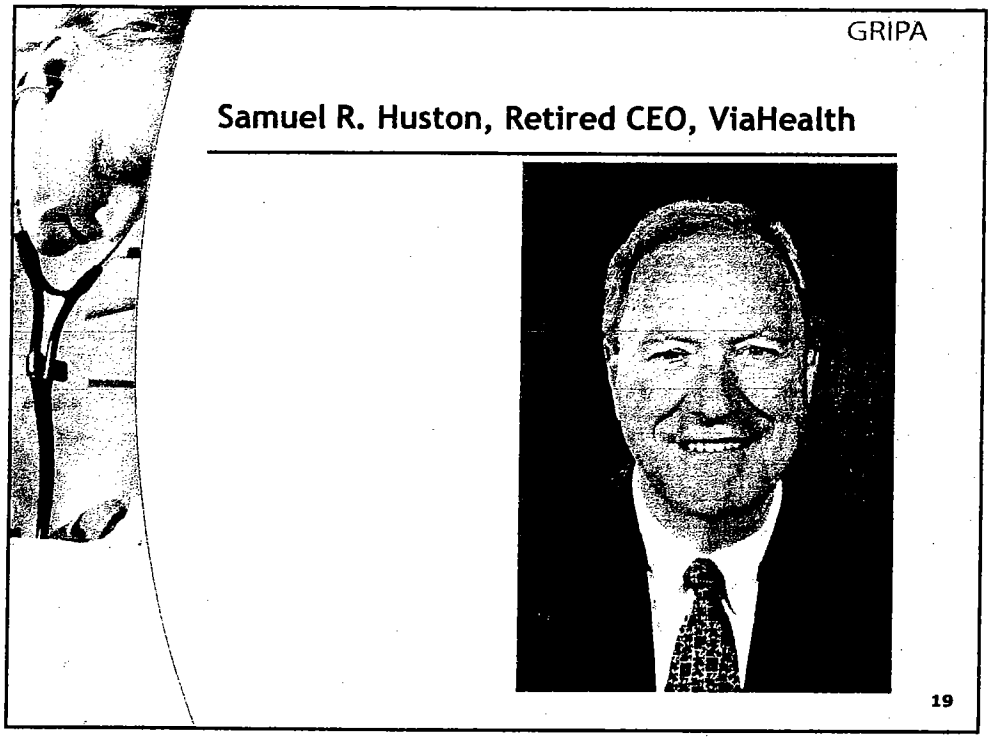
17

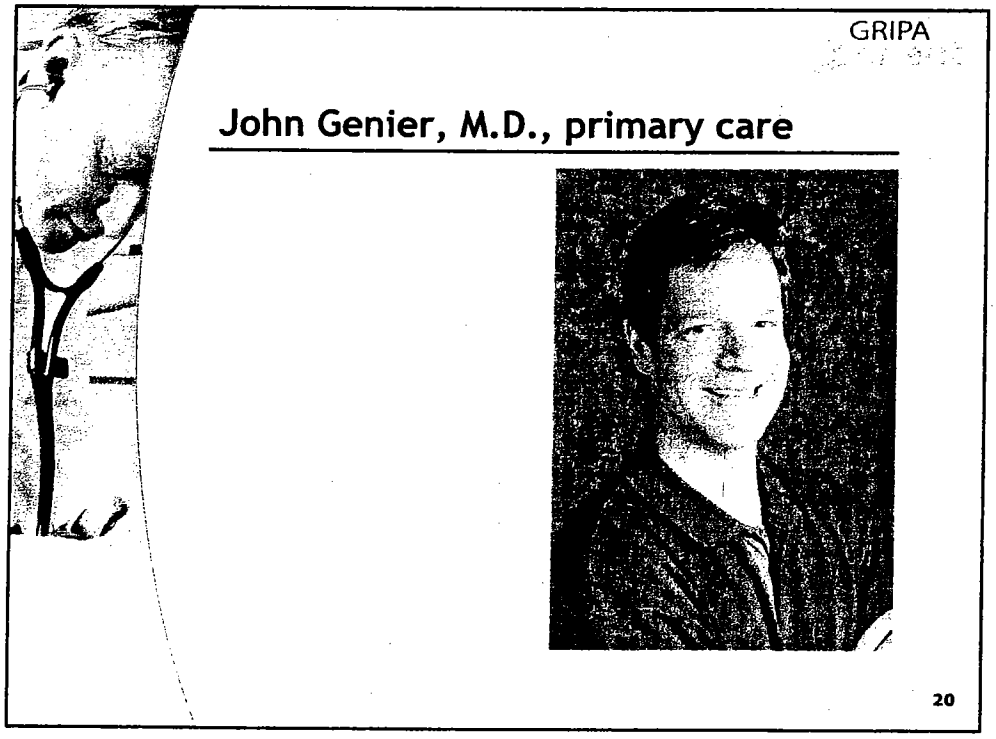


## GRIPA's plans/timeline

- ☐ Late 2006 - roll-out web portal to physician offices
- ☐ Early 2007 FTC advisory opinion response
- ☐ 2007 continue risk contracts for 640 physicians
- ☐ Late 2007 – negotiate fee-for-service contracts
  - charging a premium for a better product
  - For 400? physicians

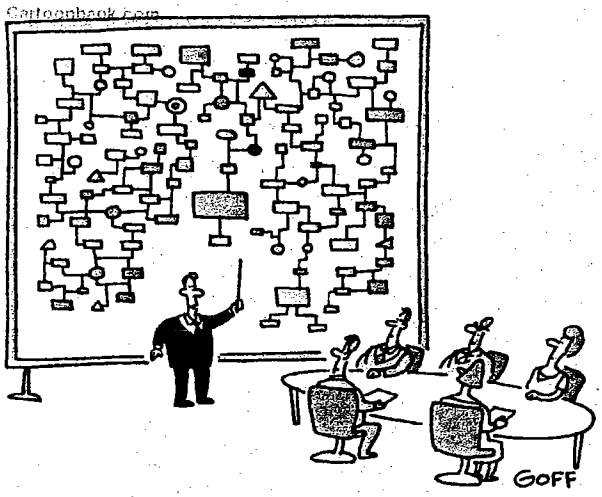
18


GRIPA
Samuel R. Huston, Retired CEO, ViaHealth
19


GRIPA
John Genier, M.D., primary care
20



## Simplify technology




"And that's why we need a computer."





## Physician Participation Contracts Non-standard features

**By signing these contracts, you agree to:**

- **Provide high-speed Internet access at each office**
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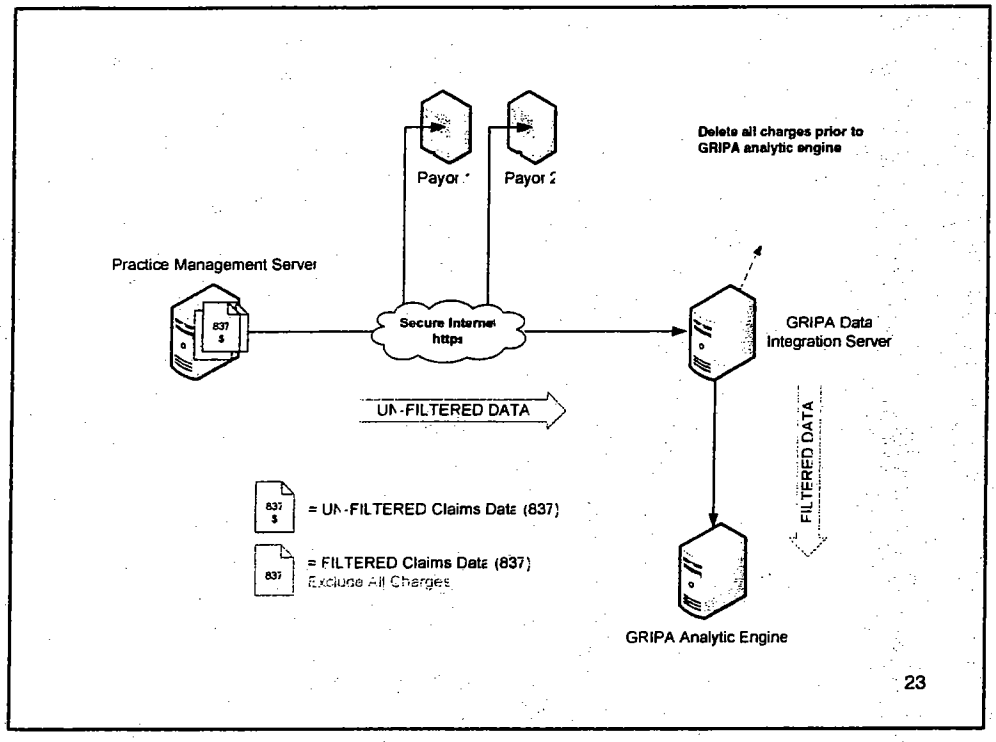
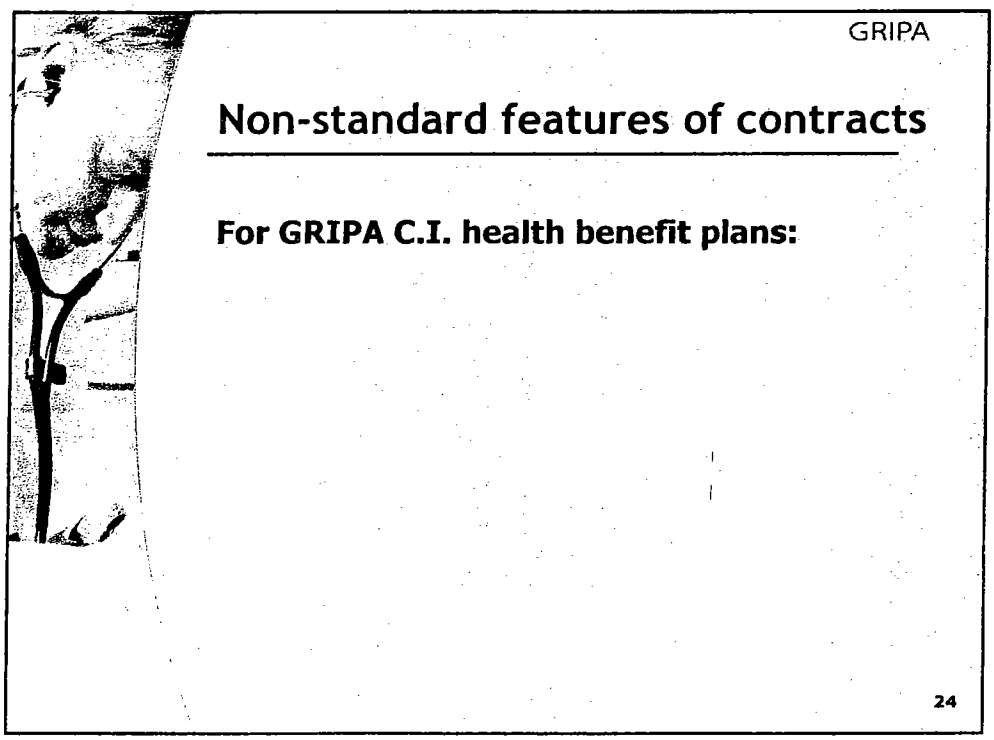

Payor 1
Payor 2
Delete all charges prior to GRIPA analytic engine
Practice Management Server
837 $
Secure Internet https
GRIPA Data Integration Server
UN-FILTERED DATA
FILTERED DATA
837 $
= UN-FILTERED Claims Data (837)
837
= FILTERED Claims Data (837)
Exclude All Charges
GRIPA Analytic Engine
23


GRIPA
Non-standard features of contracts
For GRIPA C.I. health benefit plans:
24

GRIPA

## Clinical Integration

. . . . . thank you!

Stay in touch with
GRIPAconnect.com

25

GRIPA

## Save the Date!

**RGPO and WCPO Joint Annual Meeting**

**Thursday, November 9, 2006 Time: 6:30 PM**

**Place: Twig Auditorium @ RGH**

**Brief presentations, hands on demos, great food!**

**Learn more about GRIPA Connect Clinical Integration**

**Try out the Web Portal**

**Ask questions one-on-one**

**Pick up your laptop/tablet (eligible physicians, signed CI contract)**

**Watch for your invitation in the mail shortly!**

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## GRIPAconnect Portal Features/Rollout Timeline

| Data Sources | Sept | Oct | Nov | Dec | Jan | Feb | March |
|---|---|---|---|---|---|---|---|

Not yet started | Work in progress | Part Done | Done





## GRIPA

**Greater Rochester Independent Practice Association**

- ☐ 50/50 partnership (PHO) of the ViaHealth hospital system and the physicians organizations formed in 1996 from the medical staffs of ViaHealth hospitals
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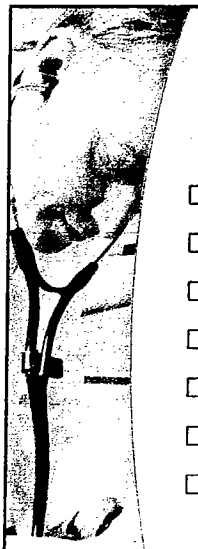

GRIPA

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- ☐ Michael Jacobs
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- ☐ Paul Mikus
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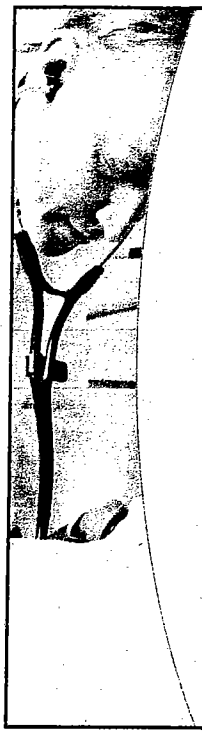



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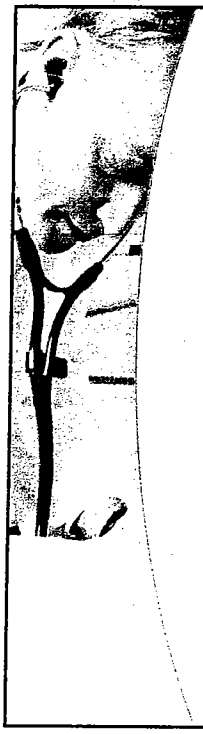



## ViaHealth perspective

- ☐ Physician recruitment & retention very important to RGH & VOW
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- ☐ Risk contracting appears to be disappearing
- ☐ Loss of the risk model leaves physicians bare & with few options
- ☐ Some aspects of CI may be mandated in next 5 years
- ☐ Makes sense to pursue now if it is to be mandated
- ☐ ViaHealth commitment to Clinical Integration

GRIPA

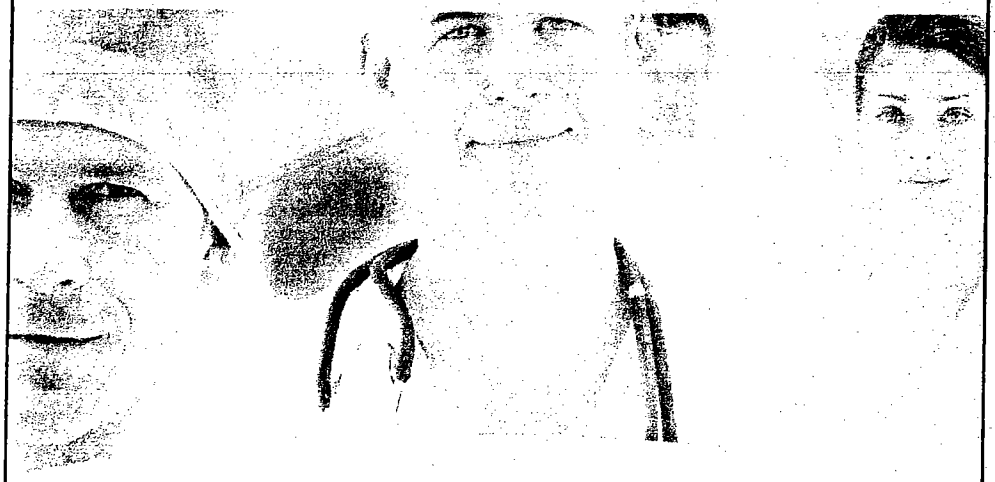
## Physician perspective

- ☐ initially skeptical
- ☐ essential to the future of physicians and RGH
- ☐ no longer "business as usual"
- ☐ allows you to be an independent practitioner
- ☐ retaining the benefits of a large group
- ☐ not ready for a full EMR
- ☐ begin the transition to use computers
- ☐ input into clinical guidelines & portal
- ☐ Pay-for-performance programs are coming
- ☐ rather set them up with "friends and family"
- ☐ maintain the bond of GRIPA physicians
- ☐ recognized for the excellent care we deliver

33

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA

## 10/26/06 Physician dinner meeting

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS

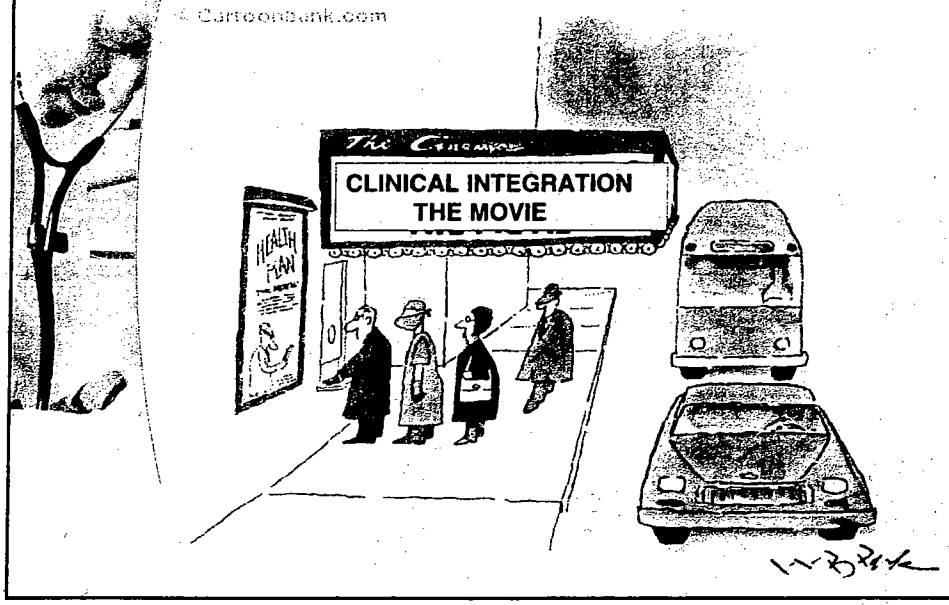
GRIPA

GRIPA

## Clinical Integration

- ☐ Natural outgrowth—pioneering step
- ☐ Short presentation followed by Q&A:
  - History and why the change?
  - Clinical integration defined
  - GRIPA Connect web portal
  - Physician Contracts
- ☐ The presenters
- ☐ Collaborative spirit - input and feedback

2






## GRIPA retreat 8/2004

GRIPA

## Why IPA's have to change Changing Marketplace

- ☐ Capitation decreasing
- ☐ Insurers want to direct contract with each MD
- ☐ Insurers want to set up their own P4Ps
- ☐ Employers want "0" premium increases
- ☐ Most private MDs in groups <=5 by choice
- ☐ Antitrust constraints on fee-for-service contracting

5

GRIPA

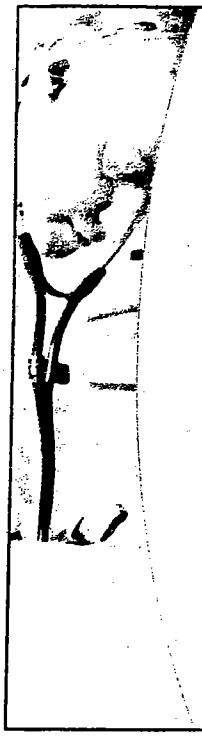
## The critical question

Can we as an IPA continue to contract for our physicians

. . . without taking capitation or another type of financial risk?

. . . without running afoul of FTC/DOJ?

6



GRIPA

## RGPO Retreat 11/2004

7

GRIPA

## GRIPA Planning Committee 3/2005

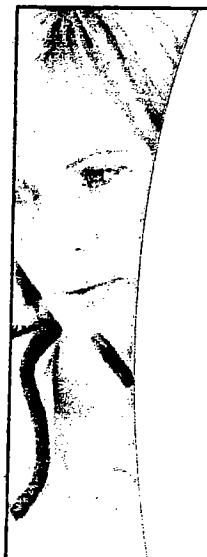
8

GRIPA

## Physician contracting

- ☐ Per FTC & DOJ, illegal for independent groups of "competing" physicians to contract together with an insurer (or even compare fees)
- ☐ Waiver only for
  - Financial Integration
    - employed group
    - group accepting capitated risk & withhold
  - Clinical Integration
    - Hard to do – MedSouth is only group in the country to get prior approval of FTC

9



GRIPA

## Clinical Integration defined

Clinical integration delivers **higher quality patient care** by creating a **connected community** of physicians, hospitals, labs and imaging facilities with **electronic access to complete patient information, support from patient care managers** and assistance to fulfill a commitment to **evidence-based clinical care.**

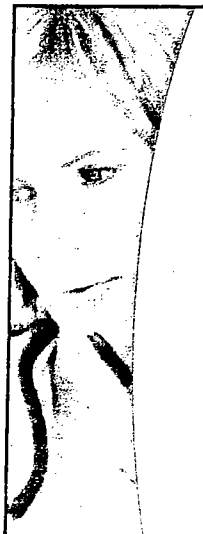
10

GRIPA

## Three key components of C.I.

1. Evidence-based guidelines on utilization – agreed upon by physicians – to control costs and assure quality of care
2. Monitor guideline-related performance to control costs and improve outcomes with sanctions for poor performance
3. Common electronic medical records system or software and data warehouse to permit shared access to patient records

11



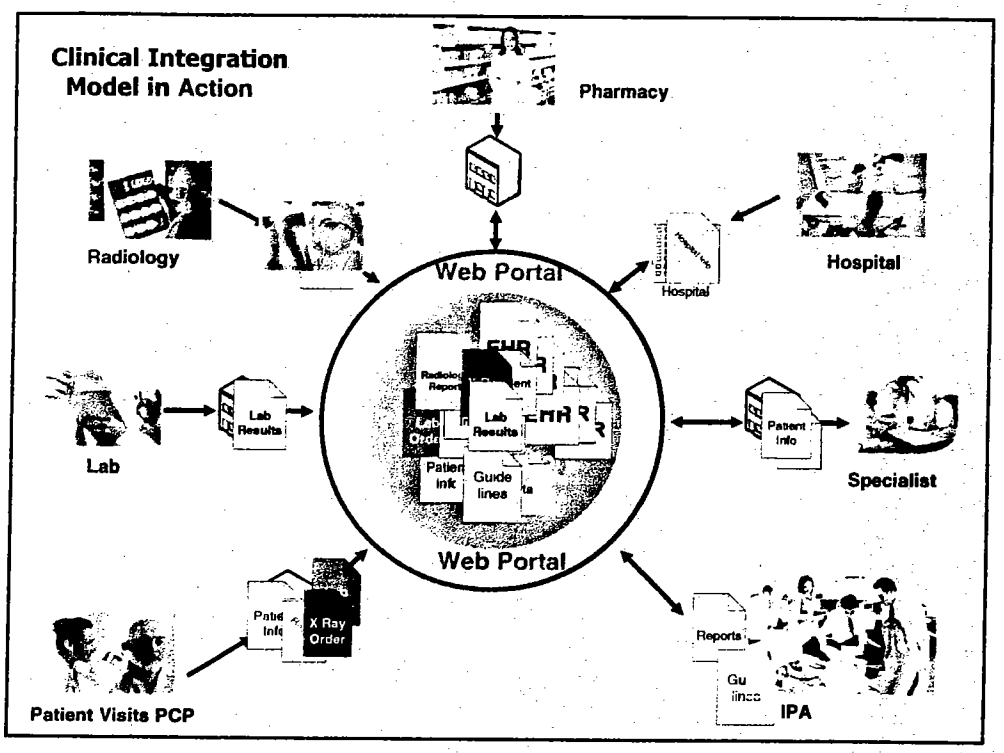
GRIPA

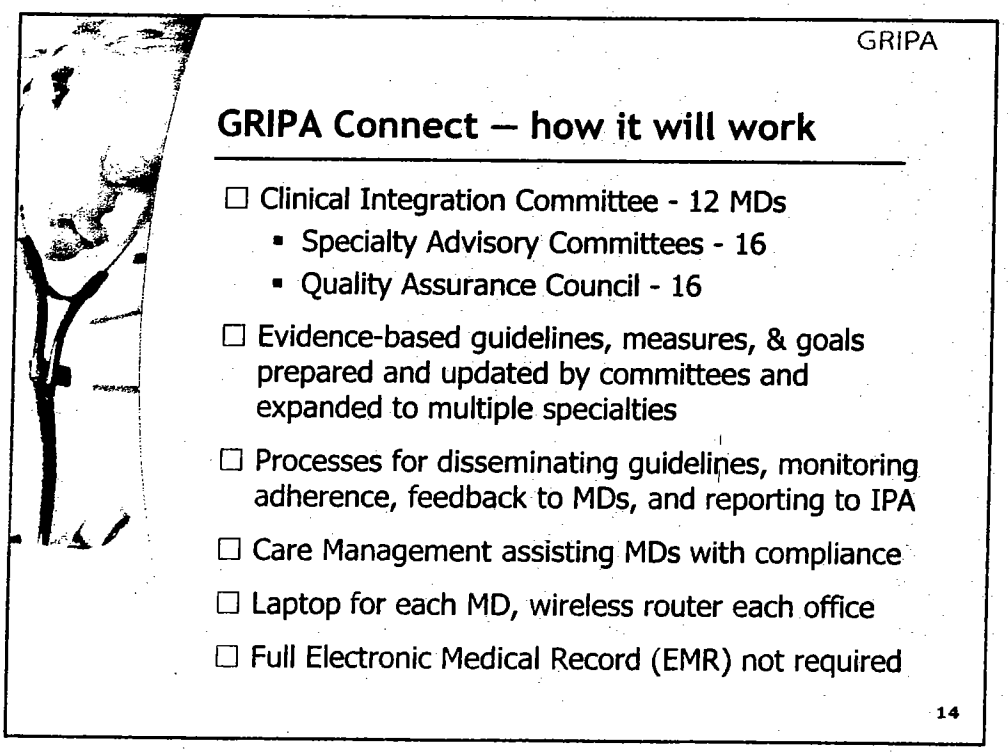
## Benefits of Clinical Integration

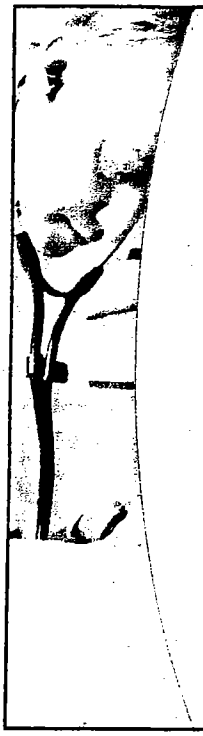
- ☐ Shared commitment to clinical improvement using guidelines, care management, and IT
- ☐ Improved quality
- ☐ Lower costs
- ☐ Maintain stable network of physicians contracting together for risk &/or fee-for-service business
- ☐ Present a common product to the community
- ☐ Better reimbursement to physicians for a better product (4% for MedSouth in 2005)

NOT MARKET POWER – must be <35% of providers in the service area

12


Clinical Integration
Model in Action
Pharmacy
Radiology
Hospital
Web Portal
Hospital
Lab
Lab Results
Specialist
Patient Info
Guide lines
Web Portal
X Ray Order
Patient Visits PCP
Reports
IPA


GRIPA
GRIPA Connect – how it will work
☐ Clinical Integration Committee - 12 MDs
▪ Specialty Advisory Committees - 16
▪ Quality Assurance Council - 16
☐ Evidence-based guidelines, measures, & goals prepared and updated by committees and expanded to multiple specialties
☐ Processes for disseminating guidelines, monitoring adherence, feedback to MDs, and reporting to IPA
☐ Care Management assisting MDs with compliance
☐ Laptop for each MD, wireless router each office
☐ Full Electronic Medical Record (EMR) not required
14





## GRIPA Connect – first steps

**View and print lab and x-ray reports**

- Ask staff to print missing lab, x-ray reports during patient appointment
- Staff prints missing reports ahead of appointment
- Least impact to office workflow

**Next step: use portal to send information to other physicians – referral management**

**Next step: view report on PC or wireless tablet in exam rooms**

**Next step: optional e-Rx and/or lab order entry**

**Next step: migrate all patient records to EMR[lite] compatible with portal**

Works with offices that are paper-based and those that already have EMR

15



## Goals of GRIPA Connect

- ☐ Provide physicians with most complete medical history at time of care
- ☐ Provide physicians with e-tools to replace manual processes
- ☐ Provide IPA with comprehensive clinical data to develop incentive and quality programs
- ☐ Employed and private physicians in contracts
- ☐ Be accountable to insurers, employers, community, regulators
- ☐ Differentiate the network based on technology and quality of care

16



## GRIPA's progress/current status

- ☐ 6/2005 Clinical Integration ratified as goal, consultants and legal team identified
- ☐ 12/2005 – BOD approved CI business plan, contracted with Healthvision for IT infrastructure
- ☐ Early 2006 – portal design
- ☐ 6/2006 - FTC advisory opinion request
- ☐ 7/2006 contracts to private physicians & ViaHealth
- ☐ 2006 - data source contracts & interfaces
- ☐ Practice Mgmt system interfaces
- ☐ IBM review of IT readiness





## GRIPA's plans/timeline

- ☐ Late 2006 - roll-out web portal to physician offices
- ☐ Early 2007 FTC advisory opinion response
- ☐ 2007 continue risk contracts for 640 physicians
- ☐ Late 2007 – negotiate fee-for-service contracts
  - charging a premium for a better product
  - For 400? physicians

GRIPA

## Samuel R. Huston, Retired CEO, ViaHealth

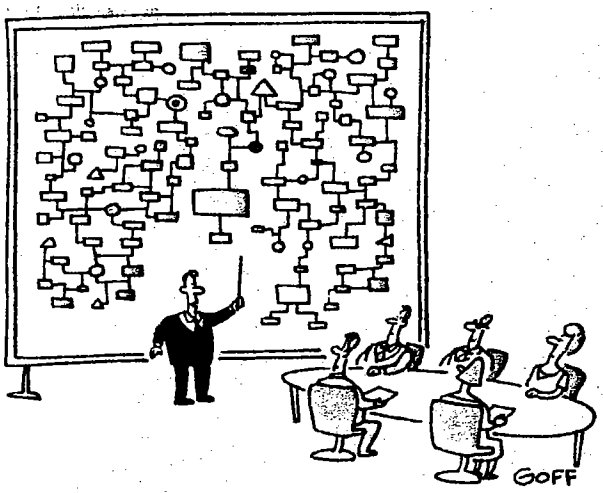
19

GRIPA

## John Genier, M.D., primary care

20

## Simplify technology




"And that's why we need a computer."

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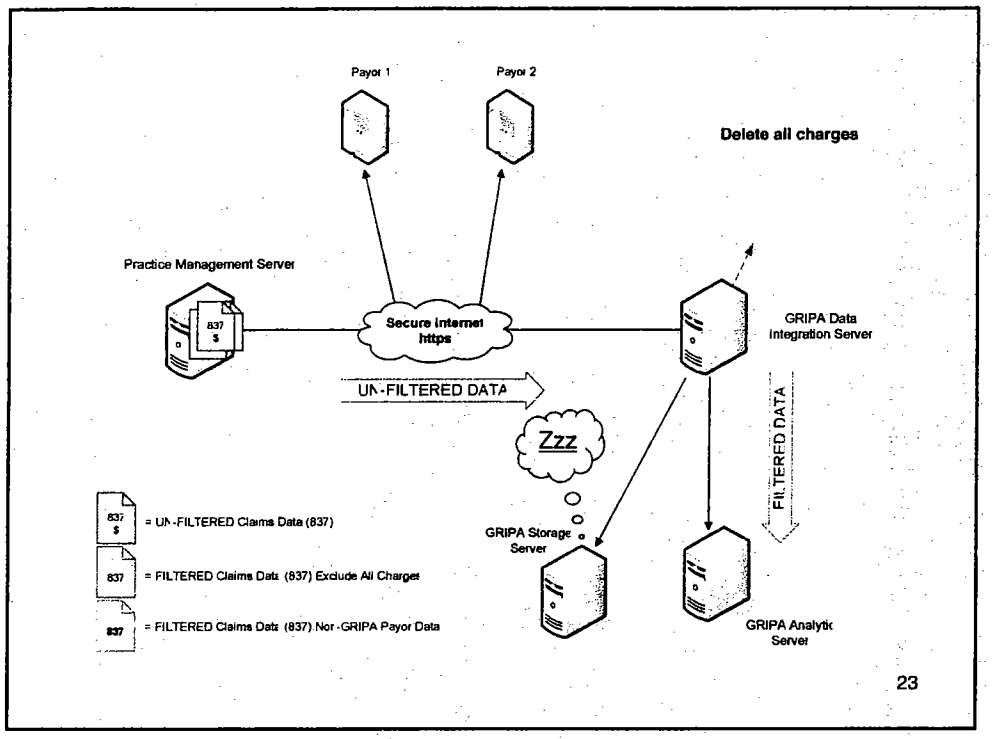
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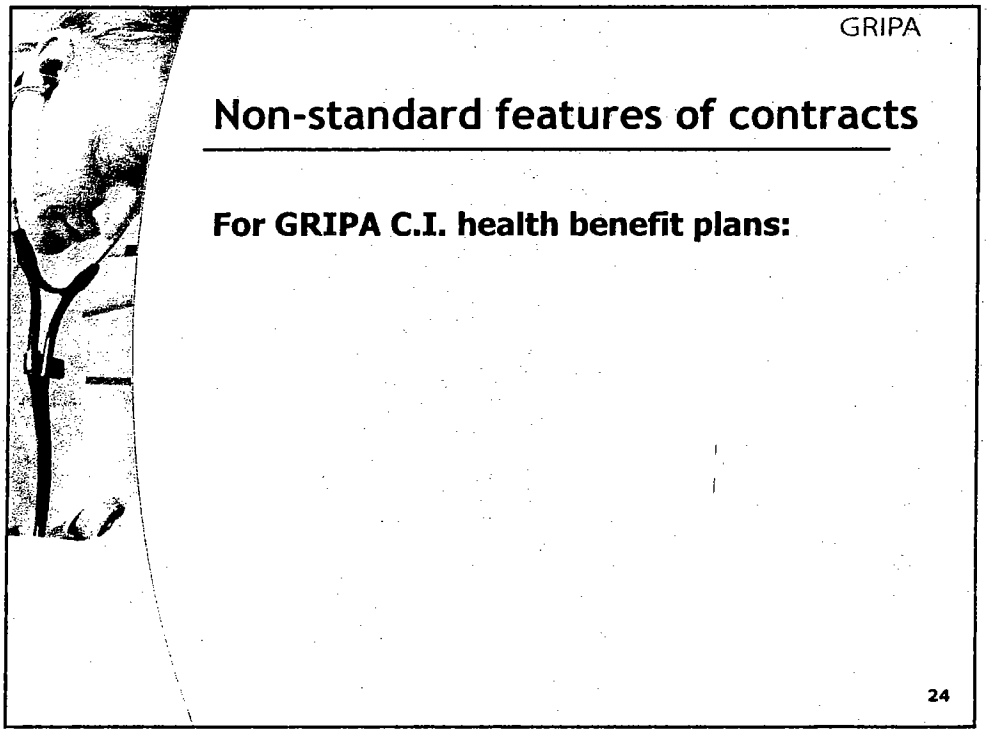
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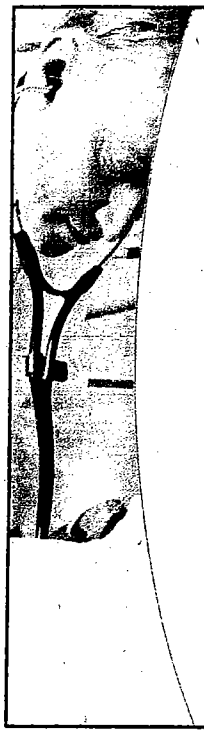

GRIPA

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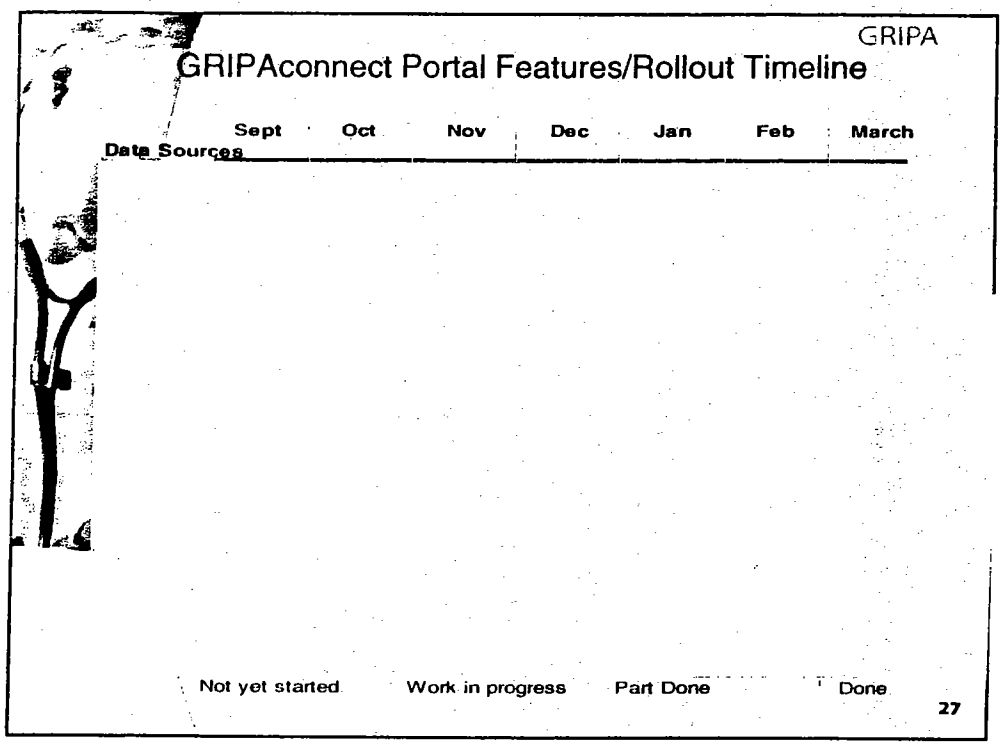
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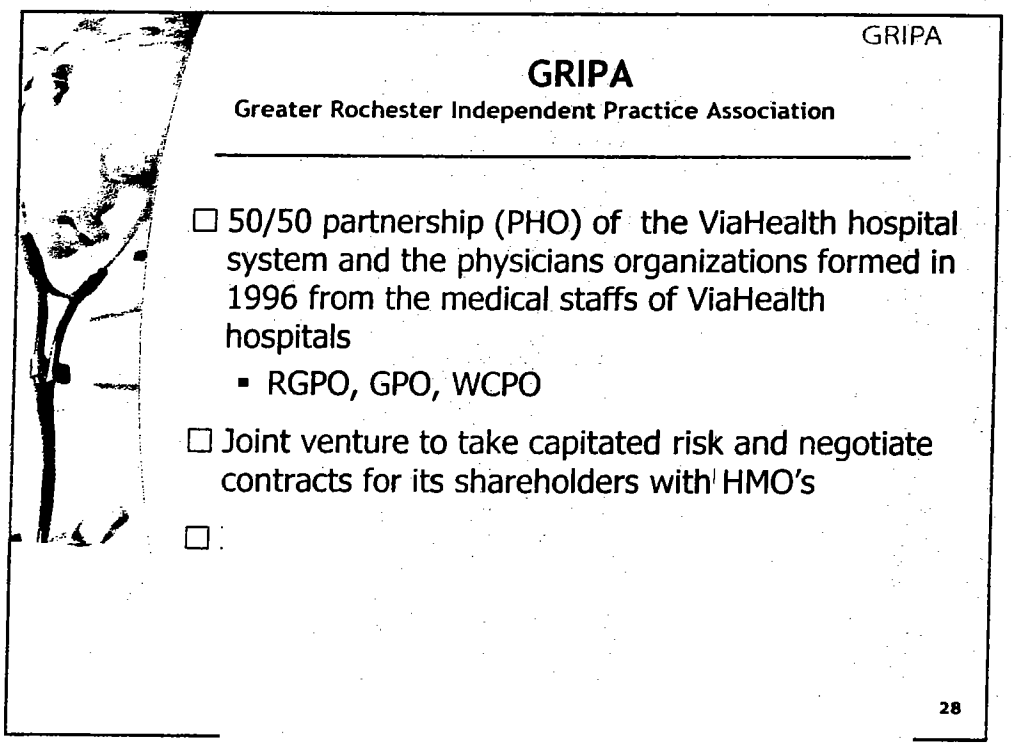
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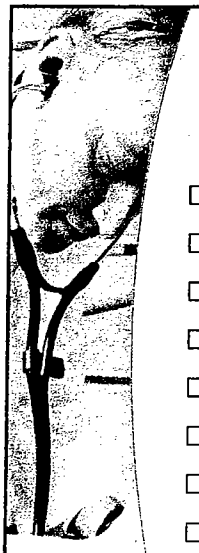



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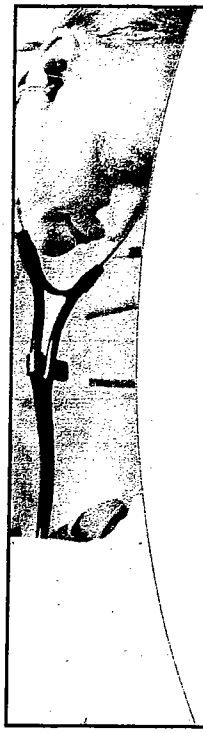



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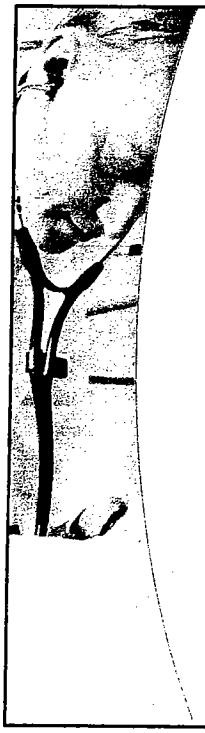



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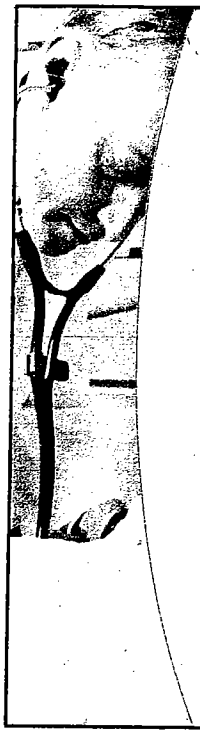
- ☐ Makes sense to pursue now if it is to be mandated
- ☐ ViaHealth commitment to Clinical Integration



GRIPA

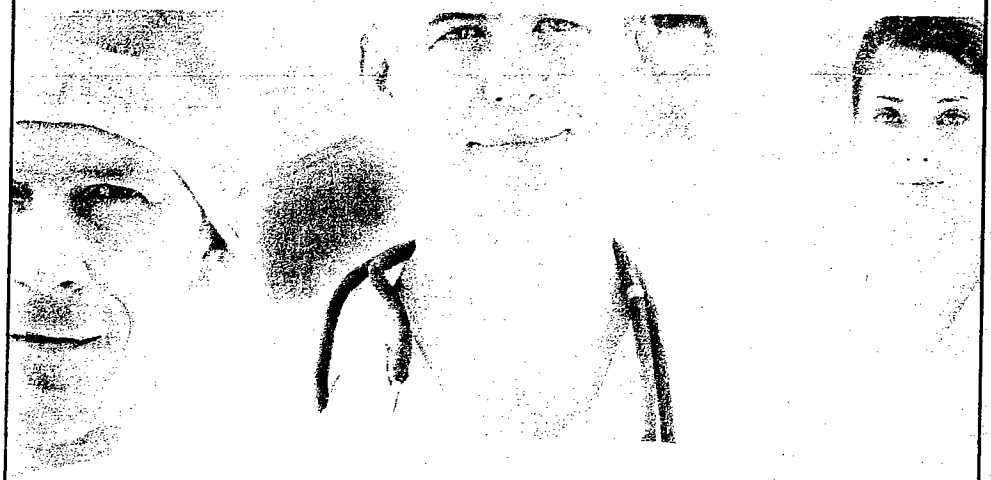
## Physician perspective

- ☐ initially skeptical
- ☐ essential to the future of physicians and RGH
- ☐ no longer "business as usual"
- ☐ allows you to be an independent practitioner
- ☐ retaining the benefits of a large group
- ☐ not ready for a full EMR
- ☐ begin the transition to use computers
- ☐ input into clinical guidelines & portal
- ☐ Pay-for-performance programs are coming
- ☐ rather set them up with "friends and family"
- ☐ maintain the bond of GRIPA physicians
- ☐ recognized for the excellent care we deliver

33

CLINICAL INTEGRATION

FOR ALL THE RIGHT REASONS



GRIPA

GRIPA

# ANNUAL 2005 REPORT

# FOCUS ON THE FUTURE

It's hard to believe that it's been 10 years since the Physician Organizations and Hospitals associated with ViaHealth forged a partnership and created the Greater Rochester Independent Practice Association. Physicians and Hospitals came together with the goal of improving the quality and efficiency of patient care in our community while also containing health care costs.

We've accomplished many milestones over the years:

- GRIPA is a · with 640 physician owners.

- Physician Compensation continues to be one of our top priorities. GRIPA has consistently led the community in paying higher conversion factors and in the distribution of significant risk withhold return and gain share. For the past four years GRIPA has paid the highest conversion factors for Preferred Care Gold and Preferred Care Commercial in the community.

- GRIPA was ranked number 3 in the Rochester Top 100 in 2004 and 2005. The Rochester Top 100 is sponsored by the Rochester Business Alliance and the local office of KPMG, a world-wide accounting firm. Companies must have at least $1 million in revenue for three consecutive years and ranking takes into account both dollar and percentage growth.

- GRIPA works with Preferred Care to administer programs for Preferred Care Commercial and Preferred Care Gold.

- Over the years, GRIPA also worked with Excellus Blue Cross Blue Shield to administer programs for Blue Choice (GRIPA *Choice-Choice*) and the ViaHealth Plan.

- ViaHealth PPO, Inc. a GRIPA affiliated company, provides a provider network and medical management services for HealthNow New York, Inc., Private Healthcare Systems, Inc. (PHCS) and Fidelis Care New York.

- GRIPA recently entered into a partnership with WellCare, the largest Medicaid and Medicare-only contractor in the nation. WellCare chose to work with GRIPA because WellCare members need access to high quality community provider networks and excellent health benefits and services.

- ViaHealth PPO, Inc. messengers contracts to Network providers for non-risk business.

- GRIPA Care Managers, Consulting Clinical Pharmacists and Information Technology staff are available to help physicians on site to improve office systems and optimize patient care.

- GRIPA staff are known as national experts in areas of compensation, reporting, information technology and data analysis and are frequently asked to speak at national conferences.

Michael Kukfa, M.D.

Gregg Coughlin

Eric Nielsen, M.D.

# WHAT'S NEXT FOR GRIPA?

Risk based contracting as we know it will soon be a thing of the past. For the past 18 months, GRIPA has been studying alternatives for the best working model for community based physicians. Based on our research and understanding of this community we are confident that the answer is **GRIPA Connect™ Clinical Integration.**

GRIPA Connect Clinical Integration

Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care.

Fully implemented, Clinical Integration will allow a physician to access patient records from a GRIPA-provided laptop in the examining room, review clinical guidelines with the patient, electronically order prescriptions and lab procedures, make notes available to a referred specialist, track patient compliance, and more. Patient records will be accessed through a secure web portal that will be compatible with a wide range of Electronic Medical Records systems, but you will NOT need EMR to use the portal.

Clinical Integration will enable us to demonstrate improved patient outcomes and cost-effectiveness so that physicians in the network, working together through GRIPA, will be able to sell payors our combined services. This ability to offer the GRIPA network and its new program through single-signature contracts will help GRIPA and our physician practices remain competitive in the market while improving the health of our patients.

We believe the result will be better clinical guidelines, better care for patients, and—as a result—better pay for physicians. Our goal is to begin enrolling physicians in GRIPA Connect by mid-summer 2006.

We are working diligently with our lawyers to assure that our processes meet Federal Trade Commission guidelines. GRIPA staff members are all involved in the development of Clinical Integration and we have developed several committees that our membership are invited to join.

There is only one other health system in the nation that has successfully implemented the Clinical Integration model but we are confident that our skilled physicians and stellar hospitals are just the right partnership to be successful in this model.

For more information on Clinical Integration please visit the website at www.gripaconnect.com

GRIPA, the Rochester General Physicians Organization, the Wayne County Physicians Organization, Rochester General Hospital and Newark-Wayne Community Hospital have made great strides over the past 10 years as we worked together for common purposes. Clinical Integration promises to be a best-practices alliance of knowledge, technology and skill that we believe will address the current pressures on our health care system and most importantly will help us achieve our common goal of the highest quality in patient care.

Sincerely,

MICHAEL KUKFA, M.D.
Chair
GRIPA Board

GREGG COUGHLIN
President
GRIPA

ERIC NIELSEN, M.D.
Chief Medical Officer
GRIPA

# GRIPA Board of Directors and Committee Members

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Jodi Lubba, B.S.N.

**Committee Changes In 2006**

A Clinical Integration Committee has been formed which reports to GRIPA BOD. This committee will replace the Utilization Management Committee and the Quality Improvement Committee. Specialty Advisory Groups are also being developed with 3-5 physicians in each major specialty. A Quality Assurance Council is also being added. The RGH HARP and the Newark-Wayne HARP Committees have been discontinued.

### GRIPA CONTACTS

**Gregg Coughlin,** President
585-922-1529
**Eric Nielsen, M.D.,** Chief Medical Officer
585-922-3062

# Greater Rochester IPA

## Audited Financial Summary for Year Ended 12/31/05

# GRIPA Connect: The Short Version

## EXACTLY WHAT IS CLINICAL INTEGRATION?

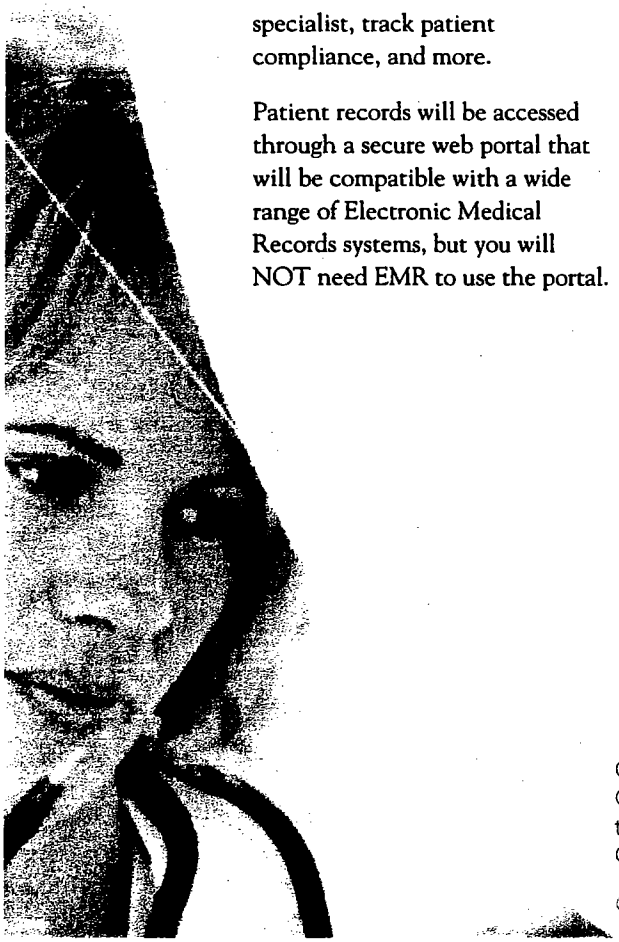
Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with:

- electronic access to complete patient information,
- support from patient care managers and
- assistance to fulfill a commitment to evidence-based clinical care.

## A LOOK AT A CLINICALLY INTEGRATED PRACTICE

Fully implemented, GRIPA Connect Clinical Integration will allow a physician to access patient records from a GRIPA-provided laptop in the examining room, review clinical guidelines with the patient, electronically order prescriptions and lab procedures, make notes available to a referred specialist, track patient compliance, and more.

Patient records will be accessed through a secure web portal that will be compatible with a wide range of Electronic Medical Records systems, but you will NOT need EMR to use the portal.



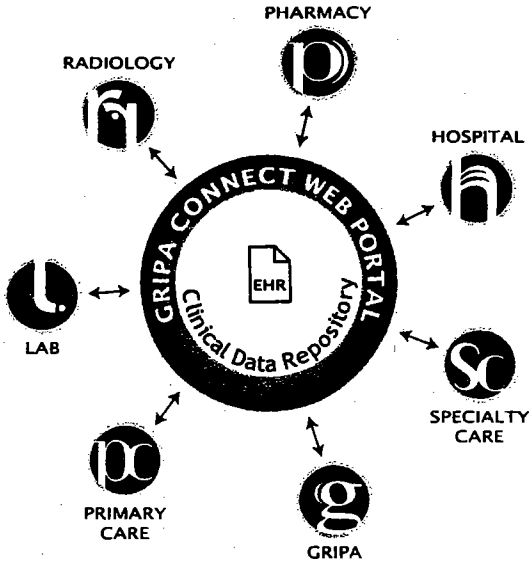
## WHAT IT MEANS FOR RELATIONSHIPS WITH INSURERS

Clinical integration will enable us to demonstrate improved patient outcomes and cost-effectiveness so that physicians in the network, working together through GRIPA, will be able to sell payors our combined services.

This ability to offer the GRIPA network and its new program through single-signature contracts will help GRIPA and our physician practices remain competitive in the market while improving the health of our patients.

**Q** If I enroll in GRIPA Connect, can I contract with an insurer that GRIPA does not contract with?

**A: GRIPA is intending to contract with physicians non-exclusively, so you could contract separately with an insurer with whom GRIPA does not have a relationship.**




**Q** Can I participate in GRIPA Connect even if my practice partners do not?

**A: Yes. All RGPO and WCPO shareholders are individually eligible to participate in GRIPA Connect. Whether you are a solo practitioner or an employee of a larger practice or entity and whether or not your partners or associates participate, you can still participate in GRIPA Connect. Some employers may have restrictions, but ViaHealth-employed physicians are being permitted to participate.**

## GET UP TO SPEED ON GRIPA CONNECT

- Look for these newsletters. We'll send them out often to keep you informed.
- Visit our web site: www.GRIPAconnect.com
- Attend a GRIPA Connect dinner meeting or another GRIPA Connect presentation. We're speaking often and everywhere. See the back of this newsletter for details.

GRIPA is a partnership of physicians and hospitals in Monroe, Wayne, and Ontario Counties of the Greater Rochester region, including 510 private physicians and 130 employed physicians, as well as the Rochester General Hospital, Rochester General Physicians Organization, Newark Wayne Community Hospital, and the Wayne County Physicians Organization.

## KELLY TADDEO TO LEAD PHYSICIAN ENROLLMENT

Kelly Taddeo, GRIPA Director of Provider Relations and Network Services, will spearhead the Clinical Integration Physician Enrollment Process. Kelly will contact physicians, be responsible for contracting activities, and be the point person for questions about Clinical Integration.

Kelly has worked for GRIPA for six years and in the ViaHealth System since 1997. She has extensive experience with physician education activities and contracting initiatives and works closely with physicians, hospitals and insurance partners.

Kelly holds a B.S. from State University of New York at Brockport and a Master's in Health Systems Administration from Rochester Institute of Technology. She resides in Greece with her husband and son.

Contact Kelly at 585.922.1543 or at Kelly.Taddeo@GRIPAConnect.com.

GRIPA™
Clinical Integration

GRIPA
60 Carlson Road
Rochester, NY 14610

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for all the right reasons

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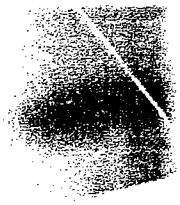

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Clinical Integration

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for all the right reasons

## On the road to Clinical Integration—
## *we're making progress!*

We submitted a request to the FTC for a prospective advisory opinion at the beginning of May. Within the next few weeks, we expect to hold face-to-face discussions with FTC staff to review our plans and receive preliminary feedback. (Stay informed by checking in on our web site—www.GRIPAconnect.com.)

# UPDATE

SEPT 2008 ISSUE 1

## Dispelling Myths & Misperceptions: Just the Facts about Clinical Integration

*Also inside...*

- **Meet Jen Giudice**, Provider Relations Account Manager & Trainer
- November 9—Save the Date for **RGPO/WCPO Annual Meeting**

GRIPA™

Clinical Integration

**Physicians coming together for all the right reasons**

GRIPA
60 Carlson Road
Rochester, NY 14610



## JENNIFER GIUDICE NAMED PROVIDER RELATIONS ACCOUNT MANAGER AND TRAINER

GRIPA welcomes Jennifer Giudice as Provider Relations Account Manager and Trainer. Jen is responsible for ongoing training and support activities of the GRIPA Connect Web Portal as well as providing professional support to physician members of GRIPA.

Jen most recently served as an Inside Sales Representative for Butler Animal Health Supply but she is a familiar face at GRIPA where she worked in Network Services for three years. She also worked as a Pharmacy Technician at Rochester General Hospital for nine years.

The Rochester native received her Bachelor of Arts degree in Health and Human Services from the State University of New York at Buffalo. "I look forward to working with physicians and their office staffs on the implementation of GRIPA Connect Clinical Integration," says Jen. "It is an exciting time to be working for GRIPA."

Contact Jen at 585.922.1536 or via email at Jennifer.Giudice@viahealth.org.

**Sign up for a Dinner Meeting in October**

Join us on October 17 or October 28 at 6:15 p.m. at the DelMonte Lodge. GRIPA Physicians and Office/Practice managers are welcome. RSVP by calling 922-1525 or online at GRIPAconnect.com.

## ERIC NIELSEN, M.D., NAMED CHAIR OF MSSNY TASK FORCE ON CLINICAL INTEGRATION

GRIPA Chief Medical Officer Eric Nielsen, M.D., has been named Chair of the Medical Society of the State of New York (MSSNY) Task Force on Clinical Integration.

MSSNY recently formed the task force to:

- Study the opportunities and risks associated with clinically integrated groups;
- Develop materials to educate the membership on the legal, business, ethical and clinical issues associated with clinically integrated groups;
- Develop policy and legislative recommendations on the issue; and
- Formulate a white paper on the issue, in concert with the AMA.

"I believe Clinical Integration will be of increasing interest to independent physicians in New York as well as nationally, and I complement MSSNY on its decision to develop a resource on this issue," said Dr. Nielsen.

GRIPA Member David Hannan, M.D., also serves on the task force.

Fname Lname, Degree
Group Practice Name
Street
Street 2
City, State Zip

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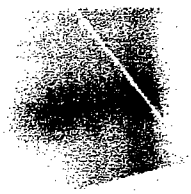
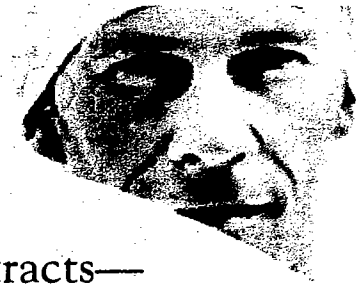




GRIPA

Clinical Integration
Physicians coming together
for all the right reasons

# Physician Participation Contracts—
## *answers to frequently asked questions*

In mid-summer of 2006, we sent out contracts to GRIPA Primary Care Physicians and Specialists in private practice. Over the last several months we have spoken to hundreds of physicians at dinner meetings and other events, but of course the details of contracts always bring up new questions. One of the most common questions has been why sharing billing information with GRIPA is necessary for Clinical Integration. Find the answer inside–and visit our web site: www.GRIPAconnect.com–for a more complete list of FAQs.

August 2006 UPDATE
GRIPA Connect

July 5, 2006

Dear Dr. ,

As you probably know, GRIPA is embarking on a new initiative, GRIPA Connect™ Clinical Integration.

Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care. It will allow us to contract as a group with various payors without accepting financial risk and withholds.

We are in the process of building the GRIPA Connect web portal and beginning to "populate" the data repository with patient information from health care providers. Several lab and imaging facilities have asked us to accelerate the process of enrolling physicians in the network so that they can feel assured that they are sharing patient data appropriately, with the consent of providing physicians.

As a result, we are attaching a **GRIPA Physician Participating Provider Contract – Clinical Integration**. This supplements but does not replace your present contracts with GRIPA for HMO business as a financially integrated group accepting capitated risk; but with this contract we can contract with HMO's without taking a withhold. We are including an **Executive Summary** of this contract so you can gain a quick understanding of the notable points. Several are different from the usual provider contract, but are essential to a clinical integration program.

We are also enclosing a **ViaHealth PPO Physician Participating Provider Contract - Clinical Integration**, which will succeed your present contract with ViaHealth PPO and cover all non-HMO business. If you choose not to participate in GRIPA Connect Clinical Integration, your present ViaHealth PPO contract will remain in place until GRIPA terminates the recently messengered non-risk payer contracts.

Enclosed you will find a total of 8 contract signature pages. **You will need to sign and return all 8, if you wish to participate in GRIPA Connect Clinical Integration. We will then send you counter signed copies of these documents by return mail as confirmation of enrollment.**

It is a requirement of GRIPA Connect participation that each provider **individually** sign the enclosed contracts. No one, including your practice

manager or an employer, can sign for you; but you should confirm with your employer that you are authorized to sign.

It is not necessary that other partners or associates in your practice sign these contracts for you to sign.

**Please mail all copies completed signature pages for both contracts and both Business Associate Agreements to:**

GRIPA Network Services
60 Carlson Road
Rochester, NY 14610

or fax to 585-922-0016

If, after careful thought, you have decided that collaborating with your colleagues in providing quality care and contracting together is not for you, please complete the enclosed letter of refusal and return to GRIPA Network Services as above. You should know that failure to sign these new contracts will terminate your present ViaHealth PPO contract and limit your participation in GRIPA to HMO contracts requiring a withhold.

**All eligible physicians are encouraged to enroll before 8/11/2006 to have your patient data, including a planned six-month backload, available to you on the portal at first productive use later this summer.** Although we will do our best to accommodate everyone, late enrollees will experience delays in data availability and may not be provided a backload.

Portal User Rules, as referenced in the contract, will be forwarded when available.

You can learn more about GRIPA Connect and about Clinical Integration by visiting our web site: http://www.GRIPAconnect.com. Please feel free to contact us with any questions or concern. I can be reached at eric.nielsen@viahealth.org or 585-922-3062. Kelly Taddeo, Director of GRIPA Network Services can be reached at kelly.taddeo@viahealth.org or 585-922-1525.

Sincerely,

Eric T. Nielsen

Eric T. Nielsen, MD
Chief Medical Officer

RISK-BASED CONTRACTS ARE GOING AWAY.

What's next for Rochester's community-based physicians?

GRIPA

Clinical Integration

PLEASE JOIN US FOR DINNER AND A FRANK DISCUSSION.

August 21, 2006

(Fname) (Lname), (Degree)
(Group Practice Name)
(Street)
(Street 2)
(City), (State) (Zip)

Dear Dr. (Lname),

Once again, the landscape of health care is changing in our country. For the last 18 months, your Greater Rochester Independent Practice Association (GRIPA) has been grappling to define the next working model for community-based physicians.

We believe Clinical Integration offers us the best of all worlds—an innovative, effective way to preserve what's best about our Network, improve the quality of patient care, and manage costs in an increasingly cost-conscious market. As we deliver on all those requirements, Clinical Integration will also allow us to sell our services as a group to payors and receive better reimbursement for a better product.

Clinical Integration will mean changes in the way we practice. It requires the creation of a connected community of physicians, hospitals, labs and imaging facilities with:

- electronic access to complete patient information,
- support from patient care managers, and
- assistance to fulfill a commitment to evidence-based clinical care.

As one of our colleagues wrote to us after an early meeting, "The idea sounds great but the details will obviously be important." Now is the time to dive into the details with us.

I hope you'll join us for one of the two dinner meetings we have planned in September. I also hope you will bring your office manager with you. We'll present the basic case, answer questions and invite your comments. We will pay particular attention to concerns you have about the GRIPA Connect Physician Participation Contracts that we have sent out for your signature. Meetings will be limited to about 20 physicians so everyone can have their say.

Please respond as soon as you can. I look forward to a lively and enlightening discussion.

Best regards,

Eric Nielsen, M.D.
Chief Medical Officer

Learn more at www.GRIPAconnect.com

## FAQ about Provider Agreements for Clinical Integration

**What is the responsibility for the office billing person or billing service for submitting billing info to GRIPA?**

GRIPA has established a process for physicians using Medent to submit a copy of all billing data to GRIPA electronically, at no charge to the physician, and is actively working with Perfect Care, Practice Made Perfect, and Specialist. GRIPA will offer technical assistance to any vendor interested in providing this service. If you want GRIPA to approach your vendor, please contact Kelly Brady, Manager of Technical Development at GRIPA, either kelly.brady@viahealth.org or 585-922-1580 or contact GRIPA Network Services at or 585-922-1525.

A generic vendor contract and a document specifying the data requirements for transferring this information electronically to GRIPA have been prepared and can be sent to any vendor on request. If your vendor cannot provide this service, you will be required to submit a paper copy of all your billings by fax or mail.

**Isn't it a HIPAA violation for offices to send billing info to GRIPA for insurance plans not contracted with GRIPA and for government programs such as Medicare and Medicaid?**

No. GRIPA is a provider organization using this information for treatment of patients and improvement of the quality of health care its members deliver. GRIPA has HIPAA Business Associate Agreements with each of its physicians, which allow for the sharing of patient information for these purposes.

**What type of information is GRIPA looking at in the billing data sent by the offices?**

GRIPA will be collecting the ICD9 and CPT codes, as well as patient identifiers. This information will be used to create patient health records in the GRIPA Connect web portal, which will be used by GRIPA members to deliver and coordinate higher quality care as part of GRIPA Connect Clinical Integration. The billing data will help GRIPA to record diagnoses for patients and monitor whether patients receive the care recommended by the GRIPA Clinical Guidelines. For example, to establish a diagnosis of diabetes requires an appropriate ICD9 code, and to verify that a physician evaluated the diabetic patient 2-4 times/year requires CPT codes.

**Is GRIPA planning to use billing data to compare productivity of one physician versus another?**

GRIPA is primarily interested in quality and efficiency of care for all patients treated by our physicians and has no interest in comparing productivity of one physician to another or in computing a physician's gross income. Everything that

GRIPA does with this information is under the direction of the Clinical Integration Committee comprised of 6 PCPs and 6 specialty physicians from our panel.

**Why does GRIPA want physicians' office schedules?**

Initially, GRIPA's Care Management Services department will use the scheduling information, when working with specific physicians and offices, to identify opportunities for case, disease, and pharmacy management services that will benefit patients coming in for appointments. In the future, GRIPA will send prompts to physicians and offices about patients scheduled for appointments who are in need of particular care under GRIPA's guidelines. For e-prescribing, the physicians' office schedules will allow GRIPA to preload expected patient lists, which will make the name-search lists shorter and save physicians time when creating electronic prescriptions. GRIPA does not plan to use scheduling information in any manner without prior approval of its physician committees, and it will only make such information available to appropriate GRIPA staff.

**Why are physicians not able to opt out of GRIPA products under Clinical Integration?**

For its future PPO fee-for-service contracting, GRIPA needs to be able to offer a reliable, defined network in order to provide value in the market-place and ensure that all members are cooperating in the improvement of the quality and efficiency of the care GRIPA's members provide. Collaboration in the care of patients, an integration requirement of the FTC, can only be optimized when all GRIPA physicians participate in all GRIPA contracts. Administrative feasibility and marketplace acceptance of the program would also be diminished if physicians were allowed to opt out.

**What happens if a physician chooses not to enroll in the Clinical Integration Program?**

He or she will be able to continue in our present risk contracts and be eligible for future fully capitated risk contracts as long as they are available. He or she will remain in our old PPO contracts only until the end of the current renewal period, usually until 1/1/07, and would not be eligible for any future PPO contracts.

**What are the Clinical Guidelines? And who makes them up?**

The Clinical Integration Committee ("CIC"), consisting of 6 PCP's and 6 specialists appointed by the GRIPA Board from the GRIPA panel for a three-year term, has the responsibility for choosing the guidelines that will be used to measure performance. GRIPA staff will present information from relevant national guidelines including NCQA, HEDIS, AHRQ, as well as the Rochester Community Wide Guidelines to meetings of Specialty Advisory Groups, which will include GRIPA panel representatives from all specialties to be measured by each

guideline. The Specialty Advisory Groups will make recommendations to the CIC regarding modifications to these proposed guidelines. The CIC will then discuss each guideline, and any necessary modifications, during at least two separate monthly meetings before recommending approval, after which each guideline will be approved by the Board and then made available on the portal. Feedback will be solicited every 6 months from all affected physicians and each guideline will be formally reviewed by the CIC annually. Guidelines will likely be chosen to touch as many specialties as possible, touch the common disease states of our patients, include preventive care, and focus on quality and efficiency of care.

**How will GRIPA deal with poor performers?**

GRIPA is primarily interested in improving quality and efficiency of care. Performing below the targets of the guideline measures will provide the physician, and his or her office staff, an opportunity to work with the GRIPA Care Management staff to improve care to high-risk patients and to help identify and correct the process issues that may be impacting performance. If a physician does not participate in these efforts and continues to have poor performance, his or her case will be discussed in detail at the monthly Quality Assurance Council meeting of 16 of his or her peers, selected by lottery from the entire panel for a one year term, and a corrective action plan will be developed and overseen. If the Council's expectations are not met, there will be sanctions in the form of loss of financial bonuses and the possibility of expulsion from the Clinical Integration Program.

**How can we deal with poor performance due to non-compliant patients?**

GRIPA will be able to identify most of our non-compliant patients from the lab, imaging, and billing data and will also solicit names from physicians' offices of their non-compliant patents. GRIPA is asking permission from our physicians for the GRIPA Care Management staff to directly contact these patients to identify and, if possible, correct the barriers to compliance and follow-up. The great services that the Care Management Services ("CMS") provides - including disease, case, and pharmacy management - will now be available on a larger scale to help physicians and their patients.

**Why can't we use the Community Wide Guidelines developed by the Rochester Health Commission in the past and now the Monroe County Medical Society?**

We are in fact using the Community Wide Guidelines as reference material along with those of national organizations such as NCQA and AHRQ. GRIPA must develop its own unique set of guidelines, agreed upon by committees of GRIPA physicians, with the opportunity of feedback from the entire panel. The guidelines must be as stringent as those we have used for our risk business; and where our

physicians disagree with national or regional evidence-based guideline, we will use the opinions of our physicians.

**Why is GRIPA separating itself from the Rochester RHIO, which has the potential to bring the entire community of physicians together?**

We consider ourselves a test case for the Rochester RHIO, as GRIPA is probably 2 years ahead of the RHIO in implementation. We hope, though, that the RHIO can build on the work that we have already done. It is possible that GRIPA's web portal could connect to the prospective Rochester RHIO at a future date if the RHIO permits it. The RHIO is, however, unlikely to provide all of the features of GRIPA's portal. As a tool for Clinical Integration, GRIPA's portal will have not only electronic health records, but also referral management, lab order entry, clinical guidelines with patient-specific prompts, e-prescribing, and monitoring and feedback for physicians.

**Is GRIPA competing with the new Rochester Regional Health Information Organization (RHIO)?**

GRIPA has been represented at meetings of the Rochester Health Commission RHIO committee and financially supported the feasibility study for the RHIO. It may have been theoretically possible for GRIPA to use the RHIO architecture for its clinical integration efforts, but it became clear that it would be at least 2008 before the RHIO would be able to start sharing clinical data. GRIPA's collection of information for a portion of the medical community will in no way disadvantage the prospective community-wide Rochester RHIO. GRIPA and the Rochester RHIO did both apply for funding from the $53M HEAL NY grant program. The Rochester RHIO received $4.4M, GRIPA received $0.228M. GRIPA will continue to work with the Rochester RHIO.

**Why do we have to become clinically integrated before the FTC makes their decision about our request for an advisory opinion?**

We are implementing our plan for the Clinical Integration Program in parallel with our submission of a request for an advisory opinion on our plan from the FTC. It is unlikely that we will be fully clinically integrated before the FTC gives us their ruling, which we expect in late 2006 or early 2007. We have been in the process of developing the Clinical Integration Program since June 2005. It will take us until 2007 to complete the process. If we had waited to begin until we had the FTC ruling, we could not hope to complete the process until 2009.GRIPA also has the staff and resources to implement the Program now and likely would not if we had waited another 2 years.

**Aren't you asking us to just trust GRIPA?**

You can terminate your participation on 90 days notice at any time. The Program is as "user friendly" as possible, while still maintaining the elements essential to achieving clinical integration. The purpose of the program as stated is to improve quality and efficiency of care, which cannot be achieved unless we contract together.

**What are the advantages of participating in the Clinical Integration Program?**

Physicians will receive assistance in providing quality care, improving efficiency, and implementing evidence-based guidelines in their practices. They will also receive assistance integrating information technology into their practices, without having to absorb either the cost or the workflow disruption of a full EMR. They will receive the satisfaction of knowing that the investment of their time and effort will benefit their patients, their community, and their colleagues. Physicians will contract with payers as a group for the Clinical Integration Program, but will not need to accept a risk withhold or give up the independence of private practice. By providing a better, higher quality product to payers, GRIPA will be able to seek premium rates for its members.

**What about the referral relationships that some specialists maintain with out-of-network primary care physicians?**

Through the participation contract, GRIPA physicians have agreed to refer patients in-network whenever medically reasonable. There are two advantages to keeping referrals in the GRIPA network. First, each referral presents an opportunity for collaboration in the care of GRIPA patients, which is an essential component of clinical integration. Second, the portal will only include information about the care provided, tests ordered, diagnostic images ordered, and prescriptions written by GRIPA physicians. In-network referrals optimize the availability of this information, giving GRIPA physicians the advantage of the most-complete information available on their patients. GRIPA does not, however, intend to disrupt existing referral relationships. Patients referred by non-GRIPA PCPs to GRIPA specialists will remain the patients of the non-GRIPA PCPs.

GRIPA alert
Published by the Greater Rochester Independent Practice Association

Att: GRIPA PHYSICIANS
Date: September 1, 2006

The new GRIPA Physician Agreements for Clinical Integration were sent to all our physicians on 7/10/06. We currently have 141 signed contracts. ViaHealth has indicated its intention to sign for its employed physicians.

It was suggested that physicians sign the contracts by 8/11/06 to be included in the data backloads from our data sources, but there is no deadline. Physicians can sign up at any time. For the most part, GRIPA staff will be prioritizing offices for rollout depending on the dates the contracts are received.

**Some of our physicians have indicated that they are waiting to sign the Agreement until they have seen the legal review of the Agreement being done for the Monroe County Medical Society, at the request of one or more of its members. The MCMS is now in the process of distributing their review of our contract.**

As GRIPA has previously learned, the issues involved in Clinical Integration require extensive legal analysis. GRIPA has enlisted the help of lawyers specializing in antitrust issues. Many of the concerns raised in the Medical Society's review have been addressed in the 2-page Contract Summary sent to physicians with the contracts and in the FAQ's already on the GRIPAconnect.com website.

Please feel free to contact us as below if there are any further legal or contractual questions, and we will get answers from GRIPA's legal team.

**Some physicians have expressed concerns that by sending GRIPA their billing data, they may be violating some HIPAA or other privacy regulation at the state or national level.**

Please be assured that GRIPA staff has discussed this issue with its attorneys based both in New York and Washington, D.C. and there is no cause for concern. The information conveyed to GRIPA or its contracted vendor(s), including billing information supplied by physicians and clinical data supplied by labs, hospitals, or other providers, will be used and disclosed by GRIPA solely for treatment, quality improvement or other purposes permitted under HIPAA. GRIPA will hold patient data on behalf of its physicians, with whom it has HIPAA Business Associate Agreements. GRIPA has entered into a written agreement with its vendor(s) requiring them to comply with the privacy and security obligations undertaken by GRIPA under its Business Associate Agreement with each physician.

If you have any questions please contact Eric Nielsen, MD Chief Medical Officer at 585-922-3062 or by email at Eric.Nielsen@viahealth.org or Kelly Taddeo, Director of Provider Relations at 585-922-1543.

Please visit GRIPAconnect.com for more information.

60 Carlson Road, Rochester, NY 14610-1021, Phone 585.922.1525, FAX 585.922.1510

GRIPA alert
Published by the Greater Rochester Independent Practice Association

Attn: GRIPA Physicians and Office Managers
Date: 8/13/2006
Re: GRIPA Clinical Integration Contracts

The new GRIPA Physician Agreements were sent to all our Primary Care and Specialist physicians on 7/10/06 and we are currently receiving signed contracts. ViaHealth has indicated its intention to sign for its employed physicians as well.

It was suggested that physicians sign the contracts by 8/11/06 to be included in the data transmissions and backloads from our data sources, but there is no deadline to sign. Physicians can sign up at any time. GRIPA staff will be prioritizing offices for rollout depending on the dates the contracts are received.

Some physicians have expressed concerns that by sending GRIPA their billing data, GRIPA would know and be able to compare their income with their colleagues. Our purpose in creating a Clinically Integrated Network is to serve our physicians and their patients.

Nevertheless, please be assured that GRIPA will not know what payors actually pay to physicians. To further allay any concerns, the GRIPA Board of Directors passed the following resolution on 8/9/06:

- **GRIPA will not store the actual monetary charges for services included in the copy of standard 837 billing transactions obtained electronically by GRIPA from physicians' practice management systems.**
- **This resolution and any future changes will be approved by the GRIPA Board of Directors and, following any such approval, will be distributed to the entire physician panel of the Clinical Integration Program.**

If you have any questions please contract Eric Nielsen, MD Chief Medical Officer at 585-922-3062 or by email at Eric.Nielsen@viahealth.org or Kelly Taddeo, Director of Provider Relations at 585-922-1543.

Please visit GRIPAConnect.com for more information.

GRIPA alert
Published by the Greater Rochester Independent Practice Association

# FAQ about Provider Agreements for Clinical Integration

**Attn: Office Manager/GRIPA Physicians**
**Date:** July 31, 2006

As you probably know, GRIPA is embarking on a new initiative, GRIPA Connect Clinical Integration.

**We have been getting many questions about the Clinical Integration contracts that were sent on July 7th. We have posted all the questions and answers on the GRIPAConnect website. To view them please go to www.gripaconnect.com. If you would rather have a copy faxed to your office please contact us at 585-922-1525.**

**Listed below are just a few of the questions and answers you will find.**

**What are the advantages of participating in the Clinical Integration Program?**

Physicians will receive assistance in providing quality care, improving efficiency, and implementing evidence-based guidelines in their practices. They will also receive assistance integrating information technology into their practices, without having to absorb either the cost or the workflow disruption of a full EMR. They will receive the satisfaction of knowing that the investment of their time and effort will benefit their patients, their community, and their colleagues. Physicians will contract with payers as a group for the Clinical Integration Program, but will not need to accept a risk withhold or give up the independence of private practice. By providing a better, higher quality product to payers, GRIPA will be able to seek premium rates for its members

**What type of information is GRIPA looking at in the billing data sent by the offices?**

GRIPA will be collecting the ICD9 and CPT codes, as well as patient identifiers. This information will be used to create patient health records in the GRIPA Connect web portal, which will be used by GRIPA members to deliver and coordinate higher quality care as part of GRIPA Connect Clinical Integration. The billing data will help GRIPA to record diagnoses for patients and monitor whether patients receive the care recommended by the GRIPA Clinical Guidelines. For example, to establish a diagnosis of diabetes requires an appropriate ICD9 code, and to verify that a physician evaluated the diabetic patient 2-4 times/year requires CPT codes.

**Please take the opportunity to join us tonight, Monday July 31st at 5:30pm in the TWIG Auditorium at Rochester General Hospital to find out more about Clinical Integration and get your questions answered. No RSVP is necessary.**

Please feel free to contact us with any questions or concern. Please contact Dr. Nielsen, Chief Medical Officer at eric.nielsen@viahealth.org or 585-922-3062. Kelly Taddeo, Director of GRIPA Network Services can be reached at kelly.taddeo@viahealth.org or 585-922-1525.

GRIPA alert
Published by the Greater Rochester Independent Practice Association

## CLINICAL INTEGRATION

**Please take the opportunity to join us on Monday July 31st at 5:30pm in the TWIG Auditorium at Rochester General Hospital to find out more about Clinical Integration and get your questions answered. No RSVP is necessary.**

## Attn: Office Manager/GRIPA Physicians

**Date: July 27, 2006**
**Subject: Clinical Integration Contracts**

As you probably know, GRIPA is embarking on a new initiative, GRIPA Connect Clinical Integration.

Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care. It will allow us to contract as a group with various payors without accepting financial risk and withholds.

We are in the process of building the GRIPA Connect web Portal and beginning to "populate" the data repository with patient information from health care providers. Several lab and imaging facilities have asked us to accelerate the process of enrolling physicians in the network so that they can feel assured that they are sharing patient data appropriately.

**Contracts were mailed to GRIPA physicians on July 7, 2006 and we are asking that you please return them by August 11, 2006. If you have not received your contracts please contact us at 585-922-1525.**

You can learn more about GRIPA Connect and about Clinical Integration by visiting our web site: http://www.GRIPAconnect.com. Please feel free to contact us with any questions or concern. I can be reached at eric.nielsen@viahealth.org or 585-922-3062. Kelly Taddeo, Director of GRIPA Network Services can be reached at kelly.taddeo@viahealth.org or 585-922-1525.

Sincerely,

Eric T. Nielsen

Eric T. Nielsen, MD
Chief Medical Officer

# Clinical Integration: How will it work for you?

Join us to learn more—
and voice your opinion.

**Physicians' Dinner Meetings**
Wednesday, June 21
Thursday, July 13
Tuesday, August 8

DelMonte Lodge
41 North Main Street, Pittsford

Dinner is served at 6:15 pm;
program begins at 6:30 pm

Attendance is limited to fewer than
20 physicians; ample time for Q&A
and a frank discussion

RSVP online at GRIPAconnect.com or by
contacting Kelly Taddeo @ 585-922-1543
or at info@GRIPAconnect.com

GRIPA

# For the earliest online access to your patient data, return your signed contracts by July 31!

Put your signed GRIPA Connect Clinical Integration contracts in the mail by July 31 and we will have all of your available patient data, plus a six-month backload, loaded onto the GRIPA Connect web portal and available to you when the portal first comes online.

Late enrollees may experience delays in data availability and may not be provided a backload.

**GOT QUESTIONS? GET ANSWERS.**

We will hold three Q&A sessions on the new GRIPA Connect contracts:

**5:30 PM**

**TUESDAY**
**JULY 11, 2006**

**THURSDAY**
**JULY 20, 2006**

**MONDAY**
**JULY 31, 2006**

**TWIG AUDITORIUM**
Rochester General Hospital

No RSVP necessary;
come whenever you can.

GRIPA

Clinical Integration

Physicians coming together
for all the right reasons


Technology made accessible

Knowledge made applicable

Collaboration made possible

patients made healthier

GRIPA™

Clinical Integration

# GRIPA™

Clinical Integration

## A best-practices alliance

### WHAT'S NEXT—AND BEST FOR EVERYONE?

The last decade in health care was distinguished by the emergence of HMO-based models in which providers shared financial risk with insurance companies, motivating everyone in the system to find ways to cut costs while improving quality of care. One of the results was the creation of physician-led networks, often in the form of Independent Practice Associations. GRIPA, or Greater Rochester Independent Practice Association, grew out of this market model.

Today, like many of our colleagues across the nation, we're faced with the market-led demise of risk-based contracting models, and have been searching for the next, best, most viable way for physicians to work together on behalf of patients. The model we have chosen is one called Clinical Integration.

At its core is a best-practices alliance of knowledge, technology and skill that we believe addresses the current pressures on our health-care system: to deliver higher quality care, to manage costs, to reimburse physicians such that we can continue to attract extraordinary talent, to stand up to stringent public accountability.

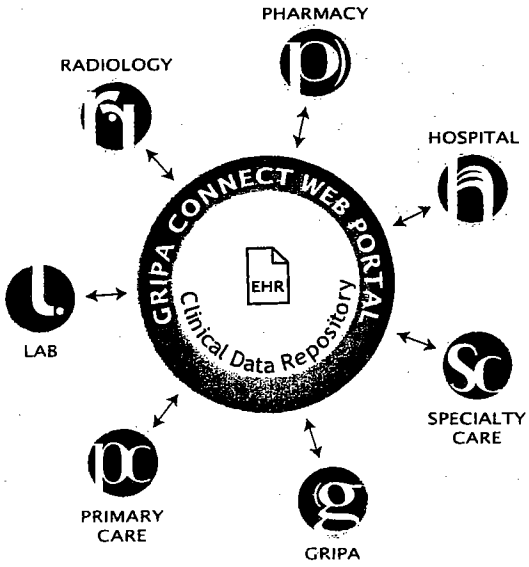
### GRIPA CONNECT™ CLINICAL INTEGRATION—DEFINED

GRIPA Connect Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with:

- electronic access to complete patient information,
- support from patient care managers, and
- assistance to fulfill a commitment to evidence-based clinical care.

We believe the result will be better clinical guidelines and better care for patients. Our goal is to begin enrolling physicians in GRIPA Connect by mid-summer 2006.

COLLABORATION THROUGH TECHNOLOGY
Instant access to a patient's health record through the GRIPA Connect web portal means physicians no longer spend valuable time chasing stray pieces of information, and patients avoid duplicative tests and diagnostic errors based on misinformation. The inclusion of evidence-based clinical guidelines, delivered as prompts during patient visits, makes possible a higher standard of care.



## THE THREE COMPONENTS OF CLINICAL INTEGRATION

The Federal Trade Commission and Department of Justice have described a clinically integrated network as one that implements "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and creates a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." The program should include: technology infrastructure to support the sharing of patient health and treatment records; collaborative disease and case management programs aimed at prevention and treatment; and commitment to evidence-based guidelines, with sanctions for those physicians not adhering to the standards.

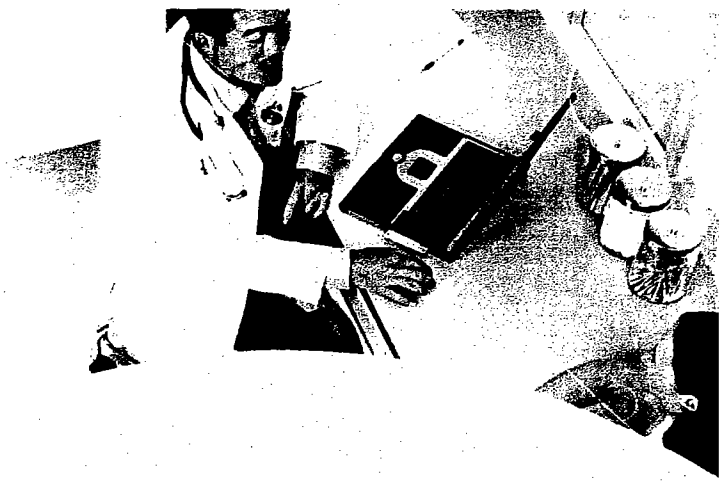
Networks that implement Clinical Integration programs are able to contract jointly with insurers where they can demonstrate that joint contracting is necessary to achieve the quality improvements in patient care. In the Greater Rochester market, this will allow independent, community-based practitioners to work together while maintaining their own practices.

## GRIPA CONNECT IN ACTION: ENVISION THIS

**A physician gets a call at midnight** that a patient suffering an acute illness in the ER. Rather than drive to his office to access the patient chart, the physician pulls the patient's record up on the GRIPA Connect web portal from his home computer. An email or phone call to the attending physician in the ER—who also has access to the record—assures that the patient's entire medical history, including drug allergies, is understood and accounted for during treatment.

**New diabetes management programs** offer great promise for managing the disease, but how best to get the information to every patient? Accessing web-based patient records, GRIPA care managers pull up the records of patients diagnosed with diabetes. They attach a clinical note to each chart about the most recent promising pharmaceutical intervention so the patient and doctor can discuss it during their next visit.

A cardiologist is called upon to see a patient. Rather than have staff take a complete medical history and order a battery of foundational tests, the **cardiologist reviews the already-complete history online and the results of tests already taken.** No reinventing the wheel or duplicating expensive procedures. The cardiologist orders a prescription electronically, and it's ready for the patient to pick up when he arrives at the pharmacy. The cardiologist can see that the patient did so.



## BENEFITS BUILT IN FOR EVERYONE

When fully implemented, GRIPA Connect Clinical Integration offers benefits for everyone.

### PATIENTS

- Improved safety
- Better access to the latest proven techniques and treatments
- Streamlined interactions with health care system—less waiting and duplication

### PHYSICIANS

- Ability to spend more time with patients, less time with paperwork
- Access to complete patient information
- Ability to deliver higher quality care
- Ability to monitor patient compliance
- Ability to sell combined services of network to payers makes independent practice more viable, especially for small practices

### HOSPITALS

- Improved clinical quality and patient safety
- Base of independent physicians aligned with hospital
- Ability to manage costs
- Differentiation in the market as high quality provider

### INSURERS

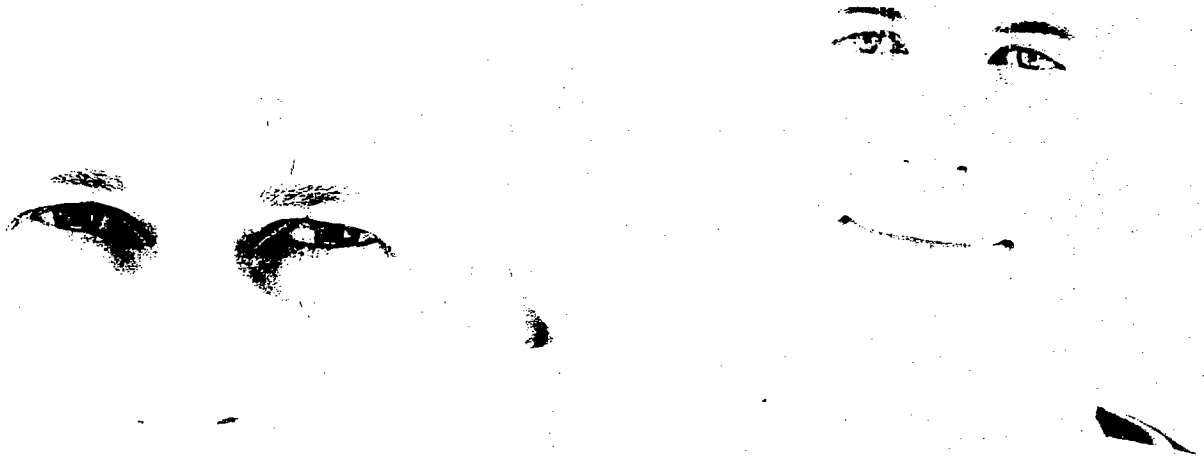
- Higher subscriber satisfaction
- Cost efficiencies and savings
- Better HEDIS scores
- Easy access to objective utilization data

### EMPLOYERS

- Containment of health care costs
- Healthier employees

### COMMUNITY

- Ability to maintain independent physician practices
- Better health care



## IMPLEMENTING GRIPA CONNECT: A MULTI-PHASE PROJECT

Fortunately, the foundation for the care management and clinical guidelines components of Clinical Integration are already in place at GRIPA. They will be strengthened through physician involvement and inclusion in the portal.

GRIPA has contracted with Healthvision, a Texas-based company with a track record of creating health care portals, to build the GRIPA Connect web portal. Development of the portal is currently underway. Phase One functionality is expected to be online in mid-summer of 2006, when GRIPA will begin enrolling physicians in GRIPA Connect.

Some physician offices will have access to advanced features during the initial rollout. E-prescribing, for instance, will be made available to physicians willing to use it. The referral management feature, which will facilitate transmission of a substantial amount of information between PCP and specialist offices, will be available to all and its use strongly encouraged. Lab order entry, which will require interfacing with those facilities, will be available a few months after the initial launch.

Because Clinical Integration is most effective with broad participation, GRIPA Connect is open to ViaHealth-employed physicians as well as those in private practice.

Physicians' offices currently run the gamut from fully electronic operations with Electronic Medical Records and Practice Management systems to those with paper records. To participate in GRIPA Connect, physicians will be required to obtain high-speed Internet access. GRIPA will provide a laptop or tablet computer to each physician, as well as training for physicians and office staff in how to use the portal. This is expected to ease and accelerate the transition to shared knowledge technology.

To assure that we are on the right track with the federal government, we are requesting an advisory opinion from the Federal Trade Commission.

*GRIPA is currently hosting meetings and informational sessions on GRIPA Connect. If you or your organization would like to learn more about this pioneering effort, we invite you to contact us.*

*Visit us at www.GRIPAconnect.com for the latest news on GRIPA Connect. Or email us at info@GRIPAconnect.com.*

**Gregg Coughlin**
**Chief Executive Officer**
**585.922.1529**

**Eric Nielsen, M.D.**
**Chief Medical Officer**
**585.922.3062**

## ABOUT GRIPA

GRIPA is a partnership of physicians and hospitals in Monroe, Wayne, and Ontario Counties of the Greater Rochester region, including 510 private physicians and 130 employed physicians, as well as Rochester General Hospital, Rochester General Physicians Organization, Newark Wayne Community Hospital, and the Wayne County Physicians Organization.

Physicians coming together
for all the right reasons

GRIPA

GRIPA | 60 Carlson Road | Rochester, NY 14610
Network Services: 585.922.1525
Care Management Services: 585.922.1520

GRIPA CONNECT™
CLINICAL INTEGRATION

# Physician Participation Contracts

We have been talking for some months about GRIPA Connect Clinical Integration, and are now ready to begin enrolling physicians in the Network. It's important that you review the attached agreements carefully before you sign. This Executive Summary will give you a brief overview of the notable features—in particular, some that may be unusual when compared to previous contracts.

## By signing these contracts,

YOU AGREE TO THE FOLLOWING:

1.

## GRIPA

### Clinical Integration

**Physicians coming together for all the right reasons**

Clinical integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care. It will allow us to contract as a group with payors.

2.

**Whenever it is medically appropriate, you will refer patients participating in GRIPA health plans to other physicians participating in GRIPA Connect Clinical Integration.** We are asking for this because we want patients to remain within the Network where they will be taken care of by physicians who are clinically integrated via the web portal, clinical guidelines, and case management. It's the best way to ensure that patients reap the benefits of our integration: safer, more effective care, with fewer gaps in care and duplicated efforts. Whenever a patient receives care outside the Network, GRIPA will be unable to collect data, resulting in a gap in the collective understanding of that patient's history and treatment. We do understand that there will be times when necessary services can only be obtained outside of GRIPA Connect.

*"Clinical Integration allows you to be an independent practitioner, while retaining the benefits of a large group. Clinical guidelines and pay-for-performance programs are coming soon, and I would rather set them up with "friends and family" than have them dictated to me by outside sources. I think Clinical Integration is an exciting opportunity to maintain the bond of GRIPA physicians and hopefully be appropriately recognized for the excellent care we deliver every day."*
—John Genier, M.D.

**You will make available to GRIPA information necessary to implement Clinical Integration: patient clinical data, medical records, and billing data.** Some of this data will be added to the central data repository, accessible via the GRIPA Connect web portal, so that providers can access it to care for patients. GRIPA will also use this data to establish Clinical Guidelines and improve the quality of care patients receive. We are asking for information in the following way:

- An electronic copy of all Claim Forms submitted to an insurer should be sent to GRIPA. If you are using Medent for practice management, this should be a no-cost, easy-to-implement request. We are contacting other practice management companies to arrange a similar agreement. Contact us or stay informed through our web site for more information about your practice management system.

- Patient clinical data and medical records should be accessible to GRIPA via the web portal, your Electronic Medical Records system (if you have one) or a visit from us to your office to review paper records as necessary.

**You will accept, and use, a tablet computer provided free of charge by GRIPA.**

**You will provide high-speed Internet access and a computer able to access the Internet at each office location where patients are seen.** Your GRIPA Connect tablet computer may be one of these computers. If you don't already have high-speed access, contact us for information on providers and rates. These will be your only out-of-pocket costs associated with participating in GRIPA Connect.

**You and your office staff will attend GRIPA Connect training sessions on the web portal.** We want to be sure that you and your patients are reaping the greatest possible benefit from all the features the portal will offer. As advanced features come online, we will offer subsequent training sessions.

**You will not opt out of any health benefit plans contracted through GRIPA under these new contracts.** Our purpose is to maintain the integrity of the Clinical Integration Network so as to provide the most choices and continuity of care for patients.

**You will agree to serve on our Quality Assurance Council if asked.** This group will have a rotating membership chosen through a lottery system. Its role is to assess performance with respect to Clinical Guidelines, agreed upon by the physicians, that all physicians will be asked to implement. We may also ask you to serve on other GRIPA committees but will not require you to serve on more than one committee at a time.

## Questions? Concerns?

### LEARN WHAT YOU NEED TO KNOW

For more information about GRIPA Connect Clinical Integration, **visit our web site:** www.GRIPAconnect.com

**Come to a dinner meeting.** We limit participation to about 20 to encourage Q&A and a frank discussion. Dates and times are on our web site.

Call us or write us:
Kelly Taddeo
GRIPA Director of Provider Relations and Network Services
585-922-1543
Kelly.Taddeo@GRIPAconnect.com

Eric Nielsen, M.D.
Chief Medical Officer
585-922-3062
Eric.Nielsen@GRIPAconnect.com

GRIPA

GRIPA | 60 Carlson Road | Rochester, NY 14610

www.GRIPAconnect.com
Network Services: 585.922.1525
Care Management Services: 585.922.1520

NOVEMBER 2006



24/7 PHYSICIAN HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION NUMBER:
**922-7333**

**MARK YOUR CALENDARS**

**RGH MDS Dinner Dance**
**January 27, 2007**
**Riverside Convention Center**

forum

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL

# Why Should I Care About the RGPO?

*By John Genier, MD, President, RGPO*

**"If fees were truly too low, he said, physicians would quit the region for more lucrative climes and thus force the insurers to raise rates."**
*- Jim Redmond, Excellus vice president of communications. Rochester Business Journal March 24, 2006*

**"Wanted: Area Rx for M.D. Exodus"**
*- Rochester Democrat and Chronicle, October 15, 2006*

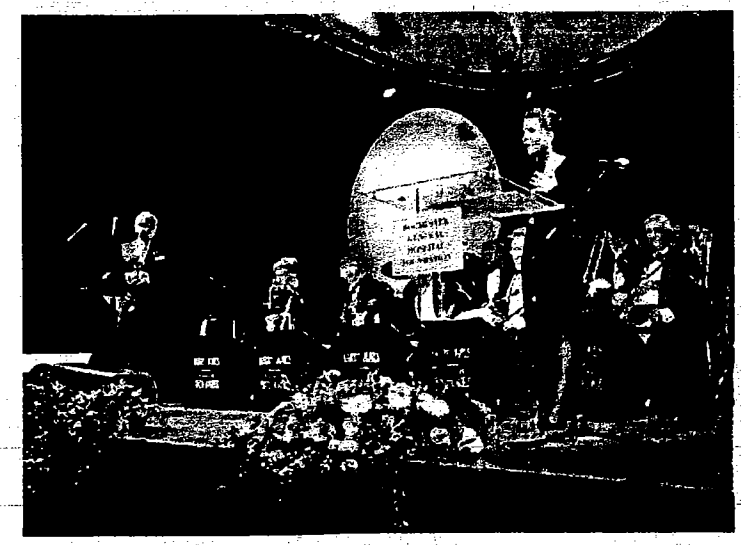
We are reaching a crisis in health care in Rochester, and now more than ever we need a strong physicians organization to represent both ourselves and our patients. I recently became the president of the RGPO, and before taking on the position I had to answer the question at the beginning of this article. Why should I get involved? I am in a two man private practice group who has struggled to recruit a new doctor for over a year, and every day I waste more time trying to squeeze my patients into overwhelmed specialists for consults or battle for prior authorization for medications the patient has been on for years. With the advent of direct contracting, will this ever improve? Will the major insurers really listen to the concerns of a two man group? After considering the options, I felt it was in my best interest to commit to help maintain a strong RGPO.

Clincal Integration is the project that the RGPO has committed to as a way of improving patient care in an electronically connected environment. Successful clinical integration will allow us to negotiate as a group and have a voice in the care of our patients- a voice that would not be possible as a small group practice. The RGPO Board has recognized there are several questions regarding the Clinical Integration contract,and are working with the GRIPA management to address those concerns so that all PO members will be comfortable with the project and want to participate. Clinical Integration can only be successful if the majority of our doctors participate. We represent you, and want your feedback to assist in making Clinical Integration what you want.

At our October Board meeting, we addressed the contract concerns we have heard in terms of charge data. GRIPA has agreed to strip and discard the charge data when it arrives at GRIPA, and will provide an independent auditor who reports only to the RGPO to ensure it is done correctly. The Board still had many concerns about the billing data required, and so we formed a committee led by Ted Tanner who will provide a list specific restrictions in regards to the billing data that we will present to GRIPA. The RGPO Board wants to protect physician interests while maintaining the momentum of Clinical Integration. We also voiced our concerns over privacy and HIPAA issues. GRIPA provided an educational piece on the privacy issues to the Board. The electronic environment has provided new questions about privacy that no one has answers for, but the state and Federal government are planning on releasing new guidelines in 2007 to deal with portal and RHIO issues . GRIPA will be involved on those task forces, and many physicians at RGH will be asked to provide their expertise in terms of developing safeguards for sensitive patient information to be excluded from our own portal.

I have committed to the RGPO Board that we will be a more transparent organization. This article is the first of many steps we have planned to keep our doctors informed and involved with the PO. Many physicians do not understand the role that the RGPO plays in relation to GRIPA, RGH and the insurers. It is up to us to educate our colleagues about the major issues and seek their opinions. I have asked the RGPO Board members to report at their practice and departmental meetings the results of our Board meetings. Each month I will submit an article to the Forum outlining

*Continued on page 2.*



# REPORT ON
# Founders Society Gala 2006

Saturday evening, October 14, 2006 was another splendid event celebrating Philanthropy at Rochester General Hospital. The party at the Rochester Riverside Convention Center was attended by over 750 people – community leaders, board members, employees as well as medical and dental staff. This year, we were pleased that 96 individuals from the RGH medical and dental staff attended. Once again, Jeanne Grove, M.D., chaired the physician committee – that encouraged support from MDS. Leaders like Steve Ettinghausen and Ralph Doerr arranged tables of physicians.

The event is held to honor those who support the Foundation. The Agnes Bartlett Curtis Philanthropy Award was presented to Tom and Heather Golisano for their $9 million gift that will name the B. Thomas Golisano Pavilion and Emergency Center. Drs. Gwen and Richard Sterns were co-recipients of the John Whitbeck, M.D. Philanthropy Award, given to honor those who are philanthropists as well as advocates for philanthropy. Congratulations, Gwen and Rick!

In addition, Florence Belknap and her daughter Nancy Belknap were awarded the Mary L. Keith Award for Nursing Philanthropy, in memoriam. The Honorary Award was given to Stewart D. Davis, Esq., an attorney with Harris Beach, for his loyal work on behalf of the Foundation, most recently as Chairman of the School to Work Program.

# Additional News from the Foundation

Partners for Progress Campaign work continues. The goal for the project to support facility master plan upgrades is $46 million. To date, almost $42 million has been committed from a number of most generous contributors. Stewart Cramer, M.D. and Rob George, M.D. have been working with several medical and dental staff on their personal gifts. Thank you to all who have already made their gifts!

# Why Should I Care About the RGPO, continued

actions taken at our Board meeting. We will also be inviting at large RGPO members to our meeting for their input and welcome anyone who has an interest to attend.

I am excited at the challenge of serving as president of the RGPO at such a dynamic time. We have an experienced group of Board members who represent the many different constituiencies of the medical staff at RGH. I want to be clear that the role of the RGPO Board is not to "sell" Clinical Integration , but rather represent all of our physicians and use their input to make Clinical Intergration the model for health care that our community deserves. The RGPO really is "physicians working for physicians". Please feel free to contact me with comments /questions at john.genier@viahealth.org.

RGPO Officers:
John Genier, MD President, Pat Riggs, MD Vice President, Robert Thomson, MD- Secretary/Treasurer
RGPO Board Members:
Joe DiPoala, MD, Mark Davenport, MD, Ronald Kirshner, MD, Eric Ingerowski, MD, Michael Jacobs, MD, Michael Kukfa, MD,
Paul Mikus, MD, Lyle Prairie, MD,Edward Tanner, MD, David Schlageter, MD, Andrew Swinburne, MD, Gordon Whitbeck, MD

# Flu vaccine coverage for seniors

*From Ghinwa Dumyati, MD, Infectious Disease*

There has been much conversation and confusion both nationally and locally about the possible impact of Medicare changes on reimbursement for flu shots given in community-based clinics. Below is a summary from T. Cleveland, coordinator of the Immunization Program and Disease Control Unit at Monroe County Health Department.

During the Medicare Part D implementation process that took place in 2005, insurance companies restructured many of their Part B insurance plans and then offered these restructured Part B plans (which cover flu shots) to consumers for purchase. Many of the new plans are Medicare Managed Care products that cover flu shots only in providers' offices unless the plan has a contract with a "mass" immunizer that covers flu shots given in community clinics. There is national speculation that many people chose less expensive Medicare managed care products that only pay for flu shots received in a provider's office and that these people will arrive in community clinics unprepared to pay out-of-pocket. However, insurance plans can (and do) enter into contracts with organizations that conduct community clinics, thus enabling the organization to bill the insurance company for a shot given in a mall, a drug store, a senior center, etc. In our community, Preferred Care covers 16,000 of the 18,000 seniors in managed care plans who usually obtain flu shots in public clinics, and Preferred Care has contracts with Maxim, Independent Nursing Care, and the Center for Nursing Entrepreneurship (UofR), the big three local mass immunizers. Consequently, in our community, most seniors will be unaffected by the Part B changes. However, we are advising consumers who changed their Part B plans to confirm their flu vaccination coverage with their plan administrators before they head out to community clinics.

# IT UPDATE

In the coming months, as space allows, I will try to include in this column, definitions of many of the terms used in IT. As the wireless network is almost completed in the hospital and many of the staff may use a wireless router at home, I will focus on some "wireless" terms this month.

**Wi-Fi** (also WiFi, Wi-fi or wifi) is a brand originally licensed by the Wi-Fi Alliance to describe the underlying technology of wireless local area networks (WLAN) based on the IEEE 802.11 specifications. IEEE is the Institute of Electrical and Electronic Engineers.

Wi-Fi was developed to be used for mobile computing devices such as laptops in LANs but is now increasingly used for more applications including Internet and VoIP phone access, gaming and basic connectivity of consumer electronics. A person with a Wi-Fi device, such as a computer, telephone or PDA can connect to the Internet when in proximity of an access point. The region covered by one or several access points is called a hotspot. Hotspots can range from a single room to many square miles of overlapping hotspots. A wireless access point (WAP) connects a group of wireless stations to an adjacent wired local area network (LAN). An access point can relay wireless data to all other compatible wireless devices as well as to a single connected LAN device allowing wireless devices to communicate with any other device on the LAN.

Wi-Fi can be interrupted by other devices, notably 2.4 GHz cordless phones. Power consumption is fairly high in wireless devices making battery life and heat a concern. The most common wireless encryption (see below) standard, Wired Equivalent Privacy (WEP), has been shown to be breakable even when correctly configured.

**ENCRYPTION**- In cryptography, encryption is the process of obscuring information to make it unreadable without special knowledge. A cipher is an algorithm for performing encryption (and the reverse-decryption) a series of well defined steps that can be followed as a procedure. The original information is known as plaintext and the encrypted form as ciphertext. The ciphertext message contains all the information of the plaintext message but not in a format readable by a human or computer without the proper mechanism to decrypt it.

Access points and computers using no encryption or the older WEP encryption, are vulnerable to eavesdropping. WEP encryption can protect against casual snooping but may also give one a false sense of security since freely available tools can determine the encryption password in under a second. The newer Wi-Fi Protected Access (WPA) and IEEE 802.11i (WPA2) encryption standards do not have the serious weaknesses of WEP encryption.

**IEEE 802.11**, the Wi-Fi standard, denotes a set of Wireless LAN (WLAN) standards developed by working group 11 of the IEEE LAN/MAN Standards Committee (IEEE 802). The 802.11 family currently includes six over-the-air modulation techniques that all use the same protocol. The most popular are those defined by b, a and g. The n standard will soon be available. 802.11b and 802.11g standards use the 2.4 gigahertz (GHz) band in the United States. Because of this choice of frequency band, b and g equipment may incur interference from microwave ovens, cordless phones, Bluetooth devices and other appliances using the same band. The 802.11a standard uses the 5 GHz band and is therefore not affected by the above products on the 2.4 GHz band.

**Michael J. Feinstein, M.D.**
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Email: michael.feinstein@viahealth.org

Just as the 802.11g protocol had a higher data rate (25 Mbit/sec) than the 802.11b (6.5 Mbit/sec), but with the same range (100 feet indoors), the new 802.11n protocol will have a much higher data rate (200 Mbit/sec) and an extended range of 160 feet indoors.

**BLUETOOTH** is an industrial specification for wireless personal area networks (PANs) also known as 802.15.1. Bluetooth provides a way to connect and exchange information between devices such as PDAs, mobile phones, laptops, PCs, printers, digital cameras and video game consoles via a secure, globally unlicensed short-range radio frequency.

The name Bluetooth is derived from a 10th century Danish king, Harald Bluetooth, who engaged in diplomacy which allowed warring parties to negotiate with each other. Bluetooth is a radio standard and communication protocol designed for low power consumption with a short range (generally 10 meters) based on a low cost transceiver microchip in each device. Devices may communicate with each other when they are in range. As radio communication is utilized, the devices do not have to be in line of sight and can be in other rooms so long as the transmission is powerful enough.

Some common uses of Bluetooth are:

- Wireless control of and communication between a cell phone and a hands free headset or car kit.
- Wireless networking between PCs in a confined space where little bandwidth is required.
- Wireless communication with PC input and output devices with the most common being the mouse, keyboard and printer.
- Wireless control of a game console.

# National Medical Staff Services Awareness Week
# November 5-11

*By Mary Lou McKeown, Manager Medical Staff Office*

In 1992, The United States Congress and George Bush, President of the United States, issued a proclamation designating the first week of November as "National Medical Staff Services Awareness Week".

The proclamation read:

*The professionals who direct or manage medical staff services, from hospital communications to the accreditation of physicians and nurses play an important role in our Nation's health care system. In addition to serving hospitals and other primary care facilities, these professionals also work in HMO's, medical societies, State Licensing Board and consulting firms. By administering rules and regulations, by ensuring accreditation compliance and by providing a wide range of support to physicians, medical staff coordinators help to promote the quality and efficiency of health care.*

*Today many medical staff services professionals are striving to promote efficiency and professionalism in health care by working through the legal, financial and regulatory requirements that have increased along with new challenges and opportunities in health care industry. This week we acknowledge such efforts.*

GEORGE BUSH, President of
the United States of America

When you go to the hospital seeking medical care, how do you know that the Medical & Dental Staff Members are properly trained, licensed and qualified to take care of your patients? The professionals working in the **Medical Staff Office investigate every practitioner** who applies for privileges to practice medicine at Rochester General Hospital. While the department may not be involved in the "hands on" care of patients, we are responsible for the physicians' hands that care for our patients on an ongoing basis.

We are dedicated professionals who are on the frontline of physician advocacy. We work with the Medical & Dental Staff leadership and Clinical Department leadership to assure that only applicants whose history can be accounted for, are presented for membership consideration. Through both the application process and the reappointment process the Medical Staff Office professionals secure information to assist the clinical leadership while making decisions on continued membership. Our actions assist the hospital by assuring protection from incompetent, troubled and impaired health care professionals. We are trained to identify problematic applications and reappointment documentation.

Within this profession, each person may become **nationally certified** as a Certified Medical Staff Coordinator (CMSC) and a Certified Provider Credentialing Specialist (CPCS). The **RGH office currently has two nationally certified** specialists.

The Medical Staff Office, which is accountable to the Medical & Dental Staff Leadership, as well as the Hospital Board of Directors, frequently interacts with many departments throughout the hospital, including notification to the Operating Room that a physician is approved to perform a specific procedure, or notifying the Emergency Room, when there is a change in privileges. It is imperative that each employee of the hospital be aware of this available information when determining which health care professionals have been approved to treat RGH patients.

In addition, we are responsible for communicating services to the 1302 members of the RGH MDS, through meetings, mailings, newsletters, directories etc. – all while maintaining the highest level of customer service that regulations allow.

The "behind the scenes of caring staff or **"THOSE PEOPLE"** as we have been called, have never been seen caring for patients directly, but our attempts to provide comprehensive services, and our dedication to quality excellence, along with our loyalty to the RGH MDS, ultimately affect the quality care our patients receive.

The dedicated members of your RGH Medical Staff Office have over 71 years dedicated to this profession and are very grateful to be working with the wonderful Medical & Dental Staff Members of RGH. They are:

- Mary Lou McKeown – Manager - 20 years, Orthopaedic Surgery, Family Practice
- Karen Curtis – 8 years, Cardiac Services, Dentistry, Psychiatry, Surgery
- Barbara Kahle, CPCS – Secretary, NYS Association of Medical Staff Services – 24 years Medicine, Ophthalmology, Pediatrics
- Bernadette Thomas, CPCS – 19 years, Anesthesia, ED, Radiology, Radiation Oncology, PM&R, Lab, Obstetrics & Gynecology

# Message from the President of the Medical & Dental Staff- Cynthia Christy, MD

My first comment would be to thank our new CEO Mr. Mark Clement and his administration for agreeing to split the cost of food and drinks at our Medical & Dental Staff Committees. Currently those expenses are approximately $15,000 per year. They include coffee, breakfast and lunch for MDS Members and the Hospital employees who participate in these extremely important meetings. As most of the attendees are not MDS Members, the Hospital was in absolute agreement that these expenses should be shared.

As President of the RGH MDS I am grateful for this acknowledgement which shows the hospitals partnership with its Medical & Dental Staff.

We also appreciate the fresh coat of paint that has been applied to the walls of the Physician Lounge area.

I need your input and feedback. All Active Members of the RGH MDS are expected to attend 50% of the Quarterly Staff Meetings each year. This data is maintained as part of the credentials file and considered at time of reappointment.

For our September Meeting we had almost 200 people sign-in, but within 20 minutes of the meeting many of you had left. These meetings are your opportunity to hear about what is going on in the hospital and ways to assure that your opinions are heard by your elected officers and Hospital Administration. Please let myself, or any of your Elected Members know what we can do to make this meeting better for you.

Ideas that we have currently heard include:

- Shortening the meeting time to 60 minutes
- Allow for questions at the beginning

As your Elected President I am here to service your needs and make sure your issues are heard. Please give me that opportunity and communicate with me on any suggestions you may have.

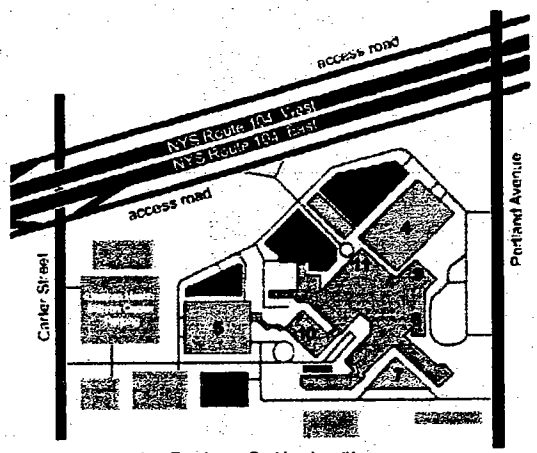
# Important Notice: Parking Lot Closures

*By Kate Pisarek, Parking Manager*

On November 10th, 2006, Rochester General Hospital will be celebrating the ground breaking of the **B. Thomas Golisano Pavilion and Emergency Department.** The celebration will take place in physician parking lot 2 which is located next the Emergency Department. A large tent and other props will be erected in this parking lot for this special event.

Please note the following:

- As of 11:30 PM on November 8th, 2006, parking lot 2 will be closed to physicians and the few employees that are assigned to this lot. The lot will re-open on Saturday November 11th. Those employees and physicians who are parking in this lot should park in the Portland Avenue ramp garage during these times. Physicians may use their "hands free" parking passes to exit. Employees should sign the back of their spitter tickets and will exit via the cashier's booths at no charge.




- Employee parking lot 3 which is located next to the Carter Street ramp garage will also be closed on November 10th for this event. Employees who park in this lot will be able to park in employee lots 1 and 8. Please see attached map which outlines the locations of these lots.
- Please post this notice for your staff and thank you in advance.

# A Sincere Thank you to our Nurse Practitioners

Every year, the first week of November, has been designated by the American Academy of Nurse Practitioners as **National Nurse Practitioner Week** in celebration of the knowledge, skills and professionalism of this group of advanced practice nurses.

In 1965, Denver Colorado graduated the first class of Nurse Practitioners. The designated role of these specially trained nurses was to take care of the health care needs of a pediatric population that was not being served by the current health care providers of the times.

Forty years later the profession has grown beyond hopes. There are currently over 115,000 nurse practitioners in the United States. They now come in many specialties and practice in many different settings.

If you see a Nurse Practitioner during their honorary week, please thank them for all they do.

# GRIPA Connect™ Clinical Integration:

## Special Thanks to Physicians

by Eric Nielsen, M.D., CMO, GRIPA

GRIPA Connect™ Clinical Integration will soon launch the information portal designed to facilitate better communication and data exchange between physicians, hospitals and other health care providers. Many offices are already being contacted by GRIPA technical staff for equipment assessments and training schedules. Clinical guidelines are being reviewed monthly by the Clinical Integration Committee, with new guidelines routinely being prepared by the Specialty Advisory Groups.

Clinical integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care.

**Special Thanks.....**

You have probably heard mention of the Clinical Integration Committee and Specialty Advisory Groups. These are groups of our physicians who have volunteered their time to help develop clinical guidelines for GRIPA. This process is essential to being considered a clinically integrated group according to the Federal Trade Commission. The reality is that there are countless guidelines being drafted by various groups and insurers every day, but these guidelines will be **developed *by* our own physicians *for* our own physicians.**

The Clinical Integration Committee is comprised of both primary care and specialist physicians who are members of GRIPA and are respected practitioners in the community. This group meets monthly and has the primary responsibility for the selection, modification and evaluation of Clinical Guidelines. The CIC receives input and recommendations from Specialty Advisory Groups, which include physicians from each of the specialties and subspecialties affected by the guidelines that are being developed.

Many physicians have given up countless hours to help with this process and we would like to thank the following doctors:

**Clinical Integration Committee:**

Michael Berlowitz, M.D.
Ralph Doerr, M.D.
John Genier, M.D.
Marvin Grieff, M.D.
Michael Jordan, M.D.
Paul Mikus, M.D.
Gregory Oleyourryk, M.D.
Patrick Riggs, M.D.
William Rolls, M.D.
Stephen Silver, M.D.
Derek tenHoopen, M.D.
Peter VanBrunt, M.D.
Gordon Whitbeck, M.D.

**Clinical Integration Specialty Advisory Groups**

Uma Aggarwal, M.D.
Darushe Anissi, M.D.
Haris Aziz, M.D.
Susan Danahy, M.D.
Michael Dobmeier, M.D.
Zachary Freedman, M.D.
Donald Gabel, M.D.
Jeffrey Gordon, M.D.
Edith Grannum, M.D.
Marvin Grieff, M.D.
Steven Howard, M.D.
Michael Jacobs, M.D.
Daniel Jacobson, M.D.
Jeffrey Liberman, M.D.
Michael Meyer, M.D.
Michael Mirwald, M.D.
Michael Myers, M.D.
Jean Nickels, M.D.
John O'Sullivan, M.D.
Anthony Ragusa, M.D.
Jane Salamone, M.D.
Scott Schabel, M.D.
Stephen Silver, M.D.
Edward Tanner, M.D.
Robert Tatelbaum, M.D.
Derek tenHoopen, M.D.
Joseph Vasile, M.D.
Maurice Vaughan, M.D.
Gordon Whitbeck, M.D.

**Also a special thank you to physicians who have been working as part of the Clinical Integration Physician Advisory Group**

P. Miller Ashman, M.D.
Joseph DiPoala, Jr., M.D.
Steven Howard, M.D.
John Huselton, M.D.
Thomas Roberts, M.D.
Frank N. Salamone, M.D.
John Seaford, M.D.

If you would like to be part of a Specialty Advisory Committee to help develop Clinical Guidelines for Clinical Integration contact Marie Tortarella at GRIPA at 585-922-1541 or marie.tortarella@viahealth.org

GRIPA

Clinical Integration

Physicians coming together for all the right reasons

*Reach Dr. Nielsen at 585-922-3063 or via email at Eric.Nielsen@viahealth.org*

## MARK YOUR CALENDAR

**RGH MDS Dinner Dance**
**January 27, 2007**

**Have fun with your peers.**
**Invitations to be mailed soon.**

## Important Coding Information

**ICD-9-CM coding updates are effective for discharges/visits as of October 1, 2006!**
**For a listing of the New, Revised, and Invalid codes go to the Vianet:**
**Departments - HIM**
**Coding Information/ICD-9-CM updates effective October 1, 2006**

Remember to:

- Check your encounter forms for new, revised or obsolete codes
- Check your reference sheets for new, revised or obsolete codes
- Check your series billing for carryover of new, revised or obsolete codes

Inaccurate codes may result in insurance company denials or reduced payment. Make sure you are using the most current ICD 9 CM version.

Contacts for coding questions regarding the ICD 9 CM updates:

- Lorri Lauzze, Manager, Health Information Management, Coding Review and Compliance
  lorri.lauzze@viahealth.org
- Carole Woods, Manager, Health Information Management, Data Quality
  carole.woods@viahealth.org

Medical and Dental staff Alumni Dinner on Wednesday November 15 from 6:00 pm – 10:00 pm at the Rochester Hyatt Regency.


## ED Medhost Update


In response to questions from the RGH Medical Dental Staff regarding Medhost and patient care issues, this is the next in a series of statements meant to address those issues.

Now that the large, hand written locator boards used to locate patients are no longer in use, the tool used to find patients in the ED has shifted to a computer generated screen. Although there are such screens all throughout the ED, they exist only at work stations and in various states of display and require password entrance. As part of our efforts to serve the RGH MDS, we have determined that there are four locations in the Adult ED where the medical staff usually transit to attend their patients. We are in the process of procuring large screen displays to be placed at those areas and will display a map of beds (similar to that which you may have observed as restaurants locate a table for you) located in specific ED areas with the patients name. They should be in place soon.

As always, asking any staff in the Department should result in assistance in locating your patient, but we plan to implement this as one more tool. Thanks in being patient with us as we implement our new Emergency Department Information System.

## MARK YOUR CALENDAR

**Quarterly Staff Meeting Dates**

December 15, 2006
March 16, 2007
June 15, 2007
September 21, 2007
December 14, 2007

Twig Auditorium
7:30 a.m.

*50% Attendance requested*

# Changes to Your RGH Directory

For those of you who access to the ViaNet, don't forget the on-line directory in Departments and Medical & Dental Staff. For those of you who do not have access to the ViaNet, there is a monthly excel directory available for you upon request. Contact Mary Lou McKeown at 922-4259 or marylou.mckeown@viahealth.org.

**Meri Atanas, MD**
Attending, Department of Radiation Oncology
1425 Portland Ave Box 233
Rochester 14621
585-922-4031

**Olivia Chiang, PsyD.**
Attending, Department of Psychiatry & Pediatrics
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Rochester 14621
585-922-2575

**Amy Fix, MD**
Attending, Department of Pediatrics
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Rochester 14609
585-654-5432

**Jeanette Guzman, MD**
Attending, Department of Emergency Medicine
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**Ann Marie Lagonegro, NP**
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490 East Ridge Rd
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**Tiffany Maynard, NP**
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**Susan Newburge, PhD**
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Rochester 14607
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**Margot Searls, RPA**
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Rochester 14621
585-922-9067

**Christopher Vereecke, NP**
Adjunct – Department of Emergency Medicine
1425 Portland Ave Box 304
Rochester 14621
585-922-3846

**Emily Wolfe, RPA**
Adjunct – Department of Medicine/Internal Medicine
1425 Portland Ave Box 258
Rochester 14621
585-922-2300

## CHANGE IN MEMBERSHIP

**CHANGE TO INACTIVE**

Jeremy Bowen, RPA-C .....Inactive/Resigned
William B. Casey, MD.....Inactive
Heather Cook-Smith, NP.....Inactive/Terminated
Jack Dorkhom, DMD .....Inactive/Resigned
Ronald Hainen, MD .....Inactive/Resigned.
Susan Hartfield, RPA-C .....Inactive/Resigned.
Amy Heimburg, RPA-C.....Inactive/Resigned
Marc Lampell, MD .....Inactive/Resigned.
Stanley Novak, MD .....Inactive/Resigned
Brenda Perez, MD.....Inactive/Terminated
Sushil Saha, MD .....Inactive/Retired
Michelle Siena, NP.....Inactive/Resigned
Roderick Spears, MD.....Inactive/Resigned

**CHANGE TO ACTIVE**

Nail Nagovskiy, MD - Attending. Medicine/Internal Medicine Hospitalist

APRIL 2006

# Forum

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL



24/7
PHYSICIAN
HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION
NUMBER:
**922-7333**

**MARK YOUR CALENDARS**

Saturday August 5, 2006
RGH MDS
FAMILY FUN
EVENT

*Rochester Rhinos*
*at their new park.*
*More details to follow.*

## A Message from the President, Linda M. Rice, MD

I recently attended a meeting at the Academy of Medicine with a few dozen others that purported to help us better understand the Excellus contract that we have all gotten and which Excellus hopes and expects we will all sign as individuals. Negotiations with RIPA are apparently ongoing, but with great uncertainty as to whether they are going anywhere. An attorney from MSSNY was brought in to clarify the issues for us. We were lead to expect a brief twenty minute overview, with a longer question and answer period. He spent the first 15 minutes clarifying that he is not a "practicing attorney" and therefore cannot give us any individual advice about our contract, and that we really should consult our own attorneys. He made it clear repeatedly that the forum that evening could not and would not even hint to us whether we should actually sign the contracts. He then went over, point by point, a document that we were given on entry that showed that the new contract did indeed meet the requirements of the settlement of the lawsuit [Dolan v. Excellus], and if at any point something occurred which did not meet those requirements, we had recourse. Rather than taking comfort in this information, the group had several questions about recourse if we didn't like the contract itself. These were met with the standard response: you are free to seek individual counsel from your own attorney. Someone asked what would happen if several individuals hired the same attorney (so he or she would get several times the fee for the same work....?). The answer was hedged, and we were basically told that only "individual" courses of action could be determined. One person said they had sent the contract back with several changes made to the wording, etc. and they were called by Excellus and told that it was not acceptable to do so—you either signed or not, that they could not negotiate in that way with an individual. (But we should still consult with and pay our own attorneys to get their opinions about the contract.) We were also reminded that only legally affiliated groups could have single signature negotiating, and that even two of us (if we are solo practitioners) discussing our contracts would be a violation of anti-trust. Someone asked what would be the critical mass of physicians not signing as individuals that would threaten the panel size and might cause Excellus to rethink the process, and after denying that he knew any such numbers, a not so subtle warning to watch what was said in public ensued.

At that point the frustration in the room was palpable, and several people (myself included) started trickling out before the meeting ended. It seems to me that the anti-trust laws in this country are being grossly abused if they are invoked against two (or more) powerless individuals who have no recourse when dealing with a huge empire like Excellus. Somehow I think our forefathers who wrote those laws had it in mind the other way around.

*You see what power is - binding someone with fear to your will and showing it to him.*
*--- Ayn Rand, The Fountainhead, 1952 -*

# Updates From Your RGH Medical Staff Office

Due to recent changes in the Medical Staff Office, contacts for your clinical department may have changed. Please keep this information in your files for future correspondence and contact.

**Karen Curtis** – Cardiac Services, Dentistry, Psychiatry & Surgery
922-4629 – karen.curtis@viahealth.org

**Barb Kahle, CPCS** – Medicine, Ophthalmology & Pediatrics
922-4477 – barbara.kahle@viahealth.org

**Bernadette Thomas, CPCS** – Anesthesia, Obstetrics/Gynecology, Radiology, Radiation Oncology, Emergency Medicine, Pathology and Lab Medicine, Physical Medicine & Rehabilitation
922-9332 – bernadette.thomas@viahealth.org

**Mary Lou McKeown, Manager** – Orthopaedic Surgery & Family Practice
922-4259 – marylou.mckeown@viahealth.org

**Other important updates**

The RGH Internet Website Heading Medical & Dental Information allows you easy access to the following information: www.viahealth.org

- Annual Health Assessment Form
- Infection Control Manual
- Infection Control Test
- Nurse Practitioner Practice Agreement - standard
- Nurse Practitioner Quarterly Review - requirement for every quarter
- Information on Mercury MD Data
- The monthly RGH MDS Calendar of Events
- Links to your Department Chiefs
- Links to your Elected Representatives
- RGH MDS Monthly Newsletter - FORUM

As always, we are more than willing to assist you in any of your needs.

# Legible Signature Requirement

*By John L. Genier, MD*

On July 1st, we began to require each medical record entry to include a printed name and contact number or license number. I am happy to report that compliance with this requirement is above 70% with our last random chart audit. With the help of Adrianne Mann of the Department of Nursing, we are in the process of reviewing a chart for each MDS member for compliance. Those attendings not in compliance will receive a reminder letter with a follow-up review one month later. If they remain in non-compliance, we will notify their respective Chief for further follow-up. We have gotten through approximately 300 members to date, and have been pleasantly surprised at the compliance. I will be asking the Medical Board in the coming month to consider compliance with this requirement as part of the re-credentialing process so we can maintain the momentum of this in the future.

Feedback from nursing and pharmacy has been very positive. We recognize how difficult it is to change old habits, and appreciate the effort put forth so far. Please remember to continue to "MAKE YOUR SIGNATURE COUNT".

# RGH MDS Election Update

*Peter H. Van Brunt, MD, Past President*
*Credentials and Nominating*
*Committee Chairs*

During the March 17, Quarterly Staff Meeting, I sented the 2006 Ballot for the RGH MDS Officers Medical Board At Large Members. As permitted by RGH MDS Bylaws, 30 days following that presentation tions nominating one or more additional candidates ma presented to me for inclusion, provided that such peti contain a minimum of 15 signatures of the MDS who eligible to vote. If you are interested, please make su have these petitions by April 17, as the ballot will be cl the following day.

For those of you not in attendance during this mee below you will find the individuals identified by the R MDS Nominating Committee who are presented as possible representatives. The actual ballot itself will mailed by the Medical Staff Office before May 1, 2006. ballots will have to be returned in the specially marked en lope and announcements of the winners will be made d ing the Quarterly Staff Meeting on June 16, 2006.

Should you have any questions, please give me a cal 585- 922-3854

**PRESIDENT ELECT:**
*One Vote*
Rick Constantino, MD
Ghinwa Dumyati, MD
Phyllis Harris, MD

**SECRETARY**
*One Vote*
Robert Mayo, MD
Derek tenHoopen, MD

**TREASURER:**
*One Vote*
Stephen Ettinghausen, MD
Roman Kowalchuk, MD, PhD

**MEDICAL BOARD MEMBERS:**
*Three Votes*
Roderick Davis, MD
Stephanie Elsen, MD
Joseph Kurnath, MD
David Schlageter, MD
Ronald Sham, MD
Maurice Vaughan, MD
Gordon Whitbeck, MD
Balazs Zsenits, MD

*Michael J. Feinstein, M.D.*
*Medical Director, Informatics*

# INFORMATION TECHNOLOGY UPDATE

## Sync Everywhere Setup from an Existing MData Install

MData SyncEverywhere is an MData feature that allows users to synchronize MData from any internet connection. To utilize this feature, the device (PDA, Smartphone, etc.) must have an active connection to the internet (ie: a data plan from a cell carrier that allows internet access, a wireless connection to the internet, etc.).

**This feature WILL NOT SYNC with a PALM OS device in the cradle attached to your PC.**

This enables synchronization and fresh data from anywhere there is an internet connection just as if you were at a sync station. The user is responsible for the configuration and maintenance of their own internet connection on their device. Since all devices require different configurations, it would be extremely difficult, if not impossible to provide support for basic internet connectivity, so none will be provided. If an active internet connection is present on a device, MData will sense it and utilize it to synchronize. To configure MData to utilize this feature, the steps below will need to be performed. This configuration will work exactly as before, with the added internet sync capability.

1. Open the MData application and login using PIN
2. Click on the 'OPTIONS' button and click 'Configure'
3. In the 'CONFIGURE' screen click on the 'SERVER' text box to get the screen below:
4. Replace the text in the 'SERVER' text box to mdatalink.viahealth.org and click 'OK'
   All other info will remain the same; do not change any other fields.
5. Uncheck (or check as appropriate) the 'CONFIGURE IR PORT' checkbox and click 'OK'

Note – The 'Configure IR port' box needs to be checked to sync at a sync station and unchecked to sync by any other method.

Having the "IR Port" checked will block a sync attempt via the internet and not having it checked will not allow a sync station synchronization, so it is very important to remember this, especially if you plan to synchronize by both methods. Toggling of the 'Configure IR Port' setting back and forth is fine, as long as the correct setting exists for the sync method being attempted.

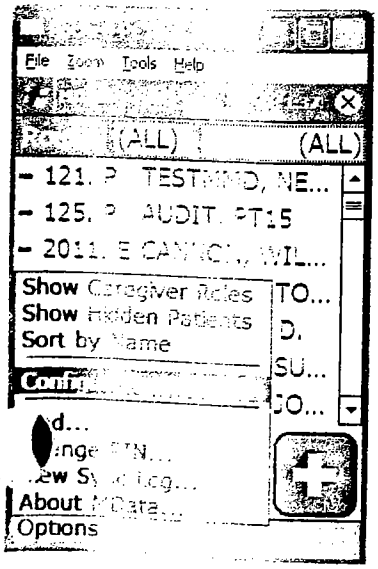
Next perform a sync. If sync does not work the first time, try a second time. If this still does not work, soft reset your device and attempt again. If sync still does not take place, check configuration above and correct. Also check to see that appropriate connection you are attempting to use is available.

A representative from the IT department is in the physician's lounge at Rochester General Hospital on Tuesday and Thursday mornings from 7:30-9:30 am for any problems or questions. Please call the help desk at 922-HELP at other times. Contact me at michael.feinstein@viahealth.org or 922-1642 or 922-2932 for any other unresolved problems.

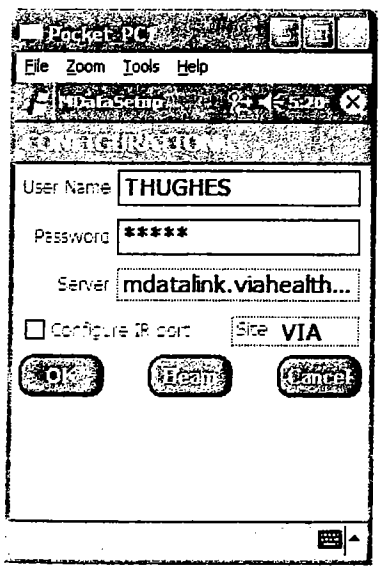
## Secure Email System (SES) - Update

For those private RGH MDS Members who wish to be able to receive and read encrypted clinical information communicated on the [illegible], please contact Mary Lou McKeown in the Medical Staff Office 585-922-4259 or marylou.mckeown@viahealth.org and she will send you documentation that explains the registration process.

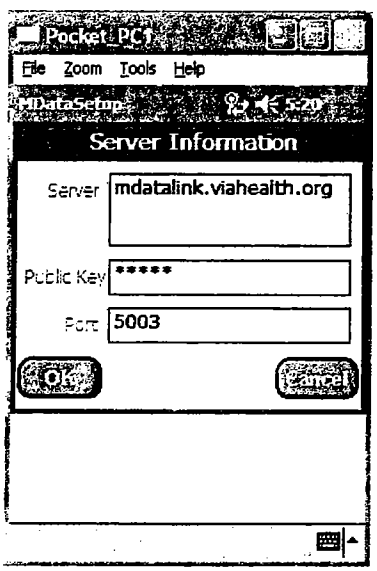
2.



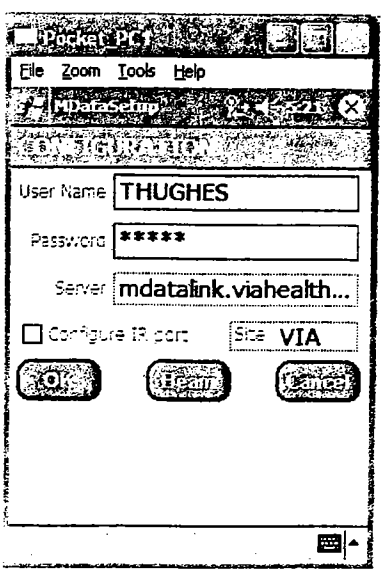

3.




4.




5.



# Highlights of ViaHealth Accomplishments 2005

## PEOPLE

- In Rochester, we marked the **employment anniversaries of 654 employees**, which totaled 10,105 years of outstanding service to our community. In Wayne County, we recognized 96 employees, which totaled 1,315 years of outstanding service.
- **Physician Appreciation Breakfasts** were held at RGH and NWCH to celebrate Doctor's Day on March 30th. This annual event commemorates the value of the work done by our fine Medical Staff.
- **Jeanne Grove, DO**, was selected as a 2005 Local Legend from New York State Congresswoman Louis Slaughter. The honor is part of a national program sponsored by the American Medical Women's Association in collaboration with the National Library of Medicine.
- **Robert Mayo, MD**, was named the first annual recipient of the Father George Norton Physician Excellence Award. This prestigious award was established this year by Patient Care Services to honor a physician for excellence in inpatient and family care, collaboration with the healthcare team and a commitment to the mission of RGH.
- **Rosemary Roth, MSN, RN, CORN, CNAA, BC** and Nurse Director of Surgery, was recognized by the American Association of Nurse Executives as one of the top 12 nursing leaders in the country.
- The Isabella Graham Hart School of Practical Nursing **graduated fifty-two Licensed Practical Nurses**. This distinguished nursing school has provided career opportunities to individuals and nursing staff to healthcare providers since 1964. The licensure exam pass rate continues to be 100%.
- Physician Services hosted a **physician social evening** which was attended by over 150 Medical and Dental Staff members from RGH and NWCH.
- **James C. Mead, MD**, attending psychiatrist and Medical Director of Inpatient Psychiatric Services at NWCH received the William T. Hart Award. Dr. Mead was selected as the person who exemplifies Dr. Hart's philosophy and demonstrates dedication for advocating for patient empowerment.
- RGH launched a **Physician Leadership Academy** that is designed to equip physicians and future leaders with the tools necessary to deal with a wide range of leadership issues. The program was initiated by Dr. Richard Gangemi, Senior Vice President for Academic and Medical Affairs.
- **Michele Unger, MS, RN, CCRN, CNAA, BC** and Nurse Director for the Rochester Heart Institute, was the recipient of the Genesee Valley Nurses Association Nurse Administration Award.
- **Edie Hill, RN, BSH, MPA, CORN** and Clinical Resource Nurse, was the recipient of the Genesee Valley Teaching Award.
- **Mary Jo Marro-Tobin, DDS**, was awarded the first annual Fred Halik Young Dentist Award. The award honors Dr. Marro-Tobin who exemplifies the philosophy of Dr. Halik who mentored young dentists throughout his career.
- Hill Haven rolled out **Quality Leadership training** for all department managers, quality improvement committee members and medical staff.

## SERVICE QUALITY

- **"Reweaving the Safety Net"** project was recognized in the Innovation category as an outstanding example of teamwork and collaboration by the Rochester Business Journal's Health Care Achievement Award
- has initiated an approach
- access to healthcare and ch
- management and receive
- attention by the Institute
- Improvement.
- NWCH participated in t
- **County Diabetes Coaliti**
- "Health Lifestyle Choices 2
- hospital and DeMay Living C
- information booths and of
- screenings to the public.
- Physician Services hosted a
- **Manager's event at RGH.**
- of departments had informa
- plays in the Atrium and educati
- sions were presented in the T
- event was a great success with o
- attendees.
- RGH became the presenting s
- for **"Rochester Goes Red"**, an
- tive of the American Heart Asso
- which addresses heart healt
- women. Activities and events oc
- throughout the year and acros
- organization.
- The newly expanded and renov
- **Women's Care Unit at RGH** was
- icated in 2005. Improvements inc
- the creation of a new four bed
- Triage area, a new central registrat
- desk staffed 24/7,expanded OB/G
- waiting areas and the creation of
- OB/GYN consultation room. The re
- ovations offer a more comfortable a
- attractive area for patients and the
- families.
- We began our cultural transformatio
- with the kick-off of **Excellence Ever**
- **Day**. The system-wide initiative puts a
- enhanced focus on service and includes
- expectations and measurable results.
- We selected 46 team leaders and affiliate champions who will lead the process. Over 250 staff members
- on teams that include Em
- Experience/ Loyalty, Patient

nce/ Loyalty, Resident
nce/ Loyalty, Physician
nce/ Loyalty, Measurement,
ds and communications. System
include the Leadership
pment and the Standards
g Committee.

rticipated in the **Making Strides**
**st Breast Cancer Walk** that is
ored by the American Cancer
y.

ffered a **"Never 2 Late"** adaptive
puter lab for participants and a
ish Spiritual Group.

**newly constructed website** went
A team of people from across the
th system worked together to pro-
e this more user-friendly and attrac-
website.

**mp Broncho Power,** a camp for
s with asthma, celebrated its twelfth
ar at Camp Haccomo. Funded by the
GH Foundation, the camp provides
opportunity for the kids to learn
ore about the condition of asthma
le having fun and participating in
merous activities.

RGH held a regional **Nurse Magnet Conference** entitled, " Rochester Rocks". The well attended two day conference highlighted keynote presentations from nationally acclaimed nursing leaders, a number of workshops, exemplar displays, and a vendor fair.

NWCH put in place a **new patient** meal tray **service,** funded by a donation form the NWCH Auxiliary. The new system helps control temperatures of the food being served.

- **The RGH shuttle service** continued throughout the year and was successful in transporting employees to and from the temporary parking lot which accommodated 600+ cars each day. The service was being provided while the new parking garage was being constructed.

- **The Behavioral Health Network** started operating two new School Based Health Centers at Freddie Thomas High School and at Martin Luther King, Jr. School #9.
- RGH is proud to be a **Global Showcase Site for the Eastman Kodak Company.** Seven visits occurred this year with healthcare professionals from several states and Mexico taking part in the program.
- Our **volunteers provided 56,886 hours** of service at RGH and 21,520 hours of service at NWCH. We are most appreciative of the service provided by these dedicated individuals.
- We hosted two **"For Your Good Health"** lectures. Over 425 people attended with an overall satisfaction rate of 9.7 on a 10 point scale. NWCH sponsored "Take Time for Yourself", a half day educational health event that included speakers, workshops, screenings and health cooking demonstrations.
- DeMay Living Center participated once again this year in a program at **Camp Haccomo** with 38 residents enjoying the experience.

## CLINICAL EXCELLENCE

- At RGH we celebrated our **Nurse Magnet designation** with a formal presentation made by the chairperson of the Magnet Program, Brenda Kelly, MA, BSN, RN, CNAA, BC, and President of the American Nurses Association Credentialing Center, Cecelia Mulvey, RN, Ph.D.
- RGH was named a **Solucient Top 100 Cardiovascular Hospital** for the sixth time, one of only 19 in the nation to do so with this frequency. This prestigious award objectively measures performance on key criteria in a number of areas of heart care. RGH is the only hospital in the region to receive the designation in 2005.
- The **RGH School of Medical Technology** celebrated its 70th anniversary in 2005 and has graduated more than 700 medical technologists.
- RGH received the **Premier Award for Quality** in the areas of Acute Myocardial Infarction and Coronary Artery Bypass Surgery. The Premier award recognizes excellence in both quality of care and operational efficiency.
- **New York State designated RGH** as a Stroke Center. In order to receive this designation a rigorous review process occurred to verify that state requirements were being met.
- **RGH earned the Quality Respiratory Care Recognition** from the American Association for Respiratory Care. Approximately 10% of hospitals in the country have received the award. This is the second consecutive year that RGH has been recognized with this distinction.
- HANYS awarded its annual **Pinnacle Award** for Quality Improvement to RGH for a project that significantly reduced hospital infection rates.
- RGH received the Solucient designation as a **Performance Improvement Leader Hospital.** The award was initiated last year and RGH is the only hospital in the region to have received the award in 2004 and 2005.
- RGH was designated as the areas first **Accredited Chest Pain Center** by the Society of Chest Pain Centers. We are the 140th in the nation to receive the accreditation.
- The **Isabella Graham Hart School of Practical Nursing** underwent an accreditation survey conducted by the National League of Nursing Accreditation Commission. A recommendation to continue the accreditation was made to extend over the next eight years.
- **Roswell Park Cancer Institute's Medical Grand Rounds** are now available weekly using WebEx meeting technology. These sessions are interactive and carry CME credit.
- **Kodak RIS/PACS** continued to be installed in various departments at RGH. This has resulted in quicker turn around time for exam results.

*Continued on page 8.*

# Carter Street Ramp Garage

*By Kate Pisarek*

The Carter Street ramp garage opened on January 30, 2006 RGH for RGH employees and physicians, patients and visitors of the Medical Office Building. Although we experienced some technical difficulties initially, the garage is running smoothly. If you haven't seen the garage, please stop by. It is truly beautiful.

We are continuing the re-register process for all physicians for the Portland Avenue garage. We anticipate that physician lot 2 will not close to the ED construction until the fall. If you haven't re-registered for parking in the Portland Ave garage, please send your registration forms to the Safety and Security Parking Office as soon as possible so that we can give you your new "hands free" tag. If you have questions regarding this process, please contact Kate Pisarek at 922-4665.

Please note that the main Safety and Security office has moved to the Carter Street Garage. All parking registration, photo IDs and security access services are provided there. We have a new main number 922-9803. Our office hours are Monday-Friday from 7:00 am-5:00 pm. Thank you.

# MARK YOUR CALENDARS

The department of Physician Services will be hosting the Medical & Dental Staff "Spring Physician Social" on Tuesday April 25 at the Daisy Flour Mill from 5:30-9:30 pm. The "Social" which has become a bi-annual event, is an opportunity to introduce the newest members the Medical and Dental staff and to provide an informal setting for the physicians to reacquaint with colleagues face-to-face. General information regarding the Hospital will also be available, along with photographs of our newest members.

Our "Fall Social' had over 150 physicians who attended last October, and we look forward to an even larger participation this Spring. Please call Arianna Parris at 922-9435 by April 17 to RSVP

**Physician Services at Rochester General and Newark-Wayne Community Hospitals**

**Invite You to Join Us for a Medical and Dental Staff**

***Spring Physician Social***

**Tuesday April 25**
**5:30–9 p.m.**
**Daisy Flour Mill**
**1880 Blossom Road**

**Please call Arianna Parris at 922-9435 by April 17 to RSVP.**

***Get reacquainted with colleagues and meet the newest members of the Medical and Dental Staff. Enjoy delicious hors d'oeuvres, pasta, carving stations and desserts.***

REMINDER TO SAVE THE DATES:

- Annual Doctor's Day Breakfast on **Thursday March 30**, from 7-11 am in the RGH Atrium. (RSVP not required).
- Spring Physician Social on **Tuesday April 25** from 5:30-9:00 pm at the Daisy Flour Mill. (Please call Arianna Parris at 922-9435 to RSVP.)
- Annual Practice Managers Event on **Wednesday May 17**, from 8-1 pm at RGH. (Please call 922-LINK (5465) to register.

EXCELLENCE EVER

## Physician Experience/L Team Update

*By Aida Casiano-Colón, Ph.D., and Mar*

The Physician Experience/ Loyalty Team has been actively working on identifying barriers to physician satisfaction at RGH. So far we have interviewed all RGH Chiefs of Service and many other RGH Physicians. We are in the process o ing a list of the Top 100 Physician I More information will be added to the li the recent Physician Phone Survey Irritants are being categorized and prio and we are already working on solutions f following items:

- Establishing a mechanism whereby pr care physicians could be promptly no when their patients are admitted.
- Having available to the MDS members an to-date, easily accessible, secured databa phone numbers that could be used to cal another directly.
- Increasing the ability of physicians to rea unit nurses from offsite locations, especial when the physicians are responding to a pag
- Looking into ways that efficiencies could b achieved by standardizing, where appropriate the organization of nursing units, such as in the availability of forms.

Please keep sending us suggestions for improvements. We will keep you posted as we move forward with this initiative.

# Cell Phone Usage

This message is sent on behalf of the Safety Committee, we are removing the restriction on use of cell phones in the hospital based on a national movement that is built on newer evidence associated with the lack of cell phone interference in hospitals. Engineering is in the process of removing the restriction signs located throughout the hospital. Please contact Ken Wedlake (Biomedical engine ing 922-4222) or Cindy Bilesch (Q Improvement 922-3793) if you have questi Thank you.

# A Connect™ Clinical Integration—
## A Connected Community Can Accomplish

Nielsen, M.D., CMO, GRIPA

The health care landscape is, once again, changing dramatically in this country. With the decline of risk-based contracts, your Greater Rochester Independent Practice Association (GRIPA) has spent the last 18 months grappling to define the next working model for community-based physicians.

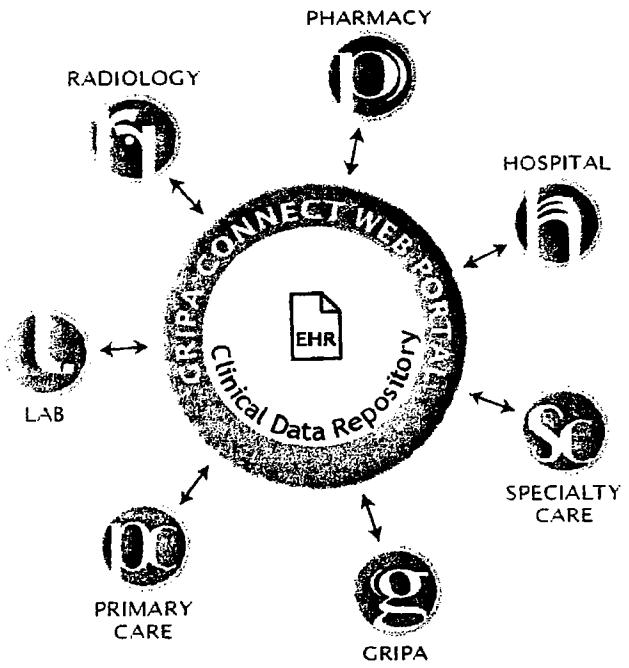
We believe our GRIPA Connect™ Clinical Integration Initiative is innovative, effective, and will pass muster with the federal government as well.

First, a working definition: Clinical Integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care.

Fully implemented, GRIPA Connect Clinical Integration will allow a physician to access patient records from a GRIPA-provided laptop in the examining room, review clinical guidelines with the patient, electronically order prescriptions and lab procedures, make notes available to a referred specialist, track patient compliance, and more. Patient records will be accessed through a secure web portal that will be compatible with a wide range of Electronic Medical Records systems, but you will NOT need EMR to use the portal.

It is our plan to have the portal operational by mid-summer, when we will begin enrolling physicians in GRIPA Connect. GRIPA Connect will enable us to demonstrate improved patient outcomes and cost-effectiveness so that physicians in the network, working together through GRIPA, will be able to sell payors our combined services. This ability to offer the GRIPA network and its new program through single-signature contracts will help GRIPA and our physician practices remain competitive in the market while improving the health of our patients.

We are attending as well as hosting a series of meetings over the next several months to bring everyone up to speed about Clinical Integration. We will also be sending information out via mail and email and posting it at: www.GRIPAconnect.com. We encourage you to take the time to understand this initiative and to provide your feedback.




"I was initially a skeptic regarding Clinical Integration, but now recognize that it is essential to the future of physicians and RGH. Major changes that we have seen just in the past few months with respect to physician contracting make it clear that it will no longer be "business as usual." Clinical Integration allows you to be an independent practitioner, while retaining the benefits of a large group. I am not ready for a full EMR—but the portal will allow me to begin the transition to use computers effectively in my office on a smaller scale. Accessing the data at the point of service is most important to me—no more stepping out of the room to find that lab or fax. I will have input into the development of the portal and data collection. Clinical guidelines and pay-for-performance programs are coming soon, and I would rather get them up with "friends and family" than have them dictated to me by outside sources. I think Clinical Integration is an exciting opportunity to maintain the bond of GRIPA physicians and hopefully be appropriately recognized for the excellent care we deliver every day."

*- Dr. John Genter, M.D.*

# HIGHLIGHTS OF OUR ACCOMPLISHMENTS 2005, Cont.

- A Kodak partnership event was held with a number of Kodak scientists observing various surgeries to better determine future innovations and products.
- Hill Haven was selected to be a member of the primary participant group in the **CMS Nursing Home Quality Initiative** which will provide additional resources to address specified clinical issues.
- NWCH upgraded its **MRI technology** and expanded the availability of services in 2005.

## FINANCIAL PERFORMANCE

- Our financial performance is expected to realize a **positive bottom line** which exceeds our budget.
- By the end of 2005, the RGH Foundation reported that over $40 million had been raised for **"Partners In Progress"**, our capital campaign. The generosity of physicians, employees and the community is most sincerely appreciated.
- RGH was deeply honored to receive a **$9 million gift from Mr. Tom Golisano.** This establishes the B. Thomas Golisano Pavilion and Emergency Center. This gift supports a master facility plan that will bring a true renaissance to the campus. All of us are most grateful to Mr. Golisano for this most generous gift.
- RGH received a **$300,000 grant** from Eastman Kodak's Rochester Economic Development fund for the School to Work program. Students are recruited from high schools throughout the city of Rochester. The program has been very successful and RGH currently employs 50 graduates of the program.
- The RGH Foundation hosted its annual gala, **"The Power of Philanthropy"**, and raised over $142,000 to benefit the hospital.
- The ViaHealth of Wayne foundation hosted **"A Gala Affair-Cranberries & Roses"**. More than $36,000 was raised to support hospital and DeMay Living Center programs.
- RGH received a **$300,000 grant from RG&E** as part of an Economic Development program to assist electric customers that are investing in improvements to their electricity delivery systems. The grant will be used to support work with the Master Facility Plan.
- The second annual golf tournament was sponsored by the **Twigs of the RGH Association**. Proceeds of $10,000 will be used for the benefit of the hospital.
- **Independent Living for Seniors** held its second annual pasta dinner. Over 300 people attended and the event raised $1,958 which will support programming for participants.
- NWCH held its 14th annual golf tournament which raised over **$25,000** to benefit the programs at the hospital.
- The **Twigs of the RGH Association** hosted th Girl Fashion show which raised funds to benefit served by the Social Services Department.
- **ILS held its Third Annual Fall Fundraiser** which w at the Monroe Country Club. The event raised $8,000 port the "Never 2 Late" computer lab for participants.

## FOCUSED GROWTH

- We served our community with **35,351 inpatient disch** and **1,128,973 outpatient visits** across our health syst 2005. This compares with 33,893 inpatient discharges in and 1,117,452 outpatient visits in 2004.
- RGH opened services at its **Linden Oaks** site which incl a satellite office for the Lipson Cancer Center, physical th py, hand rehabilitation and occupational therapy and labor ry services. The beautifully appointed center offers m access and a comfortable and convenient location for tre ment.

## Changes to Your RGH Directory

For those of you who access to the ViaNet, don't forget th on-line directory in Departments and Medical & Dental Staff. Fo those of you who do not have access to the ViaNet, the monthly excel directory available for you upon request. Co Mary Lou McKeown at 922-4259 or marylou.mckeown@via-health.org.

## New Applicants

**Mohamed Alsalahi, MD**
Courtesy, Department of Medicine/Ambulatory
1304 Driving Park Ave
Newark, NY 14513 315-359-2130

**Heather Cook-Smith, NP**
Adjunct, Department of Cardiac Services/Cardiology
2664 Ridgeway Ave
Rochester, NY 14626 585-225-5050

**Karen Mazza, NP**
Adjunct, Department of Emergency Medicine
1425 Portland Ave Box 304
Rochester, NY 14621 585-922-3846

## Change in Status

David Broadbent, MD – Pediatrics.....Inactive/Resigned
Galaa Agban, MD – Surgery/Plastic Surgery.....Inactive/Resi
Lisa Bonvino, DO – Psychiatry.....Inactive/Resi

MAY 2006

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL



24/7
PHYSICIAN
HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION
NUMBER:
**922-7333**

**MARK YOUR CALENDARS**

Saturday August 5, 2006
RGH MDS
FAMILY FUN
EVENT

*Rochester Rhinos*
*at their new park.*
*More details to follow.*

# A Message from the President, Linda M. Rice, MD

Many of you have heard of the "portal" being designed and implemented as a way to link physicians and patient information. Through the portal, we will be able to access lab data, x-ray reports, consultants notes, discharge summaries and other vital information in a more efficient way. We will be able to order x-rays and lab tests, and send electronic prescriptions (which will help us conform to the new prescribing mandates). Imagine not having to walk out of the exam room to check on a lab result, find a report, or locate a requisition. All will be at our fingertips, with a secure wireless laptop right in the exam room. And we do not have to have full electronic medical records to take advantage of the new technology.

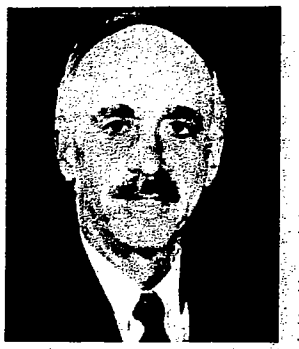
I realize there are many who are fearful of trying to learn how to use such computer technology, and might think this is something that would just be too disruptive and cumbersome to learn and apply. However, anyone who has learned the ins and outs of navigating through CCS, and figuring out how to use Mercury MD software to download patient information into one's PDA (both daunting tasks to many when first introduced), should have no fear of venturing further into the ever-expanding world of information technology.

Once the portal is up and running, and enough of us are linked, we can begin the process of clinical integration, or joining together to improve quality and efficiency. If we know the clinical guidelines that are evidence-based and promoted by ourselves, and are prompted with reminders as we are seeing patients, it will be easier to follow them. If we know what pharmaceuticals are on the individual formulary of the insurance of the patient in front of us as we order the drugs, it will save countless phone calls and rewritten prescriptions later on. If we can show that we are more efficient as a group, we should be able to use this to our advantage in future negotiations for better reimbursement. In fact, it seems this is the only way we can take control of our fate, and will be vital to our survival as individual practitioners.

There are many venues in which the portal is being discussed. If you have not attended an informational dinner meeting, or weren't at the last Quarterly Staff meeting, or the special MDS meeting the following week, I urge you to inquire in the Medical Staff Office to get more information about upcoming meetings. This is one time when ignorance is not bliss!

*"Technology means the systematic application of scientific or other organized knowledge to practical tasks."*
*- J.K. Galbraith*

# CCS Updates



*By Michael J. Feinstein, M.D.*
*Medical Director, Informatics*

## FOLDERS

Apparently some members of the medical staff have been confused by opening folders in CCS that are empty. If a folder, or a subfolder, contains documents, CCS will display an icon showing a piece of paper in a folder. If the folder is empty, a plain folder is displayed. Currently CCS is programmed to open any folder that contains documents. Therefore, if a folder is not open, it is empty and the provider should not need to open it.

## EKG's

It has been reported that some EKG's in CCS are not easily readable. Older EKG's that were scanned into CCS are, in fact, difficult to read. Current electronic EKG's display quite well and should not produce any difficulty in reading them.

## PRESCRIPTIONS IN CCS

The process of writing pr
to meet regulatory requiremen
tions are entered will display
tions as well as known medic
home. Functionality will exis
from listed medications. A fu
scription process will be availa

## SIGNATURES

CCS Provider Desktop
that need to be completed by

There are several types o
up this list. Some of these
electronically and others requi
Department in order to acc
record.

**The following deficiencies can be completed electronically through CCS:**

| Deficiency | Comments |
|---|---|
| CODE QUESTION | Assigned to imaged ED records |
| INCOMPLETE | Assigned to imaged ED records |
| SIGNATURE | Assigned to PVS (patient visit summary) and imaged ED reco |
| SIGNATURE AUTO | Assigned to transcribed documents |

**The following deficiencies can be completed electronically through CCS:**

| Deficiency | Comments |
|---|---|
| PAPER – ATTENDING DICTATE | Attending needs to dictate a report (see Comments Tab to see |
| PAPER – ATTG DICTATE ADDEND | Attending needs to dictate the discharge summary addendum |
| PAPER – ATTG DICTATE CATH | Attending needs to dictate the Cardiac Cath report |
| PAPER - ATTG DICTATE DS | Attending needs to dictate the discharge summary |
| PAPER – ATTG DICTATE OP | Attending needs to dictate the operative report |
| PAPER – CODE QUESTION | There is a coding question that needs to be answered in the pa |
| PAPER – DICTATE | Resident/PA/NP needs to dictate a report (see Comments Tab |
| PAPER – MISSING H&P | H&P must be completed in the paper chart or sent from the pl |
| PAPER – MISSING TUMOR SHEET | Tumor sheet must be completed in the paper chart |
| PAPER – SIGN DISCH NOTE | The discharge note needs to be signed in the paper chart |
| PAPER – SIGN ORDER | Orders need to be signed in the paper chart |
| PAPER – SIGNATURE | A signature is missing in the paper chart (i.e. H&P) |

If you disagree with any deficiency or for Patient Visit Summaries (PVS) need something changed prior to you
ton to send the document back to HIM. You will be prompted to type in the reason for rejecting the deficienc
any changes that need to be made on the PVS.

Please contact HIM at 922-4521 if you have any questions regarding chart completion or need assistance wit

# MD DATA ASSISTANCE

We have had a representative from IT in the physician's lounge at RGH since July 2005. The number of requests for assistance has decreased to a point where the representative will no longer be in the lounge after April 30, 2006. For any M Data problems after that date, please call the Help Desk at 922-HEL
either be handled over the phone or ar
an IT representative to meet with the c
upon time.

# Remote Patient Monitoring

Remote monitoring of chronic diseases such as coronary heart disease and diabetes will [illegible] widespread over the next five to six years. One hundred healthcare organizations involved in telehealth were interviewed including home health agencies, academic medical centers, regional hospitals, government agencies and disease management companies. Sixty-five percent of the organizations interviewed were making at least limited investments in remote patient monitoring solutions focusing on high-risk, high-cost patients with multiple chronic diseases. The major impetus driving this is cost as they need to keep these patients out of the emergency departments and out of the hospitals.

Partners Telemedicine in Massachusetts is using "smart pill bottles" and cell phones to remind patients to take their medications. The technology is still immature and would benefit from the involvement of telecommunications companies and the consumer electronics industry. For telehealth to work as it is hoped to- for a patient in rural Wyoming to have access to a specialist in Boston, for example, clinicians may have to be licensed to practice anywhere in the country and not just in individual states as they are today. Payers too have to get on board with reimbursements which they are more likely to do once Medicare leads the way.

Cell phones will play a bigger role in patient monitoring. Technology is already available to monitor vital signs and even EKG patterns and transmit that information to a call center via cell phones. For many people in the world the cell phone may be the only computer they will own. The cell phone might be a good vehicle for storing a personal health record as well as a blood glucose monitor. Institutions that have a business case for connecting with patients anytime and anywhere as in the case of clinical trials, may find the cell phone extremely useful.

# CCS Update - COMMUNICATION EASE

**Do you have trouble trying to get in touch with your fellow RGH MDS members?**

**CCS now has increased contact information, and it's available 24/7**

*Mary Lou McKeown, Medical Staff Office Manager 922-4259*
*Marylou.mckeown@viahealth.org*

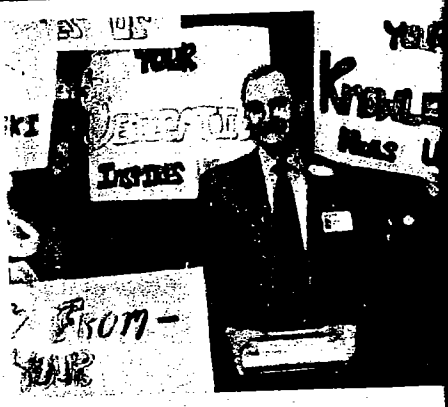
Starting the last week in March, a request made by your RGH MDS Elected Members to add additional contact information to the CCS Directory was put into place. To view the directory, log into CCS, click on "View" (drop down box) and then click on "Staff Directory". From there you can search by last name, first name, department etc.

The information found in this directory, which is only accessible to CCS users, is based on the information you have provided the Medical Staff Office from your original application, your reappointment application or any updates you have since communicated. This enhanced directory now includes:

Primary Office Phone Number
Primary Office "Back" Phone Number
Primary Office Fax Number
Answering Service Number

**You are each encouraged to review the information identified for yourself and let me know if it requires any updating.** Also, if there is no contact number appearing in these categories, please contact me so that they can be added. Cell numbers, home numbers, pager numbers can be added but only when specifically directed by you, otherwise that information remains personal/confidential. All changes immediately appear on CCS, when changed in the Medical Staff Office database.

It has been suggested that each medical office allow an early option to the telephone [illegible] ng message which would provide immediate physician to physician access. Thanks [illegible] our consideration.



# T. Jeffrey Dmochowski, MD Rec
# Father George Norton Award

Judges for Rochester General [illegible] annual Father George Norton Excellence Award selected T. Jeffrey Dm MD as recipient of the 2006 awa Dmochowski, a colon/rectal surgeon, ored in a ceremony held March 17.

The award, now in its second year, lished by Patient Care Services to annua physician recognized by staff for exc patient and family care, collaborative e the healthcare team and commitment sion of Rochester General Hospital. T named for Father George Norton, wh chaplain at Rochester General until h 2004, and recognized by RGH staff fo kindness and compassion.

Qualities that the Father Geor Award recognizes include:

- Patient focus
- Advocacy
- Collaboration
- Compassion
- Involvement in patient care p
- Building strong relationships

A wide range of staff, including n workers, nurse practitioners, physicia and housekeepers, as well as voluntee patients and medical colleagues no physicians for the award. In a letter the late Father Norton, a patient expressed her feelings for the excelle passionate care provided to h Dmochowski, including a 7:00 pm ph Super Bowl Sunday – just to see h doing. A nurse practitioner shared a Dr. Dmochowski loaned her several textbooks so that she could expand knowledge and skills.

Dr. Dmochowski, a graduate Medical College, in Philadelphia, h Rochester General for more than 2

PLEASE REPLY!

# THE ViaHealth HEALING INSTITUTE

## Mission

*The Healing Institute is a partnership with conventional and complementary medicine and is committed to improving the health of the community and the people we serve by providing care and education focused on the individual's body, mind and spirit.*

As many of you may know, the **ViaHealth Healing Institute** steering committee has been working together over the past few years to identify complementary medical services to the patients we serve, our employees and the community.

We have some services already available for our patients at Rochester General Hospital. They include: Music therapy, Humor Therapy and we have been working on the process and the credentialing for massage therapy. We have also had the wonderful opportunity to bring the **Just For You Program** to our employees. As we all know our health care employees often don't take time for themselves because of our demands for caring for our patients. So throughout this year we have brought some well received offerings to our employees such as massage therapy sessions, open sessions with pastoral care and aromatherapy educational sessions to name a few.

At this time, **ViaHealth** is beginning to explore the feasibility of providing integrative medical services as an adjunct to ongoing medical care. We feel that input from the medical staff is critical to any decision making and planning for this project. Our plan is to have evidenced based services available by credentialed practitioners. But, we need your input. We would be grateful if you would take a minute to complete the questionnaire below.

So, if you could take a moment to complete this questionnaire and fax back to me at 922-2864 it would be greatly appreciated and help design a valuable program of services.

- Would you like to learn more about complimentary therapies for the purpose of making referrals or counseling patients? ❑ Yes ❑ No
- Would you refer patients to a physician-supervised RGH Integrative Medicine facility? ❑ Yes ❑ No
- If yes, please estimate how many referrals you would make each month:

| | # per month |
|---|---|
| **Manipulation** (check one) | |
| ❑ Chiropractic | _____ |
| ❑ Osteopathic | _____ |
| ❑ Either | _____ |
| **Acupuncture** | _____ |
| **Massage Therapy** | _____ |
| **Stress Reduction/relaxation training** | _____ |
| **Homeopathy** | _____ |
| **Diet/herbs/supplement counseling** | _____ |
| **Other** (please write in) | _____ |

- Would you use this program for educational purposes, i.e. requesting published literature on the complimentary therapies or a specific herb or supplement? ❑ Yes ❑ No
- Are there any specific therapies you would like included?

_____

- Do you currently refer patients for any complimentary therapies? ❑ Yes ❑ No
- If yes, to which therapies do you refer?

_____

- What is your specialty? _____
- Would you like to assist in this project in any way? _____

**Beth Treiber (585) 922-1119**
**beth.treiber@viahealth.org**
**FAX: (585) 922-2864**

Name_____ Email_____

Phone_____ Best Time to Reach_____

# IPA Connect™ Clinical Integration

## equently Asked Questions on portals, contracts, participation, etc.

ic Nielsen, M.D., CMO, GRIPA

each Dr. Nielsen at 585-922-3062 or
via email at Eric.Nielsen@viahealth.org

Last month in Forum we gave you an overview of Clinical Integration and we have been making presentations at physician meetings on the topic. This month we are addressing some of your questions.

**Q: Will we have to have an Electronic Medical Record (EMR) System to access the web portal?**

A: No. You will need a computer, laptop, electronic tablet or handheld personal digital assistant (PDA) with an Internet connection to access the web portal. GRIPA will provide you with either a laptop or a computer tablet. You will need to provide the high-speed Internet access.

**Q: Will GRIPA Connect work with my EMR?**

A: We are in discussion with several leading EMR vendors to assure interoperability (compatibility) wherever possible. Our system will have an open, non-proprietary architecture, so if your EMR vendor offers the same, it should be no problem to make the two systems works together. If you are considering purchasing an EMR system, or a practice management system, we suggest you contact us and we can give you more details.

**Q: Will the hospitals be a part of this system? What about the labs?**

A: Rochester General Hospital and Newark Wayne Community Hospital have agreed to participate in the web portal. Labs that will be online when we launch the portal include ViaHealth and ACM. We are continuing discussions with other providers.

**Q: How much will this cost me?**

A: The bulk of the cost will be in providing high-speed Internet access to your office, and in the labor cost to transition to the system. We will work with you on the latter to be sure that the transition is as easy as possible.

**Q: Who's paying for all this?**

A: The major cost for this initiative is being borne by GRIPA. We are also applying for a New York State grant to defray some of the cost.

**Q: Can I participate in GRIPA Connect even if my practice partners do not?**

A: Yes. All RGPO and WCPO shareholders are individually eligible to participate in GRIPA Connect. Whether you are a solo practitioner or an employee of a larger practice or entity and whether or not your partners or associates participate, you can still participate in GRIPA Connect. Some employers may have restrictions, but ViaHealth-employed physicians are being permitted to participate.

**Q: What's our legal liability for antitrust lawsuits?**

A: Although the FTC and Justice Department have sued more than 25 physician organizations in the past five years, the only individual physicians sued were the organizations' board members and physicians who facilitated the agreements on price with their competitors. GRIPA physicians should not need to worry about this. First, GRIPA has hired knowledgeable attorneys to help ensure that GRIPA Connect meets all legal requirements. Second, GRIPA is taking the proactive step of seeking an advisory opinion from the FTC before it begins contracting with payors for GRIPA Connect. Receiving a favorable advisory opinion will greatly reduce the chance that anyone will sue GRIPA.

**Q: Will participating in GRIPA Connect be mandatory for members of GRIPA?**

A: No, although we are hoping for robust participation. For members in private practice wishing to engage in single-signature contracting for non-risk contracts, this is probably the only open avenue.

**Q: If I enroll in GRIPA Connect, can I contract with an insurer that GRIPA does not contract with?**

A: GRIPA is intending to contract with physicians non-exclusively, so you could contract separately with an insurer with whom GRIPA does not have a relationship.

**Q: What is ViaHealth's stance on this?**

A: ViaHealth leadership has been very supportive. President Sam Huston spoke in favor of Clinical Integration at our first three physician meetings.

**Q: Will employed physicians be able to participate?**

A: Yes, as long as they are members of GRIPA.

**Q: Have other IPAs done this? What has been their experience with reimbursement for physicians?**

A: Other IPAs have successfully sold their services, as clinically integrated networks, to payors. Any increase in rates, though, did not come in the form of leverage. It came in the form of a competitive product that the payors were willing to buy.

GRIPA

**Log on to www.GRIPAconnect.com**

**You can:**

- **learn more**
- **sign up for a Physician Dinner Meeting**
- **take our Clinical Integration Survey**
- **contact us**

# CEO UPDATE

*By Sam Huston, President & CEO ViaHealth*

The process to recruit a new CEO for ViaHealth is continuing. It is anticipated that a list of potential candidates will be presented to the Search Committee at the end of April or the beginning of May and that interviews will be carried out shortly thereafter. Following the initial interviews, a smaller group will be invited back for second interviews. These interviews probably will take place around the end of May with the goal of an employment offer being made sometime in June. If all goes well, my best guess is that a new CEO will take office in the fall--September?

# Annual Doctor's Day Celebration

A crowd of more than 250 gathered in the Atrium on March 30 during the annual Doctors' Day celebration breakfast. The event hosted by the RGH Foundation, GRIPA and Physician Services is held annually to pay tribute to our physicians for their dedication to the health and welfare of their patients.

Each physician received a special RGH Doctor's Day coffee mug and entered to win one of several raffle gift baskets prizes. Among the winners were: Christine Stewart, MD, John Genier, MD, Roderick Spears, MD, Steve Ognibene, MD, Robert Heinig, MD, Rahul Laroia, MD, Paul Burns, MD, Scott Hicks, MD and Pamela Sullivan, MD and Kelly Hynes, DDS. Congratulations to the lucky winners, and a very special thanks to the departments of Education, ILS, Surgical Services, Ambulatory Division, Medical Nursing, RHI, Medical Nursing, PR/Marketing, Women's Care Unit/ Emergency Department/ Bed Coordination, Deb Zimmerman, RN, and Physician Services for their generous donations. If you were not able to attend the breakfast and would like a coffee mug, please stop by the MDS office to receive one.

# Practice Manager Event

On Wednesday May 17, the depart of Physician Services will be hosting the Annual Practice Managers' Conference Open House from 8:00am-1:00pm here Rochester General Hospital.

The event will highlight over 30 the ho pitals programs and services, provide opportunity for practice managers to see th hospital first hand and communicate our plan for expansion and renovation. We will als provide practical information on topics mar medical practices face today, and perha most importantly, continue a dialogue wi practice managers, a constituency import to the growth of the hospital.

"RGH Showcase" an exhibit area v take place during the entire morning in hospital's Atrium where representatives fr a variety of RGH departments and progra will offer information and answer questi Four different 45 minute educationa focused discussions will be presented in Twig Auditorium. Included will be session the **RGH Master Facility Plan Independent Living for Seniors "Your at Home Choices", "Excelle Everyday" and Human Resources tip The "how-to's" of Interviewing Conflict Resolution.** Tours of the renovated Clinical Laboratory Depart and the Women's Care Unit will also be able. Breakfast and lunch will be serv addition to special door prizes and a g everyone who attends.

Your office can register for this ev calling 922-LINK (5465)

We hope that you encourage your s participate.

**2006 Quarterly Staff Meeti**
**6/16, 9/22, 12/16**
**7:30-9:00 am Twig Auditoriu**
*50% attendance recommended for all attending Physicians*

Nam

Phon

JUNE 2006



24/7
PHYSICIAN
HOTLINE NUMBER:
**322-444**

DIRECT ADMISSION
NUMBER:
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**MARK YOUR CALENDARS**

Saturday August 5, 2006
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*Rochester Rhinos*
*at their new park.*
*More details to follow.*

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL

# A Message from the President, Linda M. Rice, MD

As my tenure as president comes to a close, I reflect on what I have learned over the two years. First and foremost, I have learned the importance of involvement in the hospital to better understand the issues and the problems, as well as to feel more fully a part of the community in which we practice medicine. Running a hospital in this environment of so many regulations and such tight financial constraints is a challenge that most of us recognize but may not fully appreciate. The role that we, as physicians, can play here is critical and crucial to the ongoing provision of high quality care for our patients. Our input is vital and encouraged. Too few take advantage of the opportunities to make a difference. I have learned that the common excuse of "no time" simply doesn't hold water. If we all are willing to put in some time, no one is overly burdened and the job will get done, hopefully all the better for a constant influx of new views and new energies. Somehow, when you make the commitment, there is time, and I've never felt it was time poorly spent.

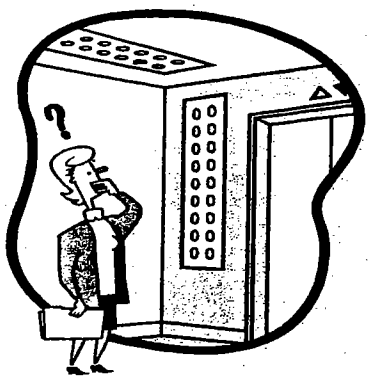
I have learned that more is accomplished by listening and brainstorming to come up with practical solutions, than by just complaining. I have learned that those with the power to make things happen respond more positively to concrete proposals, than by simply restating the problems with anger that nothing is done. We have more access to the administration at RGH than do the medical staffs in many hospitals, and should take full advantage of that.

There have been many positive changes at RGH in the past few years: financial turnaround, including several large philanthropic donations; significant progress and improvements in information technology with RIS/PACS and CCS access via our offices and our PDAs; planned and implemented improvements to the physical campus, including the expansion of the ED and the new entrance complex just breaking ground; the "Excellence Everyday" campaign which has instilled new energy into everyone contributing to making RGH a better place to work and to be a patient; the clinical integration proposal which should serve to improve quality and efficiency for all of us, and will hopefully help us to negotiate better reimbursement rates; the new Dept. of Physician Services which has helped to recruit more new physicians than we have seen in a long time; and more successful nursing recruitment and retention (nursing vacancy rate is at an all-time low, even in this time of nursing shortage).

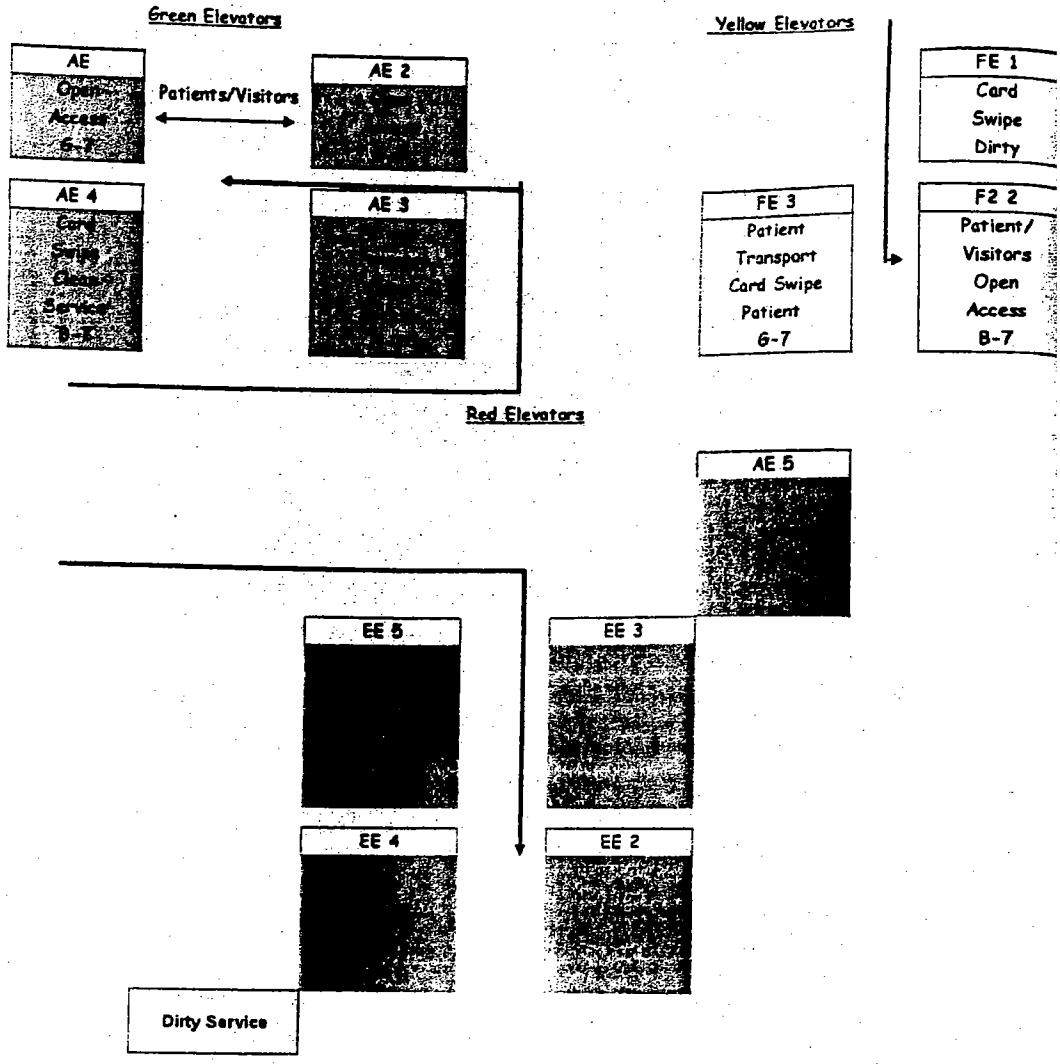
There are still issues to be addressed: recruitment in many specialties is still difficult, especially in our chronically low reimbursement milieu; the new construction will add further stresses to the system until it is completed; transitioning to a new CEO in a way that is smooth and constructive, while maintaining the present positive momentum is always a challenge.

So I turn the gavel over to Dr. Cynthia Christy and her successors. I strongly encourage more of you to come to the forefront and offer your ideas and expertise as officers and representatives of the RGH MDS. It truly has been a privilege and honor to serve.

# Elevator Etiquette Recently Shared With RGH Employees



- Remember, patient privacy and comfort is a priority. Please step off the elevator to allow transport of patients and wait for the next elevator.
- As a guideline, and to live a healthier lifestyle, walk up at least one flight, and down two whenever possible.
- Pause before entering to allow current riders space to step off.
- When escorting someone, stop and hold the door for them to step on ahead of you.
- Use elevators as appropriately assigned – such as transport elevators, clean and soiled service elevators.
- When asking staff or visitors to step off the elevator so that patients may be transported, used judgement to determine visitor needs – such as visitors who appear frail or who may be using walkers or wheelchairs.
- When visitors appear to need assistance, please offer help and escort them to their destination.
- If the elevator is full, do not attempt to squeeze in.

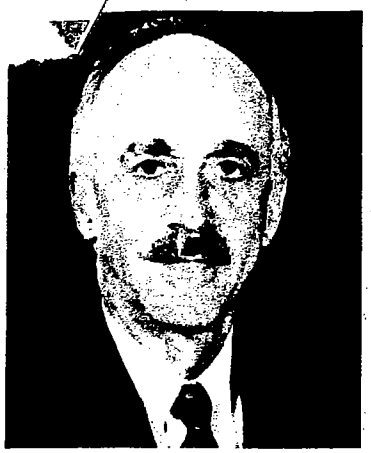



## Changes Coming in Elevator Use at Rochester General Hospital

In keeping with the spirit of Excellence Every Day and our commitment to provide the best possible environment for patients and visitors, there will be changes in the use and availability of elevators at Rochester General Hospital.

Soon, card swipe readers that have been installed will be used to call elevators for patient transport, and clean and dirty service. Individual elevators within each bank – red-yellow and green – are clearly marked for their intended use. Other elevators within each group will remain available for general use by visitors, staff and ambulatory patients.

The diagram included above illustrates the intended use for each elevator. Staff cooperation is key to the success of this plan, and is greatly appreciated. Our system standards for elevator etiquette are also included for your reference.



**Michael J. Feinstein, M.D.**
*Medical Director, Informatics*
ViaHealth-Rochester General Hospital
Voice: 585.922.1642 (Humboldt);
585.922.2932 (RGH)
Fax: 585.922.1655
Email: michael.feinstein@viahealth.org

# Privacy Biggest Challenge to Nationwide Healthcare Information Network

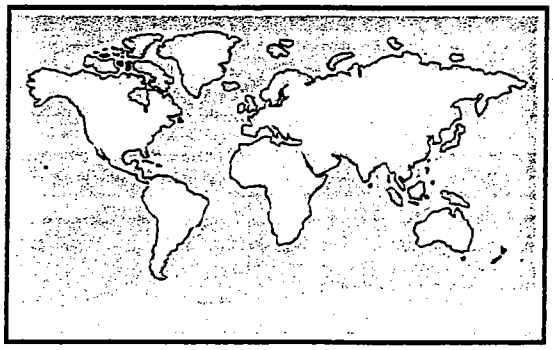
Privacy continues to top the list of potential stumbling blocks to a nationwide healthcare information network (NHIN). It is felt that unless the public is given strong control over their online records, the network might never get off the ground. For many, the fear of loss of privacy is so strong that forcing Americans to participate in the NHIN could doom it at the outset. Patients may need to be able to opt out of the NHIN. One study showed that only one in three Americans say that they trust health plans and government payers to protect their information. Another twenty per cent say that their personal health information has been illegally disclosed.

A study by Connecting for Health found that consumers' top priorities for the NHIN remain authenticating users, controlling and limiting who has access to health data, building in permission-based controls and guaranteeing that employers would not have access to health data. Thus, the most challenging aspect of the whole project is policy and not technology. The policy needs to be built in at the outset.

The emphasis on privacy is not shared by all experts. Scott Wallace, the CEO of the National Alliance for Health Information technology, says, "It's not privacy they want but confidentiality." The difference is that privacy, in terms of safeguarding data, is almost an antithesis to the goal of a NHIN, which is to share data with providers when they need it most. Confidentiality is compatible with data sharing with the expectation that data is shared with care professionals and no one else.

# United States Behind Other Nations on Healthcare Information Technology Adoption

A report published in the journal Health Affairs found that the United States is at least twelve years behind other industrialized nations in its adoption of healthcare information technology (HIT). The report looked at healthcare spending and IT adoption in countries that are members of the Organization of Economic Cooperation and Development (OECD). In other industrialized nations, the government, health insurers, or both pay for healthcare IT implementation.



Germany was the first country to start developing a national IT network, expected to be completed this year. The United States spends the least per capita on healthcare IT compared with five other nations. Total investment per capita as of 2005 was 43 cents, compared with $4.93 per capita in Australia, $31.85 in Canada, $21.20 in Germany, $11.43 in Norway and $192.79 in the United Kingdom.

Physicians in the U.S. have been reluctant to adopt HIT over concerns about lost productivity and inadequate financial incentives. Small groups and solo practices find the startup and maintenance costs too expensive. Many nations have begun to subsidize healthcare IT purchases on the condition that the systems interconnect. The U.S. has just begun to make modest investments in this area.

The report also found that the U.S. spent more per capita on healthcare than other industrialized nations that are members of the OECD and had fewer doctors, nurses, hospital beds and MRI machines than the OECD median.

# Official NYS Prescription Update

- Practitioners in hospitals and their affiliate clinics and practitioners in designated non-profit diagnostic and treatment centers are exempt from the requirement to prescribe non-controlled substances on official prescriptions until April 19, 2007.
- Adhesive stickers and labels, if limited to patient information, are valid for use on official prescriptions for non-controlled substances.
- Oral prescriptions for non-controlled substances do not require an official prescription follow-up.
- Refill authorizations may be faxed to pharmacies from practitioners for non-controlled substances only.
- Electronic prescriptions for controlled substances are not yet permissible in New York State.
- Prescriptions faxed from a practitioner's office to a pharmacy must be on an official prescription unless the practitioner's office is exempt under the hospital and affiliate exemption.
- The quantity of refills and the number quantity of drug to dispense for controlled substance prescriptions must be listed numerically and written word [example: 1 (one) refill, dispense 30 (thirty)]

Information received from:
James Giglio, Bureau of Narcotic Enforcement
NYS Department of Health - April 2006

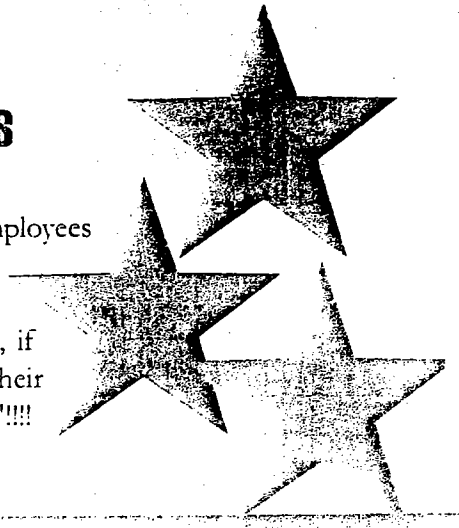
# Frequently Asked Questions

- **Is an official prescription written by a Physician's ... required to be countersigned by the supervising physi...**
  No. However, official prescriptions written by a Physician... must contain the imprinted (stamped or typed) name of... Physician's Assistant and the Supervising Physician.
- **Does a practitioner have to possess a DEA registration ... receive official prescriptions?**
  No. However, practitioners that do not possess a DEA re... number are prohibited from issuing prescriptions for contr... stances.
- **Are practitioners without a DEA registration allowed to ... facility's DEA number when issuing controlled substa... scriptions for patients of such facility?**
  No. Practitioners who are eligible for a DEA registration must ... their own DEA registration number to issue controlled substa... scriptions. The only practitioners who, upon authorization fr... facility, may use the facility's DEA number to issue controlled sub... prescriptions for patients of such facility are residents, interns a... eign physicians. Residents, interns and foreign physicians are not ... ble for their own DEA registration number.
- **Do residents need to include any additional information?**
  Residents who do NOT have their own license number MUST plac... the prescription the supervising physician's name and license numbe... MMIS number.
- **What if a prescription is written on a non-official form?**
  Controlled substance prescriptions not written on an official prescri... tion will not be filled by a pharmacy. Non-controlled substance pr... scriptions will be filled but the pharmacist is required to report th... practitioner's name to the Department of Health unless the prescri... tion is from an exempt facility.
- **How do I order official prescriptions?**
  Call 1-866-811-7957 or visit www.health.state.ny.us/nysdoh/narcotics/

# Welcome New Employees

<u>NEW EMPLOYEE BADGES</u>

At orientation this morning (May 15), new employees received a small, colorful foam star to place on their badges as a "signal" to the rest of the organization that they are new employees!!! So, if you see employees walking around with a star on their badges, say "hi", "welcome", "glad you're with us"!!!!



# Concierge Office Update

The Concierge Office has relocated. It can now be found behind the grey elevators (former archives office) near the entrance to the old parking garage.

Phone: 922-2190
Fax: 922-2922
Email: concierge@viahealth.org
Hours: 7:30am - 4:30pm

# Update on GRIPA Connect™ Clinical Integration

## From Federal Trade Commission filings to enrollment schedules

by [illegible], M.D., CMO, GRIPA

### Federal Trade Commission application process underway

As many of you know, GRIPA embarked on its GRIPA Connect Clinical Integration program with the intention of asking for a prospective advisory opinion from the Federal Trade Commission. A favorable opinion from the FTC would allow us to move forward with more confidence that we are on the right track.

With the help of our attorneys, Ober|Kaler—who represented MedSouth in its successful request for an advisory opinion—we submitted our request to the FTC during the first week of May. Within the next few weeks, we expect to hold face-to-face discussions with FTC staff to review our plans and receive preliminary feedback. (Stay informed by logging on to our Web site—www.GRIPAconnect.com).

We expect a six- to eight-month wait before the FTC will publish a written advisory opinion. Because our plan is comprehensive in addressing the fundamental components of Clinical Integration, we feel confident about the outcome of this effort.

### Portal implementation, or . . . when can I log on and start?

We are currently building the GRIPA Connect web portal. Our plan is to begin enrollment process in July of this year, when we will accept both primary care and specialty care practitioners.

Early enrollees will have access to the basic HealthVision features—including communal browser offices and access to lab and x-ray results) as well as Referral Management and the e-Prescribing feature. In early fall of 2006, we will add access to the Lab Order Entry feature. These features are the ones most needed to meet the "letter and spirit of the law" requirements for Clinical Integration.

| | |
|---|---|
| ❍ July | ❍ Enrollment begins<br>❍ Secure Messaging<br>❍ Results Viewer |
| ❍ late July | ❍ e-Prescribing<br>❍ Referral Mgmt |
| ❍ October | ❍ Lab Order Entry |

Interested in becoming an early enrollee? We'd be happy to welcome you! Contact Kelly Taddeo, Director, Provider Relations and Network Services at 585-922-1543 or Kelly.Taddeo@viahealth.org.

### Get informed. Get active. Get connected. It all begins at www.GRIPAconnect.com

Our informational web site is the source for information and opinion-sharing. Log on and make a difference:

- **Join our email update list**—we will send you regular updates on our activities by email. Follow the link to *Join our email list.*
- **Reserve your place at a GRIPA Connect dinner meeting.** These are small gatherings where you can ask questions and join in a frank discussion. Find a current schedule and RSVP right on the site.

GRIPA

- **Download our brochure** or most recent Clinical Integration newsletter.
- **Complete a GRIPA Connect survey.**
- **Stay up to date** on the latest news about GRIPA Connect—or get up to speed with our in-depth discussion of the background and components of Clinical Integration.

### Comments by Medical and Dental Staff President Linda Rice, M.D.

Dr. Rice delivered an endorsement of GRIPA Connect in last month's issue of *Forum*—as well as encouragement for doctors feeling slightly computer-phobic. For those who didn't catch her article, it's worth repeating a few lines:

"If we know the clinical guidelines that are evidence-based and promoted by ourselves, and are prompted with reminders as we are seeing patients, it will be easier to follow them. If we know what pharmaceuticals are on the individual formulary of the insurance of the patient in front of us as we order the drugs, it will save countless phone calls and rewritten prescriptions later on. If we can show that we are more efficient as a group, we should be able to use this to our advantage in future negotiations for better reimbursement."

### Data in the Doctor's Lounge

We're stocking the Doctor's Lounge at RGH with GRIPA Connect brochures and newsletters. Put your feet up for a minute and read all about this ground-breaking program—in which physicians come together for all the right reasons.

# Dialysis and Nephrology Move Offsite Under One Roof

On June 12, 2006, the Dialysis Unit of Rochester General Hospital will make a long awaited move to a large and beautiful off-site facility located at the corner of Ridge Road East and Seneca Avenue. The dialysis population is growing rapidly, and the new building will allow Rochester General Hospital to serve this population in friendly, convenient surroundings for many years to come. They will be joined by the Nephrology Unit of the Department of Medicine, who will have their offices in the same building, providing on-site support by doctors and mid-level practitioners.

The Dialysis Unit will be divided into 2 separate suites: 1) In-center hemodialysis in a new state-of-the-art facility, and 2) Home Dialysis, providing peritoneal dialysis, and in the future, hemodialysis in the home setting. The nephrology office will expand to have 8 exam rooms for more efficient care of patients. Two of the nephrologists will continue on a rotating basis to provide in-patient consultation and care for hospitalized dialysis patients, maintaining our commitment to in-patient services.

"It will be a big change, and a great one", said Dr. Steve Silver, head of the Nephrology Unit. "This new Nephrology Center is a joint effort of Rochester General Hospital and the Department of Medicine and is a sign of our commitment to excellent care of patients with kidney disease. They will be receiving state-of-the-art care."

**Center for Kidney Disease and Hypertension**

370 Ridge Road East, Suite 20
Rochester, New York 14621
Office phone: (585) 922-0400
Office fax: (585) 922-0455

# Safety and Secu Parking Update

The Department of S Security is pleased to announ lowing parking upgrades:

- The ground floor of the Avenue garage has been de for attending/community cians who are here for limite ods. Faculty physicians shou above the ground floor where will be able to use the "hands lane at the express exit. Safety Security will be enforcing parkin these physician spots and encourage all Physicians to disp the red and white parking decal your vehicle. Please contact t Parking Office at 922-9803 if yo need a replacement decal.
- As stated above, an additional "hands free" reader has been installed at the left hand express lane exit from the lobby level of the Portland Avenue Garage. This reader will allow for easier egress for Physicians electing to park above the ground floor.

Safety and Security would also like encourage all Physicians that have not yet registered for parking to visit or call the Parking Office to register and receive your "hands free" parking pass for the Portland Avenue Garage. The parking office is located on the first floor of Carter Street ramp garage.

**2006 Quarterly Staff Meetings**

**6/16, 9/22, 12/16**

**7:30-9:00 am Twig Auditorium**

*50% attendance recommended for all attending Physicians*

# Physician Services

175 Medical and Dental staff members from Rochester General and Newark Community Hospitals and their senior administrative staff gathered on April 25th at Sahlsy Flour Mill for the 2006 Spring Physician Social.

Hosted by the Department of Physician Services, the event was held to welcome and introduce the newest 31 members of the Medical and Dental staff and to provide and informal setting for the physicians to see colleagues face-to-face. The second annual Fall Social is being planned, and future announcement will be forthcoming.

Special thanks to everyone who helped to make this event possible.

# Medical Library to offer First Consult and Nursing Consult

The RGH Medical Library will have a one month free Trial of 2 new database products, First Consult and Nursing Consult, starting on May 30, 2006.

First Consult is targeted mainly to physicians, and is a type of product that has been compared to UpToDate. First Consult is an evidence based, continuously updated resource which compiles and summarizes the latest information on evaluation, diagnosis, management, outcomes, and prevention.

Nursing Consult is targeted mainly to nurses, and is a type of product that has been compared to MD Consult, except being geared to nurses instead of physicians. Nursing Consult provides an integrated search of full text journal articles, full text books, detailed drug information, and more.

Both of these products are scheduled to start being available on the ViaLibrary page on the ViaNet on May 30. In addition, First Consult is scheduled to be available remotely, which means it can be accessed from any computer with Internet access, such as your home computer.

The Medical Library will be considering adding one or both of these products to the Library's list of subscribed databases, if there is enough demand for either or both of them after the end of the free trial.

Further information on how to access these databases will be made available shortly before the start of the free trial period. For more information, including a User's Guide for either of these new products, contact the Medical Library at 922-4743, or stop into the Medical Library to pick up a copy of the User's Guide.

# Changes to Your RGH Directory

For those of you who access to the ViaNet, don't forget the on-line directory in Departments and Medical Staff. For those of you who do not have access to the ViaNet, there is a monthly excel directory available for request. Contact Mary Lou McKeown at 922-4259 or marylou.mckeown@viahealth.org.

# New Applicants

**Elaine Dailey, NP**
Provisional Adjunct, Department of Emergency Medicine
1425 Portland Ave Box 304
Rochester 14621 922-3846

**Matthew Fleig, MD**
Provisional Attending, Department of Family Practice/Medicine & Pediatrics
Genesee Valley Family Health Group
3800 Dewey Ave
Rochester 14616 922-2440

**Joseph Hart, MD**
Provisional Attending, Department of Surgery/Vascular Surgery
Uof R Vascular Surgery
601 Elmwood Ave
Rochester 14642 275-6772

**Eric Kerr, RPA-C**
Provisional Adjunct, Department of Surgery/General Surgery
1425 Portland Ave Box 173
Rochester 14621 922-3458

**Cheryl Kline, NP**
Provisional Adjunct, Department of Surgery/Urology
601 Elmwood Ave
Rochester 14642 275-3342

**Christopher Richardson, DO**
Provisional Attending, Department of Surgery/General Surgery
1445 Portland Ave #301
Rochester 14621 922-4518

**Tracy Vasile, DO**
Supplemental Staff, Department of Emergency Medicine
1425 Portland Ave Box 304
Rochester 14621 922-3846

**Jan Walker, MD**
Provisional Courtesy, Department of Pediatrics
Wayne Medical Group
4425 Old Ridge Rd
Williamson 14589 315-589-3312

# Change in Status

Laszlo Boros, MD ..... Inactive/Resigned
David Broadbent, MD ..... Inactive/Honorary
Ann Burbank, NP ..... Inactive/Resigned.
Timothy Chilelli, RPA-C ..... Inactive/Resigned
Richard Deter, RPA-C ..... Inactive/Resigned
William Driscoll, MD ..... Inactive/Resigned
Deborah Englert, MD ..... Inactive/Resigned
James Fetten, MD ..... Inactive/Resigned
Jane Khuri, DPM ..... Inactive/Resigned
Marvin Lederman, MD ..... Inactive/Resigned
Sarwat Malik, MD ..... Inactive/Resigned
Rajan Ravikumar, MD ..... Inactive/Resigned
Jonathan Rubins, MD ..... Inactive/Resigned
Susan Sargent, RPA-C ..... Inactive/Resigned
John Schmidt, MD ..... Inactive/Resigned
Alexxander Solky, MD ..... Inactive/Resigned

OCTOBER 2006

# forum

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL



24/7 PHYSICIAN HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION NUMBER:
**922-7333**

**MARK YOUR CALENDARS**

**RGH MDS Dinner Dance**
**January 27, 2007**
**Riverside Convention Center**

## Dear Members of the Rochester General Hospital Medical and Dental Staff:

Let me begin by telling you how pleased and excited I am to be joining ViaHealth at this dynamic time in its history. The health system has earned a reputation for excellence, and it is a real privilege to be a part of and leading such an exceptional organization.

I would first like to acknowledge and thank Sam Huston for the extraordinary leadership he has provided the system over the past six years – a period of great change and many challenges. I would also like to acknowledge the essential role that you the medical/dental staff, the board, and our employees have played these past six years in strengthening ViaHealth and Rochester General Hospital, and positioning our organization as one of the strongest and most respected health systems in western New York State.

During my first week, I toured Rochester General and each of the ViaHealth affiliates, and met with hundreds of employees, physicians, and patients. What I discovered very early on is just how unique and special ViaHealth and its physicians and staff really are! Physicians and staff proudly described the quality improvement initiatives they are working on; I was enthusiastically told about the plans to develop and expand clinical capabilities ranging from the Emergency Department to a new 64-slice CT; and I was educated on efforts to improve the patient experience – a central focus of the organization this past 12-18 months. I also saw first hand the many initiatives underway to improve the work and practice environment for our employees and physicians – something that is vital to delivering exceptional clinical and service quality to our patients and community.

Over the next several months, I will be returning to each of the affiliates to complete a more comprehensive orientation to the system. I will also be meeting with Rochester General Hospital medical staff officers and department chiefs, and will be working very hard to meet as many practicing physicians as possible. My goal during the first 60-90 days is to listen and learn, and hear from our physicians, staff, and patients how we can make Rochester General Hospital and ViaHealth an even better healthcare organization for our patients and community.

During the next six months, one of my most important priorities will be to lead the organization through the development of a new strategic plan to build on the wonderful work and progress that has occurred at ViaHealth over the years. The planning process will be highly collaborative and will involve our board, medical staff, management team and employees, as well as community leaders. This plan will map out the ways in which we will continue to earn the confidence of our community and practicing physicians and deliver even higher levels of service and quality to our patients and community who so much depend on Rochester General and ViaHealth.

I would like to close by thanking you for such a warm welcome to Rochester and ViaHealth. I look forward to working with you in the months and years ahead to make ViaHealth the healthcare provider of choice for the residents and the preferred health system of practice for the physicians of the Greater Rochester area.

Mark C. Clement
President
Rochester General Hospital

# Message from the President of the Medical & Dental Staff- Cynthia Christy, MD

- RGH and Newark Wayne Hospitals have joined together with Strong and Highland hospitals in becoming smoke-free on November 16, 2006 in conjunction with the American Cancer Society's Great American Smokeout. I am really proud that we are participating in this initiative to promote healthier lifestyles for our patients and employees.
- Tobacco use is the leading preventable cause of disease and death in the United States. Smoking is a factor in heart disease, cancer, stroke, and lung disease, and it costs the U.S. nearly $150 billion each year in health care and other expenses. About 438,000 people die each year from smoking related diseases. Second hand smoke is the third leading cause of preventable death following smoking and alcohol abuse. In addition, a pack-a-day smoker spends about $1,460 - $2,190 a year on cigarettes.
- Smoking cessation classes have been offered for staff and nicotine-replacement alternatives will be offered to staff (for a six-month period), patients and visitors. Clinical staff will assess each hospitalized patient, prescribing nicotine replacement therapy and offering smoking cessation counseling to those who use tobacco.
- Many committees that including physicians, nurses and other staff have been meeting for months to plan for this transition to a totally smoke-free environment.
- Please take a moment and mention these options to a smoker in your midst. It could save their life.

# New Expanded Outpatient Hours for the Rochester General Hospital Department of Diagnostic Imaging

In order to improve patient convenience and access and to meet the needs of our referring health care professionals, the Diagnostic Imaging Department has expanded the hours of operation for Outpatient examinations into the early evening. The Radiology Department is now staffed and open for walk-in patients until 6:30 pm Monday thru Friday.

In addition to providing unscheduled routine Outpatient X-Ray examinations on a walk-in basis, we have added a 5 and 6 PM Outpatient Ultrasound appointment time and a 4:30 and 5:30 Outpatient CT appointment time. An Attending Radiologist will be onsite during the performance of these exams. Preliminary interpretations will be given upon request. The actual images will be available via the PACS Webserver immediately from selected PC's as soon as the exam is performed and in CCS when the report is sent to CCS. If you would like training on accessing reports or images in CCS or have Webserver questions, please call us at **922-2987.**

Please have your office call the Scheduling desk at **922-2160** to schedule an appointment, for any Ultrasound or CT procedure. For routine X-Ray exams, your patients can simply stop by during these later hours.

Please post the new hours of operation grid near your appointment desk for quick reference. Should you have any questions or would like to talk with the Radiology Director, please call Stephen Doerner at **922-3250.**

**Rochester General Hospital - Department of Diagnostic Imaging**
**OUTPATIENT HOURS OF OPERATION**

| | | | |
|---|---|---|---|
| **General Diagnostic X-Ray exams** | 8:00 am – 6:30 pm | Walk-in No Appointment needed | * The Radiology Registration Area is open until 6:30 pm Monday – Friday |
| **Mammography Screening** | 8:00 am – 4:00 pm | By appointment | Monday – Friday |
| **Ultrasound** | 8:00 am – 6:30 pm | By appointment | Monday – Friday |
| **CT** | 8:00 am – 6:30 pm | By appointment | Monday – Friday |
| **Nuclear Imaging** | 8:00 am – 5:00 pm | By appointment | Monday – Friday |

# UPDATE: RGH EMERGENCY DEPARTMENT

*By John Schriver, MD*

**Census:** For the past six months there has been a 9% ED census increase, fueled by an increase of several hundred additional ambulance arrivals per month. Concurrently, the number of "Code Red" (ambulance diversion) hours has decreased.

**Physician Recruiting:** The arrival of Bryan Gargano, M.D., Eve Williams, M.D., (both Adult ED) and Kevin O'Gara, M.D. (Pediatric ED) increases the complement of physicians trained in Emergency Medicine to eight. Active recruitment continues with dinners planned in Albany, Syracuse, Rochester and Buffalo, the sites of Emergency Medicine residency training programs.

**Nurse Recruiting:** In the Adult ED, nine RN's (including three already RGH staff) have been added to the department staffing in the last two months reducing the number of open positions significantly. The concept of a dedicated nursing staff in the Transitional Care Unit (TCU) was implemented in July.

**Quality Improvement:** Patient complaints are steadily decreasing (50% in the last 6 months) and triage to booking by providers remains less than 2 hours average for 90% of admissions. Average Adult ED length of stay remains 5-6 hours (90 minutes in the Fast Track unit).

**Emergency Department Information System:** Implementation of the MedHost EDIS commenced in July (includes Newark-Wayne Hospital ED) with full operational status scheduled for November 2006. This touch screen system will include patient locator, order-entry, nurse and physician documentation functions.

**New Emergency Department:** Designing the new RGH ED is near completion with the beginning of construction slated for the late Fall.

# MEDHOST-Phase One

*By Randal Christenson, MD*

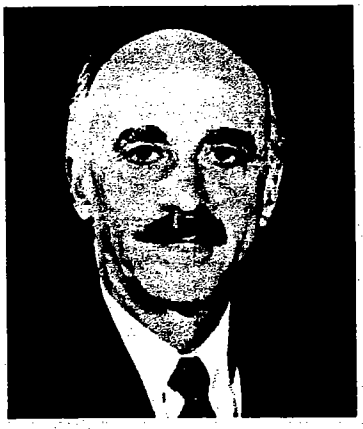
The transition from paper to paperless has begun in the Emergency Department.The start date for GO LIVE for Phase one in the implementation of Medhost ,the Electronic Medical Record for the ED, has come to pass, and has been called a Success. According to the Medhost Support Staff here for the initial days of the Go Live and the RGH Project Team Leaders the transition went smoothly. During this Phase Medhost is mainly a Tracking System and Locator Board. The most notable change in the ED is the now barren Locator boards which were hung on the halls through out the ED. Their function is now being found on the various computer work stations in the Department. With literally the touch of a finger any Patient in the ED can be found from any terminal. The ability to track the progress of Lab and Radiology tests can also be ascertained by the Status of the various icons on these screens.

As an Historical note, Medhost has it origins in the Restaurant Business. It was originally a Table and order tracking software system used by the Waiters and Waitresses and it is this same mapping system that Medhost currently uses to track and locate Patients thru the ED.

Another feature of this phase is the ability to generate comprehensive Standardized Discharge Instructions and information on the prescriptions given to Patients for the Patients. It is now also possible for the ED Provider to Fax to the Follow-up Provider a brief synopsis of what that Patient was Discharged with. As we become more proficient with this system the MDS should start seeing more of this kind of information coming to their Offices on their Patients that have been seen in the ED.

We in the ED are excited about this new Tool. It provides a better handle on the flow of Patients and allows for better Teaching on Patient Discharge. There will be more to come, stay tuned for Phase II.

# IT UPDATE



**Michael J. Feinstein, M.D.**
*Medical Director, Informatics*
ViaHealth-Rochester General Hospital
Voice: 585.922.1642 (Humboldt);
585.922.2932 (RGH)
Fax: 585.922.1655
Email: michael.feinstein@viahealth.org

**HOSPITAL WIRELESS SYSTEM**- At this time the wiring for the entire hospital is complete and the access points have been installed. Testing is now being done to be sure there are no "dead" spots and that all zones are overlapping. When completed in the next few months, not only will many wireless devices be utilized in the hospital but also your PDA's may be synced at any location within the hospital. The present infrared sync stations will still be available should the wireless system be down or for the staff that does not have wireless capability on their PDA's.

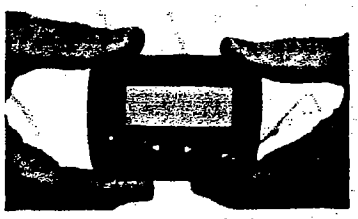
We will be working to have the capability for the staff to have a physician directory on their PDA's.

**CHARGE CAPTURE**- The charge capture module from Mercury MD for PDA's will be implemented in the very near future for all employed physicians. We are also looking at a HandOff module for "change of coverage" which would initially apply to all Hospitalis and house staff.

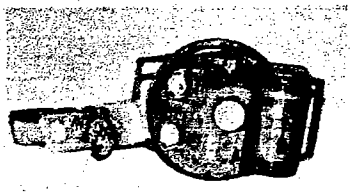
**NURSE CALL SYSTEM**- The new Wescom nurse call system has been completed on 4200,5800,2800 and 4800. 5200 and 7800 will be completed this year. Units that were completed in the past two years include, B7, DOSA, PACU, CTICU and Radiation Oncology.

Nurses and technicians wear both pagers and locator devices. When a patient presses his or her call button, the call goes directly to the nurse or technician assigned to that patient. If they are unavailable, the call goes to the nurse manager. When a nurse enters the patient's room, the time is noted from a device at the foot of the bed. An LED outside the room tells where nurses and technicians are at any time. The system allows for a marked reduction in noise levels by eliminating overhead pages on the floor as well as call bells.

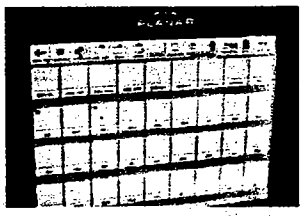
The entire nurse call event, from receipt of call through delivery of service is recorded in a database for assisting in planning, staffing and for risk management.



*Pager worn by nurses and technicians*



*Locator device worn by nurses and technicians*



*Computer screen of nurse call system*

**IS&T STRATEGIC PLAN**- The Information Systems and Technology group is presently undergoing an evaluation by the First Consulting Group with an overall strategic plan for the department to be developed. Various focus groups will be convened, including a physician focus group, for questions, problems and suggestions.

**M Data PDA PROGRAM**- Active users of the M Data program (those who have synced at least once during the month) generally run between 105 and 115 users. However, inactive users (those who have signed up but not synced their PDA's with the program in one or more months) run approximately 145 to 150. If any of the staff is having problems or questions with the program or with their present PDA (or choosing a new PDA) please contact me at the above phone or email. For simple technical problems or questions please call the Help Desk at 922-HELP.

# RGH Selected "Mentor" Hospital

*By Linda G. Nicholson, RN,MS,MSEd,CNAA*

We are pleased to announce that Rochester General Hospital has applied and been selected as a mentor hospital for the Institute of Healthcare's (IHI) 100,000 Lives Campaign to increase patient safety. Vicky Orto's "Rapid Response Team" and Linda Greene's "Preventing Central Line Infections" team have been deemed official "mentors" for other hospitals who are implementing these quality/safety improvements. Congratulations to all those that have participated and are leading the charge.

# A Sincere Thank You to All Our Physician Assistants

On October 6, 1967, the first Physician Assistants graduated from Duke University. Today, more than 42,000 PAs are providing essential medical and surgical services to people from all walks of life.

Rochester General Hospital has the honor of seeing 119 of you work with our patients on a daily basis.

You have assisted each of us in assuring that patients receive the attention and care that we would all wish for our family members to receive.

The Medical & Dental Staff of RGH honor you on your nationally recognized day and thank you for your service and dedication. Please keep up the good work and continue to assist the hospital and its physicians with your invaluable care.

# Changes in Contacting RGH Medical and Dental Staff Members Through the RGH Switchboard

In an effort to enhance the ability for RGH Medical and Dental Staff members to be contacted more easily, especially by one another, the process by which "page" requests will be handled by the RGH Switchboard has been clarified. The desired objective is to establish as streamlined a mechanism as possible utilizing the available resources in an efficient, customer-friendly manner.

The resultant process to be used when someone calls the Switchboard asking them to page an RGH MDS member is as follows, depending on whether or not the Switchboard has been given the member's pager number:

- If the Switchboard has a pager number: The operator will page the individual to the caller's number and inform the caller that if he or she does not get a call back then the caller should phone the member's office or the answering service, and one or both of these numbers will be given to the caller.
- If the Switchboard does not have a pager number: The operator will inform the caller that a pager number is not available and the caller will need to call the office or the answering service, and one or both of these numbers will be given to the caller.
- NOTE: Residents will continue to be paged via their pager numbers and overhead paging will be reserved for STAT calls only.

In order to have as accurate and comprehensive a database of pager, office, and answering service numbers as possible, the Medical Staff Office is contacting each member of the RGH Medical and Dental Staff. As this information is gathered, it is loaded into a database that will be made available to the Switchboard. Please note that if the member chooses to provide a number other than a pager at which he or she can be contacted, for example, a cell phone number, that option is available at the discretion of the member, but only one "pager" number will be stored in the database.

This procedure, **which will be in effect as of October 1, 2006,** is the result of a cooperative effort among Mary Lou McKeown, Manager, Medical Staff Office; Donna Piano, Manager, Telecommunications; and the Physician Experience/Loyalty Team, co-chaired by Aida Casiano-Colón and Mark Mancuso; and was approved by Richard Gangemi, MD, Senior Vice President, Academic and Medical Affairs. Any questions or feedback regarding the implementation of this policy by the Switchboard staff should be directed to Donna and any concerns with the policy itself should be forwarded to Dr. Gangemi.

# To All of our Dedicated Certified Nurse Midwives In Honor of National Nurse-Midwifery Week

The American College of Nurse-Midwives (ACNM) and certified nurse-midwives across the country will work to raise public awareness of domestic violence, as the theme of Nurse-Midwifery Week (October 1-7). This effort coincides with the millions of Americans observing National Domestic Violence Awareness Month.

This reaffirms your commitment to being With women, for a lifetime. You are to be congratulated. Rochester General Hospital has the honor of seeing you work with our patients on a daily basis. You have assisted many physicians, patients and their families by providing the attention and care that we would all wish for our family members to receive.

To honor you on your nationally recognized week and thank you for your service and dedication, the Medical & Dental Staff is sending you the enclosed token of our appreciation.

Please keep up the good work and continue to assist the hospital and its physicians with your invaluable care.

# Upgrade in CME Requirements at Reappointment

*By Mary Lou McKeown, Manager Medical Staff Office*

At time of reappointment a notice is sent to each RGH MDS Member asking for the provision of the previous two years of CME's. A very large percentage of the reappointment applications which are returned do not contain any CME's. This in turn, prolongs completion of the reappointment process.

In an effort to make documentation easier for everyone, the Chiefs and the Credentials Committee agreed to add a statement to the reappointment process instead of requiring submission of all CME Certificates. It is anticipated that this will assure the receipt of a greater number of completed reappointment applications. This statement will now be included in all reappointment documentation for each RGH MDS Member to sign.

In addition, the **documented actual requirement for CME credits has been upgraded to 50 per year.** The change from 20 CME to 50 CME credits takes place starting October 2006.

Should you have any questions, please contact your Medical Staff Office Representative.

# Dentistry at Rochester General Hospital

*By Richard Speisman, DDS, FAAHD*
*Chief, Department of Dentistry*

With the sale of the Genesee Campus and the close of the Pluta Family Center for Oral Health, the Department of Dentistry has lost two of our senior attending staff. While we have been striving to make more efficient use of our space at RGH, we will be expanding our space in phases so that we can accommodate our 5 general practice residents and senior attending staff. In phase I of our expansion we will be adding 2 additional treatment rooms and upgrading our air handler system to improve air flow to the treatment areas where nitrous oxide is used for sedation. We will re arrange our administrative suites to accommodate our attending and resident staff so that they have a quiet place to discuss patient care and review charts. We are excited to be working with Roop Hazarie, a new member of our senior leadership team specializing in lean six -sigma process improvement, to look at ways to improve patient access, improve the processes through which we deliver patient care, and to improve the environment of care to better serve our patient's needs.

We will be adding hours dedicated to our employed staff and look forward to providing cosmetic services and minor orthodontic care to correct cosmetic deformities in our adult patient population. We are recruiting new senior staff members to assist with the increased demand for services.

Our goal continues to be to become the dental health care provider of choice for our staff at RGH and the community.

**Support services**

The Department of Dentistry continues to provide support services for our other centers of excellence at RGH. The relationship between diseases of the oral cavity (periodontal disease) and cardiovascular disease, premature birth, low birth weight infants and other chronic diseases is becoming stronger as more research data becomes available.

Our staff is working with The Women's Center to provide dental health screening, education, preventive programs and dental care for at risk pregnant women early in their pregnancy to help avoid complications later on. Our senior and resident staff continues to provide support to the patients of the Mary Gooley Hemophilia Center, the Dawn and Jacques Lipson Cancer Center, The Rochester Heart Institute, and the Pediatric, Medical and Surgical Services at RGH. In addition we provide care for Independent Living for Seniors clients and continuous coverage for our Emergency Department for dental and oral and maxillofacial trauma and after hours emergent oro-facial problems.

**General Practice Residency Program**

Dr. MaryJo Tobin stepped down as our residency director and handed the reigns over to Dr. Samantha Vitagliano who has been an active member of the dental staff since the completion of her residency. Dr. Tobin continues to support the program and remains as one of our dedicated voluntary attending staff members.

**Our new resident staff are:**

| | |
|---|---|
| Dr. Puneet Gill | R1 |
| Dr. Vivian Luong | R1 |
| Dr. Ravi Vasudeva | R1 |
| Dr. Svetlana Yurovskiy | R1 |
| Dr. Albert Zak | R1 |

**Oral and Maxillofacial Surgery (OMFS)**

Our department has hired a part time Oral and Maxillofacial Surgeon (OMFS), Dr. Jolly Caplash. Dr Caplash did his post graduate training at the U of R, relocated to Maryland after graduation and has returned home to Rochester. Dr. Caplash recently received his board certification in Oral and Maxillofacial Surgery. Dr. Salahuddin continues to assist with the supervision of our OMFS residents rotating through our department from the University, and to help our patients with oral and maxillofacial surgery needs.

**Access to care and Enhanced Patient Service**

We are currently exploring new telephone systems to decrease patient waiting time or busy phone lines. We are also looking at ways to better scheduling employees to make it more convenient for them to come in for appointments. The addition of Dentists has increased our ability to provide comprehensive care for employees and their families. We have had discussions with Kodak on the digital imaging system are hopeful that we will join radiology in the use of the new system.

**Acquisition of new technology**

The Department of Dentistry is the last bastion of film based technology at RGH. Digital radiography will offer us significant benefits in patient care and access to care. Having radiographic information available in real time in the OR and for our outpatients will reduce the time our patients have to spend under general anesthesia and increase the number of patients we will be able to see in our department. We a re looking for ways to raise funds to begin obtaining the technology needed for our transition away from film.

**Pediatric Dentistry**

Dr. Nicole Mooney has been providing services to our pediatric patients both for outpatient and through ambulatory surgery for those young patients who can not be cared for in an out patient setting.

# UPDATE ON "Do Not Use" Abbreviations and "legibility"

As of mid- August , the occurrence of "Do Not Use" abbreviations in the medical record has increased.


Simultaneously, the use of the printed name and phone number to clarify entries in the medical record has decreased.

**This is not a good combination to prevent error.**

Remember particularly to ***avoid*** using "qd" and "qod" and to print your name and phone number to facilitate any needed clarification of record entries.

The "Do Not Use" abbreviation list can be found at www.viahealth.org, under Medical Professional Information.

Thank you from,

Hospital staff and your patients!

# Dispelling Myths & Misperceptions

## Just The Facts About Clinical Integration

by Eric Nielsen, M.D., CMO, GRIPA

*Reach Dr. Nielsen at 585-922-3062 or via email at Eric.Nielsen@viahealth.org*

**Thank you to the many physicians who have already signed their GRIPA Connect Clinical Integration contracts.** For those of you who still have questions, we want to clarify some of the facts about Clinical Integration. Please call us at (585) 922-1525 if you have additional questions and we'd be happy to discuss your concerns.

**FACT: It is NOT a HIPAA Violation for physician offices to send billing info data to GRIPA for insurance plans not contracted with GRIPA and for government programs such as Medicare & Medicaid.**

HIPAA permits a physician to share health information, without patient authorization, for purposes of improving the quality of care provided by the physician or other health care providers. HIPAA also allows a business associate, such as GRIPA, to aggregate the data supplied by multiple providers for analytical and benchmarking purposes related to quality improvement.

To participate in GRIPA Connect Clinical Integration, all physicians must sign a Business Associate (BA) agreement, which is attached to the Clinical Integration contract. The BA agreements are written such that the covered entity (the physician office) cannot contractually authorize the business associate (GRIPA) to make any use of, or disclosure of, protected health information that would violate HIPAA.

**FACT: You DO NOT have to have an Electronic Medical Record (EMR) System to access the GRIPA Connect web portal.**

All you will need to access the web portal is a computer, laptop, tablet or handheld personal digital assistant (PDA) with an Internet connection. GRIPA will provide private physicians who are members of RGPO/WCPO with a laptop / tablet. You will need to provide and pay for the high-speed Internet access.

**FACT: Clinical Integration will NOT cost you a lot of money.**

The bulk of your costs will be in providing high-speed Internet access to your office, and in the labor cost to learn, and transition to, the system. We will work with you on the latter to be sure that the transition is as easy as possible. The major cost for this initiative is borne by GRIPA.

**FACT: It will NOT take a lot of time for your office staff to send billing data to GRIPA.**

GRIPA is working with physician office billing vendors to create a method for each practice to send data electronically, without extra work for the office staff and at no charge to the physician.

**FACT: Clinically Integrated physician organizations CAN legally contract with insurers on a fee-for-service basis.**

The Federal Trade Commission allows joint contracting that does not involve the sharing of financial risk where the physician organization can demonstrate that joint contracting is necessary to achieve measurable quality improvements in patient care. To be successful in demonstrating quality improvement, GRIPA must implement Clinical Guidelines to which its members will adhere, and GRIPA physicians must share their billing data so that improvements can be measured.

**FACT: Clinical Guidelines ARE NOT being developed by GRIPA Staff. They ARE being developed and approved by Primary Care Physicians and Specialists in the GRIPA Network.**

The Clinical Integration Committee is comprised of both primary care and specialist physicians who are members of GRIPA and are respected practitioners in the community. This group meets monthly and has the primary responsibility for the selection, modification and evaluation of Clinical Guidelines. The CIC receives input and recommendations from Specialty Advisory Groups, which include physicians from each of the specialties and subspecialities affected by the guidelines that are being developed. The GRIPA Board of Directors has final approval on all guidelines.

Want to learn more about GRIPA Connect Clinical Integration? GRIPA Physicians and Practice Managers: If you haven't yet attended one of our dinner meetings, join us on either October 17 or October 26 at 6:15 p.m. at the DelMonte Lodge. RSVP by calling 922-1525 or online at GRIPAconnect.com.

**Up Close with GRIPA Connect at the RGPO/WCPO Annual Meeting**

This year's annual meeting of the Physician's Organizations will feature demonstrations on the GRIPA Connect Web Portal, a chance to 'try out' the portal's functionality on the new laptops/ tablets—and information you need to get your office up and running on GRIPA Connect. **Mark the evening: November 9 at RGH.** We'll send more details to physician members' offices.

GRIPA

Clinical Integration

Physicians coming together for all the right reasons


Medical and Dental staff Alumni Dinner on Wednesday November 15 from 6:00 pm – 10:00 pm at the Rochester Hyatt Regency.

# CHANGE IN MEMBERSHIP

**ENTERED LEAVE OF ABSENCE**

- Rosemary Janofsky, CNM –Department of OB/GYN
- Nandini Joshi, MD –, Department of Physical Med & Rehab
- Jane Pardee, MD –Department of Pediatrics
- Shariq Sayeed, MD –Department of Surgery/General Surgery Hospitalist

**RE-ENTRY**

- Pamela Martin, MD – Department of Medicine/Internal Medicine
- Cynthia Reddeck, MD – Department of Cardiac Services/Cardiology

**CHANGE TO INACTIVE**

Armin Afsar-Keshmiri, MD
Jason Batley, MD
Aida Casiano-Colon', Ph.D.
Heather Cook-Smith, NP
Teresa DeSantis, NP
Catherine Ernsthausen, NP
Paul Holman, MD
Kelly Hynes, DMD
Dana Jackiw, NP.
Jimmy Julia, MD
Jenifer Kent, CRNA.
Vinaya Konduri, MD
Elizabeth Masco, NP
Nail Nagovskiy, MD
Nancy O'Rourke, NP
Anace Said, MD
Bipin Shah, MD
Michelle Siena, NP
Scott Thompson, MD
Paul Weiss, MD
Michael Wittek, RPA-C

# The New Hard Copy
# RGH MDS Directory is Available

*By Mary Lou McKeown*

As with previous years, a current hard copy version of the Rochester General Hospital Medical & Dental Staff Directory has been created and is available to each MDS Office. Please contact me to have a copy sent to your office. In addition, a monthly updated electronic excel version is available for you at any time. I maybe reached at 922-4259 or marylou.mckeown@viahealth.org.

The directory includes all 1287 Members of the RGH MDS – Active, Courtesy, Consulting, Adjunct and Supplemental and their membership status as of the 7/2006. Those who are noted as "provisional" means that they are within their first year of appointment to the RGH MDS at the time the directory was printed.

When you review the pages you will find:

1. Directory is in alphabetical order.
2. Last Name, First Name, Degree, and Membership Status
3. Primary Clinical Department the person has privileges within and the division if applicable.
4. Office Name, Primary Office Location, City, State Zip Code
5. Primary Office Location Phone, an Alternate Phone Number, a Pager and a Fax Number

This information is based on the daily updates you provide your Medical Staff Office (MSO). If the information in this directory is not correct, then the MSO has no record of corrected data. Please contact your MSO representative to have this corrected. Corrections will appear in the electronic versions as soon as received. It will also be corrected in the hard copy version when it is next printed.

For those of you looking for MDS professionals by clinical department or division, there is a alphabetical listing at the back of the directory. When you locate the MDS professional you are looking for, you can then cross reference that person in the main directory.

We hope this assists you in your daily involvement with Rochester General Hospital and the Medical & Dental Staff. Please contact me with any comments you may have.)

# MARK YOUR CALENDAR

The Department of Physician Services will be hosting the semi-annual Medical & Dental Staff

**"Fall Physician Social"**

**Wednesday October 25 • 5:30 pm- 9:00 pm**

**Oak Hill Country Club**

Join us and meet Mark Clement, new President and CEO of ViaHealth, and the newest members of our Medical and Dental Staff.

More than 175 physicians attended our Spring Social in April, and we look forward to an even larger participation this Fall. Please contact Lisa Tantalo at 922-9435 by October 15 to RSVP.

# Changes to Your RGH Directory

For those of you who access to the ViaNet, don't forget the on-line directory in Departments and Medical & Dental Staff. For those of you who do not have access to the ViaNet, there is a monthly excel directory available for you upon request. Contact Mary Lou McKeown at 922-4259 or marylou.mckeown@viahealth.org.

Patrick Basile, MD, Attending
Surgery/General Surgery Hospitalist
1425 Portland Ave #113
Rochester 14621
585-922-4518

Theresa Bingemann, MD
Attending
Medicine/Allergy/Immunology
220 Alexander St #402
Rochester 14607
585-922-8350

Michelle Bloom, RPA
Adjunct
Medicine/Internal Medicine
1425 Portland Ave #258
Rochester 14621
585-922-2300

Adrienne Brydalski, RPA
Adjunct, Medicine/Internal Medicine
1425 Portland Ave #258
Rochester 14621
585-922-2300

Kathleen Byrne, NP
Adjunct
Emergency Medicine & Pediatrics
John James Audubon School
500 Webster Ave
Rochester 14609
585-482-9290

Mirabai Chockalingam, MD
Attending, Medicine/Internal Medicine
2828 Baird Rd
Fairport 14450
585-586-2355

Shirley Cirillo, MD
Attending, Medicine/Neurology
1734 East Ridge Rd
Rochester 14622
585-467-8888

Carla Culhane, NP
Adjunct, Medicine/Endocrinology
222 Alexander St. #5500
Rochester 14607
585-922-4800

Emily DeBadts, RPA-C
Adjunct, Obstetrics/Gynecology
1200 Driving Park Ave
Newark 14513
315-331-6737

Sarah Dewitt, PA-C
Adjunct, Orthopaedic Surgery
1425 Portland Ave #143
Rochester 14621
585-922-3963

Naga Garikipati, MD
Attending, Medicine/Internal Medicine/Hospitalist
1425 Portland Ave #287
Rochester 14621
585-922-4368

Carlise Gross, NP
Adjunct, Emergency Medicine
1425 Portland Ave #304
Rochester 14621
585-922-9332

Jeanette Guzman, MD
Attending, Emergency Medicine
1425 Portland Ave #304
Rochester 14621
585-922-3846

Marc Halterman, MD/PhD
Attending, Medicine/Neurology
1425 Portland Ave #220
Rochester 14621
585-338-4371

Valerie Hamann, RPA-C
Adjunct, Medicine/Internal Medicine
1425 Portland Ave #287
Rochester 14621
585-922-9067

Susan Hartfield, RPA
Adjunct
Surgery/Critical Care Medicine
1425 Portland Ave SICU
Rochester 14621
585-922-3860

Sara Hines, PA-C
Adjunct, Medicine/Internal Medicine
1425 Portland Ave #258
Rochester 14621
585-922-4635

Minique Ho, MD
Attending, Obstetrics/Gynecology
601 Elmwood Ave Box 668
Rochester 14642
585-275-7824

Jason Huang, MD
Attending, Surgery/Neurosurgery
601 Elmwood Ave Box 670
Rochester 14642
585-276-3049

Jennifer Kendall, MD
Attending, Anesthesiology
1680 Empire Blvd #300
Webster 14580
585-347-0030

Anna McNanley, MD
Attending, Obstetrics/Gynecology
125 Lattimore Rd #258
Rochester 14620
585-442-8020

Michael Meyer, MD
Attending, Medicine/Neurology
1425 Portland Ave #220
Rochester 14621
585-922-4371

Heather Michalak, MD
Attending, Pediatrics
1800 English Rd
Rochester 14616
585-225-2525

Mathew Mingione, MD
Attending, Obstetrics/Gynecology
601 Elmwood Ave #668
Rochester 14642
585-275-7824

Anne Olinger, MD
Attending, Medicine/Geriatrics
2066 Hudson Ave
Rochester 14617
585-922-8950

Gina Overhoff, PA-C
Adjunct, Surgery/General Surgery
1425 Portland Ave #362
Rochester 14621
585-922-3458

Joanne Pauliny, MD
Attending, Pediatrics
1700 Hudson Ave
Rochester 14617
585-342-5665

Nancy Pelino, MD
Attending
Medicine/Internal Medicine
2350 Ridgeway Ave
Rochester 14626
585-225-0410

A. David Penney, Jr., MD
Attending, Obstetrics/Gynecoloy
1415 Portland Ave #400
Rochester 14621
585-922-4200

John Pietropaoli, MD
Attending
Medicine/Internal Medicine
1401 Stone Rd #201
Rochester 14615
585-865-1110

Kristin Rooney, MD
Attending, Obstetrics/Gynecology
500 Helendale Rd #265
Rochester 14609
585-266-2360

Salima Sadruddin, MD
Attending, Medicine/Internal Medicine/Hospitalist
1425 Portland Ave #287
Rochester 14621
585-922-4368

Bryan Scott, MD
Attending, Radiology
1425 Portland Ave #226
Rochester 14621
585-336-5626

Gavin Scott, RPA
Adjunct, Surgery/General Surgery
1425 Portland Ave #173
Rochester 14621
585-922-3458

Roshan Sher Ali, MD
Attending, Medicine/Internal Medicine/Hospitalist
1425 Portland Ave #287
Rochester 14621
585-922-3458

Becca Spaulding, NP
Adjunct, Psychiatry
490 East Ridge Rd
Rochester 14621
585-922-2500

Jamie Marie Yee, RPA-C
Adjunct, Orthopaedic Surgery
293 West North St
Geneva 14456
315-789-0993

JULY 2006

# The Forum

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL

## RGH MDS ELECTED REPRESENTATIVES

**Cynthia Christy, MD**
President, 922-4028

**Richard Constantino, MD**
President-Elect, 922-3496

**Linda Rice, MD**
Past-President, 266-0730

**Robert Mayo, MD**
Secretary, 922-4707

**Stephen Ettinghausen, MD**
Treasurer, 922-4715

**T. Jeffrey Dmochowski, MD**
266-8401

**Robert George, MD**
342-0140

Joseph Kurnath, MD
641-0400

Ronald Sham, MD
922-4020

Pamela Sullivan, MD
922-3846

Maurice Vaughan, MD
338-2700

Michael Jacobs, MD
*Editor of Forum*

24/7 PHYSICIAN HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION NUMBER:
**922-7333**

## MARK YOUR CALENDARS

Saturday August 5, 2006
RGH MDS
FAMILY FUN
EVENT
*Rochester Rhinos*
*at their new park.*
*More details to follow.*

# A Message from the President, Cynthia Christy, MD

Thank you for the privilege of being the representative of the Medical and Dental Staff for the next 2 years. I appreciate the honor and will represent the needs of both our patients and staff members to the best of my ability. I will always keep quality of patient care as my highest priority.

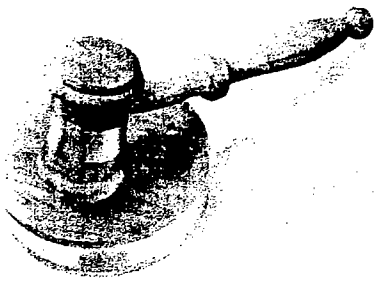
At this time, I would like to introduce the newly elected members of the MDS: Richard Constantino, President-Elect; Robert Mayo, Secretary; Stephen Ettinghausen, Treasurer; and Maurice Vaughan, Ronald Sham and Joe Kurnath as elected members of the Medical Board to join Pam Sullivan, Robert George and Jeffrey Dmochowski. I would like to thank all those who ran and didn't get elected this time. We hope to call on you in the future!

There are many opportunities for members of the MDS to get involved in the running of our Hospital. One of these would be to serve as a member of one of our committees which for the most part meet on a monthly basis. Below I have listed the various MDS committees and their chairs. If you are interested in serving on one of these committees, please let either the Chair or Mary Lou McKeown (922-4259) know.

| COMMITTEE | CHAIR |
|---|---|
| Bylaws | Michael Jacobs, MD |
| Credentialing | Linda Rice, MD |
| Infection Control | Ghinwa Dumyati, MD |
| Medical Records | Joseph Rube', MD |
| Nominating | Linda Rice, MD |
| Quality Council | Richard Constantino, MD |
| Pharmacy & Therapeutics | Cynthia Christy, MD |
| Utilization Management | Anthony Fedullo, MD |
| Cancer | Stephen Ettinghausen, MD |
| Critical Care | David Lee, MD |
| Ethics Grand Rounds | David Lee, MD |
| Operating Room | Ralph Doerr, MD |
| Patient Advocacy | Richard Constantino, MD |
| Radiation Safety | Sanjeev Taneja, MD |
| Transfusion | William Fricke, MD |
| Laser Usage | Ralph Pennino, MD |
| Medical Library | Scott Schabel, MD |

I will do my best to continue the spirit of cooperation among our members and work to improve communication. I see collaboration both among our members and other key players in the area as crucial to taking our organization to the next level.

I would like to offer my thanks and that of the rest of the MDS for the kind and thoughtful leadership and commitment that Linda Rice, MD has contributed over the last 2 years as President. Luckily for us she will continue to serve as Past-President for the next 2 years and will, therefore, stay very involved in our organization.



# Newly Elected Rochester General Hospital Medical & Dental Staff Representatives 2006-2008

## ELECTION RESULTS

**PRESIDENT-ELECT**
Rick Constantino, MD

**Treasurer**
Stephen Ettinghausen, MD

**Secretary**
Robert Mayo, MD

**Medical Board Representatives**
Joseph Kurnath, MD
Ronald Sham, MD
Moe Vaughan, MD

## CURRENT OFFICERS
**2006-2008**

**PRESIDENT**
Cynthia Christy, MD

**PAST-PRESIDENT**
Linda Rice, MD

**Current Medical Board Members**
**2005-2007**
Jeff Dmochowski, MD
Robert George, MD
Pam Sullivan, MD

# Health Information Management Medical Records Update

*Barb Gerringer & Melissa Collins*

Signing the Patient Visit Summary (PVS) on line

When you are reviewing the PVS for signature and disagree with the coding or wish to add or clarify a diagnosis or procedure, please do not create an addendum. If the PVS needs to be edited, please **reject deficiency** and indicate what needs to be changed on the PVS. This reject process sends the PVS back to the coder and assures that the appropriate changes are made in all systems. Adding an addendum will do just that. It **does not** notify any of the HIM staff that an addendum has been added and coding changes may be required.

On Line Deficiency/Imaging Issues

This is just a reminder that there are forms available in the HIM Physician Record Completion area that you should complete if you are experiencing any problems or difficulties with the system. We do follow up on every issue we receive. The staff in this area of HIM will complete the form for you if you point out the issue to them.

> One issue identified recently was a "package error" that occurred when the provider opened their desktop and the first deficiency was a paper deficiency. That issue has been resolved as of 6/9/06.

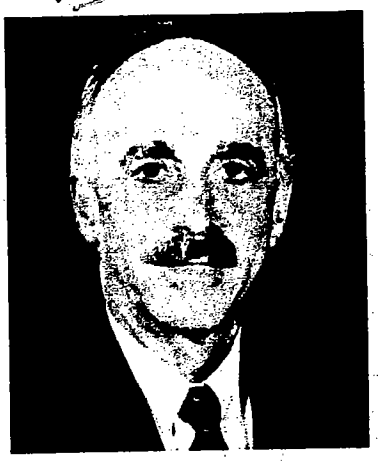
Imaged Documents

Do you know that you can also find these documents in CCS?

- Inpatient MRI reports
- Inpatient echocardiogram reports
- Fetal monitor strips
- OPBED visits
- Antenatal reports

Vacations

Please remember to let us know when you will be on vacation. The clock stops counting your charts while you are away if we have entered your time off in the vacation database. Please call **922-4232** and let us know the dates you will be away. There is also a form in the HIM Physician Record Completion area that you can complete with this information if you are there working on your records.



**Michael J. Feinstein, M.D.**
*Medical Director, Informatics*
ViaHealth-Rochester General Hospital
Voice: 585.922.1642 (Humboldt);
585.922.2932 (RGH)
Fax: 585.922.1655
Email: michael.feinstein@viahealth.org

# Electronic Health Record (EHR) Certification

Since July 2004, the Certification for Healthcare Information Technology (CCHIT) has been developing criteria to judge whether physicians will find a vendor's electronic health record system secure, functional and reliable. This July, the first EHR's wearing CCHIT's stamp of approval will be unveiled.

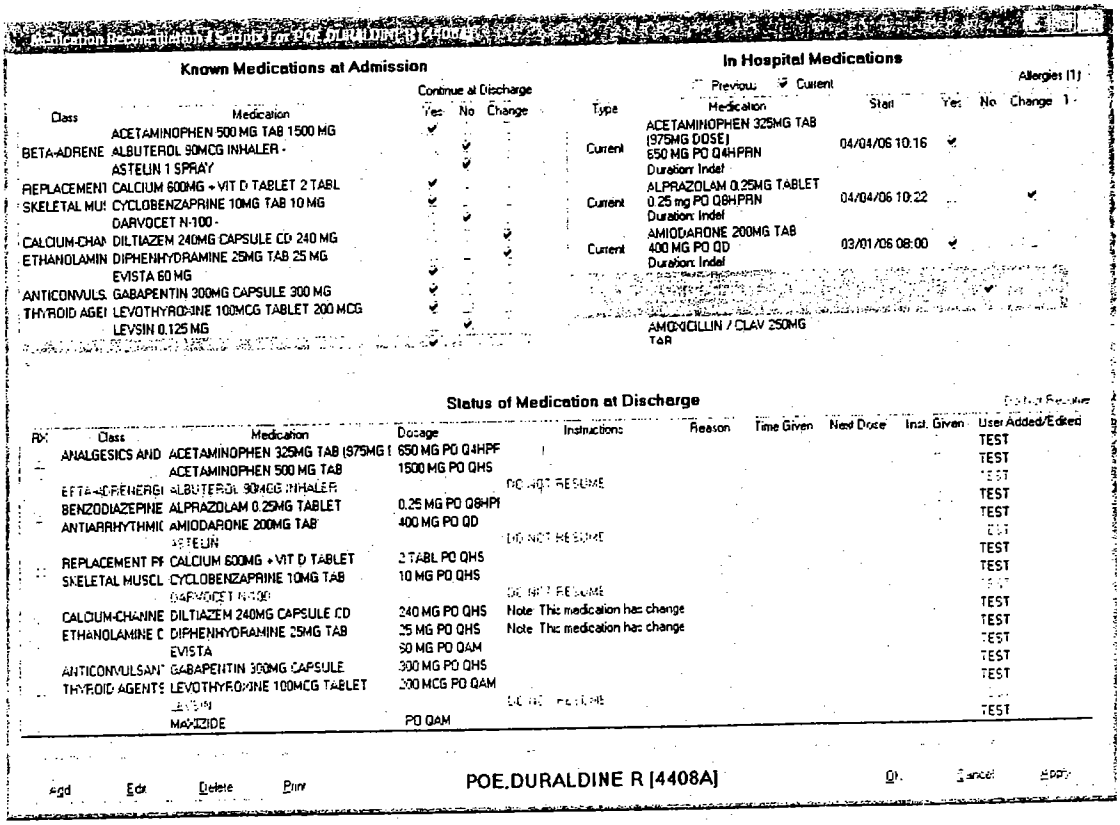
CCHIT is a Chicago based private organization that was awarded an HHS contact to develop certification criteria for ensuring the interoperability, privacy protection and quality of EHR products. One goal was to reduce physician risk and to spur wider adoption of health IT. Applications were taken from vendors in May, 2006 with results being released in July. CCHIT will only release the names of those who pass, with a score of 100% needed to pass. Interestingly, during the pilot test, none of the vendors scored 100%.

The certification is web-based and should take one day to complete. Jurors will include physicians, non-physician providers and computer experts. An appeal process is in place for vendors to be retested with different jurors. The test script involves several scenarios that test functionality such as a well child's visit to a primary care physician where an EHR's ability to document immunizations, prescriptions and lab results, Provide guidance on preventive health measures and provide a history of tuberculosis exposure. Another scenario might involve an elderly patient with multiple, chronic medical problems. This tests an EHR's ability to assist with disease management, prevent harmful drug interactions and generate quality improvement reports. Another general scenario tests the security and privacy protection of the system.

# Medication Reconciliation is just a "Click" away!

Providers are now able to easily reconcile discharge medications and to create scripts from the Known Medications at Admission list & from the In Hospital Medication list.

More detail can be found in CCS by selecting "Instruction Manual" under "Help".




## CORRECTION

In the May, 2006 issue of the FORUM, there was a typographical error. Any HIM deficiencies that are preceded by the word "Paper", CANNOT be completed electronically through CCS.

## ViaHealth Corporate Compliance Hotline

We want to take this opportunity to announce our new Hotline for individuals who wish to anonymously or confidentially report suspected violations of our standards of conduct, policies, or laws and regulations. You should call the Hotline number to report compliance issues such as suspected fraud, abuse, or violations of patient privacy.

The Hotline number is a channel available to you 24 hours a day, 365 days a year.

It is operated on ViaHealth's behalf by National Hotline Services, Inc., an independent firm.

**The toll-free Compliance Hotline number is 1-877-347-9725**

## Annual Practice Managers Conference and Open House

On May 17, the **Department of Physician Services** hosted their 2nd Annual Practice Managers' Conference and Open House at Rochester General Hospital. Over 100 practice managers and community representatives from the Monroe County attended.

The event included the "RGH Showcase Exhibit" area of over 30 departments and services. The following four educational sessions were presented in the Twig Auditorium through the morning: "Excellence Every Day", "RGH Master Facility Plan", Independent Living for Seniors "Your Stay at Home Choices" and the "How To's" of Interviewing and Conflict Resolution. Also available were tours of the newly renovated Clinical Laboratory Department and a special presentation on "Babies and More' and tour of the Women's Care Unit.

**2006 Quarterly Staff Meetings**
**9/22, 12/16**
**7:30-9:00 am Twig Auditorium**
*50% attendance recommended for all attending Physicians*

# Changes to Laboratory Policy for Providing Laboratory Reports to Patients

*By Deb Giambo*

In the past the laboratory has provided copies of laboratory reports to patients with the written approval of the ordering physician. The written approval by the physician is a New York State Department of Health requirement. Up until recently we received about 20 requests per week to provide patients with copies of their laboratory reports. However, over the last few months the number of these requests has markedly increased to over 40 per day. It requires much manual manipulation and intervention to reproduce the requested reports and send them to the patients. The process of providing the laboratory copy to the patient is creating a workload for our client services staff that is no longer manageable.

Beginning July 1st, 2006, we will no longer be able to provide this service to patients. We will be directing them to obtain the copy of the laboratory report from the ordering physician's office. We apologize for any inconvenience this may cause but we just cannot keep up with the number of requests we are currently getting with our staff workload levels at this time. Thank you for your understanding regarding this decision.

# RGH Bariatric Program Designated as Program of Medical Excellence by Excellus BCBS

Rochester General Hospital is pleased to announce that it has been awarded designation by Excellus BlueCross BlueShield as a Bariatric Surgery Program of Medical Excellence. The attainment of this award attests to the fact that RGH has met or exceeded Excellus' criteria for quality performance in bariatric (weight-loss) surgery.

The established standards include the following:

- Designated staff serving bariatric surgical patients, including a dedicated Medical Director
- A full complement of consultative services and equipment required for care of the bariatric surgical patient
- Organized and supervised support groups
- Ability of patients to maintain weight loss
- Ongoing quality management and improvement programs
- Number of operations and death rates meet proven quality standards

Such a designation confirms that RGH has developed a well integrated program that helps improve patient safety and provide multidisciplinary team support for bariatric surgery patients.

RGH's bariatric surgery program is led by Daniel Galvin, DO, who serves as medical director, and Flavia Gusmano, MD. It is located in the Medical Office Building at 1415 Portland Avenue, Suite 525. More information about the program can be obtained by calling 922-2900.

# CCS Update

# Contacting Your Peers

*Do you have trouble trying to get in touc with your fellow RGH MDS members CCS now has increased contact information, and it's available 24/7.*

*Mary Lou McKeown, Medical Staff Office Mana 922-4259, Marylou.mckeown@viahealth.org*

Starting the last week in March, a reque made by your RGH MDS Elected Members add additional contact information to the CC Directory was put into place. To view the dire tory, log into CCS, click on "View" (drop dow box) and then click on "Staff Directory". Fro there you can search by last name, first nam department etc.

The information found in this director which is only accessible to CCS users, is base on the information you have provided th Medical Staff Office from your original applica tion, your reappointment application or an updates you have since communicated. Thi enhanced directory now includes:

- Primary Office Phone Number
- Primary Office "Back" Phone Number
- Primary Office Fax Number
- Answering Service Number

**You are asked to review the information identified for yourself and let me know if it requires any updating.** Also, if there is no contact number appearing in these categories, please contact me so that they can be added. Cell numbers, home numbers, pager numbers can be added but only when specifically direct ed by you, otherwise that information remains personal/confidential. All changes immediate ly appear on CCS, when changed in the Medical Staff Office database.

An observation that has been made at that each office is asked to be sympathetic to relates to the ease with which one staff physician peers can contact [illegible] office directly. Your peers request [illegible] always be an allowance [illegible] message that allows for immediate [illegible] physician communication.

# An update on GRIPA Connect™ Clinical Integration

## Grant money, who to call, enrollment update, tech review, and...free din

GRIPA

Clinical Integration

Physicians coming together for all the right reasons

Clinical integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care.

### One source for GRIPA Connect questions and enrollment: contact Kelly Taddeo

Kelly Taddeo, GRIPA Director of Provider Relations and Network Services, will spearhead the Clinical Integration Physician Enrollment Process. Kelly will contact physicians, be responsible for contracting activities, and be the point person for questions about Clinical Integration.

Kelly has worked for GRIPA for six years and in the ViaHealth System since 1997. She has extensive experience with physician education activities and contracting initiatives and works closely with physicians, hospitals and insurance partners.

**Contact Kelly at 585.922.1543 or at Kelly.Taddeo@GRIPAConnect.com.**

### GRIPA Connect enrollment update

We are in the process of building the web portal and beginning to "populate" the data repository with patient information from health care providers. Several lab and imaging facilities have asked us to accelerate the process of enrolling physicians in the network so that they can feel assured that they are sharing patient data appropriately, with the consent of providing physicians.

As a result, we have already sent out Enrollment Contracts for review and signing. We are including an Executive Summary of the contract so you can gain a quick understanding of the important points. Please feel free to contact us if you have any questions about the contract. The sooner we can reach a critical mass of participants, the sooner we can have the portal operational. We are targeting launch of the portal in late summer.

Questions on the contract should be directed to Kelly Taddeo (see contact information above) or **Dr. Eric Nielsen, 585-922-3062 or via email at Eric.Nielsen@GRIPAconnect.com.**

### NYS recognizes GRIPA Connect with $227,835 grant

We were pleased to be notified of this grant for the implementation of GRIPA Connect Clinical Integration. Twenty-six regional health care networks across the state received $52.9 million in grant awards as part of New York's Health Information Technology (HIT) Initiative. We will use the grant to defray the considerable costs of the technology infrastructure we're building to facilitate clinical integration.

A grant was also awarded to the Rochester Regional Health Information Organization, or RHIO, for a community-wide data exchange network. We've had several questions from physicians and others about how GRIPA Connect and the RHIO network will work together. The RHIO project is in its very earliest stages. We've met with and will continue to be in communication with leaders of the RHIO to address this question and other concerns that will arise. Our primary goal with GRIPA Connect is to make high-quality practice easier and more efficient for physicians, and we will remain focused on that goal. We will keep you posted as we learn more.

### Moving toward technology: a little help for the process

We are aligning ourselves with an IPRO program called Doctor's Office Quality – Information Technology (DOQ-IT), which will assess readiness of adult primary care practices for electronic health records.

This is not a requirement of GRIPA Connect participation, but we expect it will help you–and us—better understand the effort required and benefits to be gained in moving to electronic management of records. DOQ-IT team members will perform a 30-minute survey at your office in 2006 and again in 2007. It is a free service to you. You can opt out of the agreement at any time. We have already sent out Participation Agreements for your signature, and urge you to sign up quickly if you have an interest.

### Have we treated you to dinner yet?

We continue to host our series of dinner meetings to give physicians an in-depth view of Clinical Integration and how it will work to improve quality of care and efficiency in your practices. These are small gatherings where questions and a frank discussion are encouraged.

Please join us! We currently have meetings scheduled for July 13, August 10, September 14 and September 26. But we recommend you check our web site, where you can register online, for the latest on dates and times. It's www.GRIPAconnect.com. Dinner meetings are generally held at the Del Monte Lodge in Pittsford. You can also RSVP by contacting Kelly Taddeo.

AUGUST 2006

# forum

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL



24/7 PHYSICIAN HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION NUMBER:
**922-7333**

## MARK YOUR CALENDARS

Saturday August 5, 2006
RGH MDS FAMILY FUN EVENT
*Rochester Rhinos at their new park. More details to follow.*

## A Message from the President, Cynthia Christy, MD

The following article is an explanation of the revised Medical Record suspension process. A revision was needed to both clarify the suspension process and then to add steps to increase communication between HIM and suspended members. The intent of the revised process is to make the process easier for the suspended member to get their records completed. The main points are that records should be completed within 15 days of the patient's discharge. A medical record is deliquent if it remains incomplete 30 days after discharge. Members are at risk for suspension if they have 30 or more deliquent records. A warning of suspension letter is sent to the Member with an email to the respective Chief. **If the records are not completed and the Member is suspended, scheduling of admissions and surgery will not be permitted.** At the recommendation of the RGH MDS Elected Members and approved by the RGH MDS Medical Board the lifting of the suspension requires that **all available medical records** be completed for the suspension to be lifted.

## Changes to the Medical Record Suspension Process And How They Effect You

The Medical Board of the RGH Medical & Dental Staff recently approved some very important changes to the Medical Record Suspension process that you must be aware of. One example of the change is that when you are placed on suspension, **you must complete all medical records, not just reduce the number of delinquent medical records to below 30.** The changes to the process are indicated below and will be put into place starting **August 10, 2006.**


- The weekly notification of incomplete medical records that is mailed each Tuesday will now state the **number of deficiencies** as well as continue to state the **number of medical records.** This letter will also indicate to call the HIM Clerk at 922-4232 to have your records pulled prior to you coming in to HIM.
- When incomplete records are pulled for physicians prior to them coming into HIM, they will be organized into 3 categories: Unbilled/ROI, Delinquent/Warning, and Incomplete. The categories will be marked by labeled laminated sheets.
- The HIM department will e-mail to the Department Chiefs a list of all RGH MDS Members that receive a warning letter.
- The Medical Staff Office will contact the Member's office when the warning letter is signed notifying the physician of the potential suspension.
- When HIM receives the certified receipt of delivery from the suspension letter mailed to the RGH MDS Member, HIM will contact their office.
- The suspension letter will now include the following statements:
  - **Suspensions in place for greater than 3 months are subject to RGH MDS Corrective Action.**
  - **$50 is payable to the RGH MDS for each 30 days the suspension is in place – not to exceed 90 days.**
  - **Suspended MDS Members may not admit patients and or perform surgery or procedures. In addition, scheduling of admissions and/or surgery will not be permitted.**
- Two days prior to suspension, the Chief will contact the Member as a reminder of impending suspension.

*Continued on page 2.*

## Changes to the Medical Record Suspension Process, cont.

- ED will be included in the communication to the departments of current suspensions.
- Any **suspended RGH MDS Member will be notified each week** of their suspension status.
- On the day the suspension occurs, HIM will contact the Member to notify them they are suspended.
- The RGH MDS Member **will remain suspended until all available medical records are complete.**
- A letter signed by the RGH Medical and Dental Staff President and RGH CEO Representative will be issued to the suspended Member notifying them that the suspension was lifted and the effective date.
- Names of those RGH MDS Members suspended for medical records will be posted in a prominent spot in the Medical Staff Office and HIM Department.

**Access to CCS** is important for you to assure your ability to keep your medical records updated. If you have not secured CCS access through your home or office, please contact Mary Lou McKeown, in the Medical Staff Office and she will arrange this for you. Mary Lou maybe reached at 922-4259 or marylou.mckeown@viahealth.org. For Medical Records completion, CCS allows you to electronically edit and/or sign all transcribed reports typed by HIM and electronically sign the Patient Visit Summary (PVS) (coding summary). You can also view your list of incomplete records in CCS (those that are delinquent are highlighted in red).

Also a reminder - all entries to a medical record must include a legible signature and contact number. This continues to be monitored by RGH MDS for compliance and you are asked to keep up the good work.

If you have any questions or concerns regarding these changes please contact one of the RGH MDS Elected Representatives.

## Changes to Your RGH Directory

For those of you who access to the ViaNet, don't forget the on-line directory in Departments and Medical & Dental Staff. For those of you who do not have access to the ViaNet, there is a monthly excel directory available for you upon request. Contact Mary Lou McKeown at 922-4259 or marylou.mckeown@viahealth.org.

### New Applicants

**Sanjiv Amin, MD**
Courtesy, Pediatrics
501 Elmwood Ave Box 651
Rochester 14642 585-275-2972

**Stephen Bauer, MD**
Attending, Pediatrics
1425 Portland Ave
Rochester 14621 585-922-4698

**William Bowen, MD**
Attending , Radiology
1425 Portland Ave Box 226
Rochester 14621 585-922-3222

**Harp Deol, DDS**
Attending, Dentistry
151 Sully's Trail #2
Pittsford 14534 585-248-3672

**Sean Halligan, MD**
Attending, Family Practice/
Internal Medicine & Pediatrics
77 Sully's Trail
Pittsford 14534 585-389-6010

**Seung Hur, MD**
Courtesy, Medicine/Ambulatory
215 Fair St.
Newark 14513 315-331-6636

**Amir Moheet, MD**
Attending, Medicine/Hospitalist
1425 Portland Ave Box 287
Rochester 14621 585-922-9067

**Jill Nikas, DDS**
Attending, Dentistry
200 White Spruce Blvd.
Rochester 14623 585-424-5710

**Carl Reynolds, MD**
Attending, Medicine/Hospitalist
1425 Portland Ave Box 287
Rochester 14621 585-922-5067

### Change in Status

Change to Inactive Status
Dorrie-Susan Barrington, MD – Inactive/Resigned
Gary R. Green, MD – Inactive/Resigned
Leila Kirdani-Ryan, MD – Inactive/Resigned
Jeannette Koster, NP – Inactive/Resigned
Vernon Loveless, DMD – Inactive/Emeritus
Imelda MacDonald, MD – Inactive/Resigned
Richard Maniace, NP – Inactive/Resigned
Scott Mattoon, RPA-C – Inactive/Resigned
David Oxley, MD – Inactive/Resigned
Cynthia Reddeck, MD – Inactive/Resigned
Robert Sinkin, MD – Inactive/Resigned

## Update on Pa... and Constru...

*By Gary Smith, Director Suppor...*
*Contact Number 922-4251*

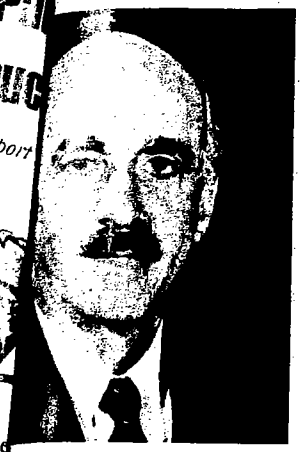
...J. Feinstein,
...Director, Inform...
...th-Rochester
...85.922.1642
...2932 (RGH
...5.922.1655
...michael.fein...

On Thursday July 13th, the side entrance to the Parnall Office Building from the ramp garage will be closed permanantly.The exterior entrance into the Hinshaw Building as well as th... entrance on the ground floor close, as construction of the ... Pavilion is ready to start. There ... barrier walls put up to close off th... mentioned areas, along with the ... signage to alert patients, visitors a... on how to get to their location ... building. A new emergency exit was ... ed on the ground floor in what used ... Dr. Henion's suite. This was requir... Code and is not to be used as a g... exit. It takes you out of the building ... leads back to the main entrance

We have our Way Finding Sta... place at this time. They will be con... trating their efforts around the Par... Office Building to assist patients and ... ers in getting to their appointmen... These changes will have the follow... impacts:

- Patients will have to use the lobby ... the hospital to get to the Parna... Office Building, or they can g... dropped off at the front entrance.
- Way finders will direct them from th... ground floor and first floor down th... lobby concourse into the Parnall o... will assist them in wheelchairs to get ... into the building if needed.
- A third alternative and recommended ... one for Parnall Patients is to use the ... Valet service from the Main Lobby of ... the hospital.
- Parnall Staff will have to use the hospital lobby, or the Parnall front entrance as well to reach the building.

Please call if there are any questions or concerns about these updates. These walls may not be totally in place until the afternoon of the 13th. Thank you



**Michael J. Feinstein, M.D.**
*Director, Informatics*
Strong Memorial-Rochester General Hospital
(585.922.1642 (Humboldt);
585.922.2932 (RGH)
585.922.1655
michael.feinstein@viahealth.org

# COMBATING ERRORS AT THE "HAND-OFF"

Dangerous errors and oversights can occur in the gap when a patient is moved to another unit or turned over to a new nurse or physician during a shift change. There is growing evidence that communication breakdowns during such transfers are the single largest source of medical errors. The Joint Commission on Accreditation of Health Care Organizations is requiring hospitals to establish standards for hand-off communication and break down long standing cultural differences in the exchange of patient information between physicians and nurses.

Hospitals generally have some hand-off procedures but they tend to be ad-hoc arrangements that vary from unit to unit or even from nurse to nurse. Many hospitals have just begun to implement new checklists, forms and routines. A few hospitals, however, have been ahead of the pack borrowing communication strategies used in aviation and the military where hand-off failures can be devastating. The non-profit Institute for Healthcare Improvement is working with hospitals on a communication model known as SBAR - an acronym for Situation, Background, Assessment and Recommendation - adapted from a program used to quickly brief nuclear submariners during a change in command.

- S: Describe the Situation. In a few seconds get someone's attention.
- B: Background. Provide enough information to give the listener some context for the problem
- A: Assessment. Give your assessment of the overall condition.
- R: Recommendation. Give your specific recommendations.

Kaiser Permanente, which operates 30 medical centers, has pioneered the use of this model to help nurses and physicians quickly organize their thoughts and convey the most critical information in just 60 seconds. The Veterans Administration is funding development of a hand-off tool for medical teams using similar principles at its hospitals.

"A hand-off is a precision maneuver but, in medicine, it has been left to happenstance", said Richard Frankel, a professor of medicine at Indiana University. Reduced work hours for residents may have reduced some errors due to physician fatigue but the number of hand-offs, due to shorter shifts done without precision, has increased.

The University Health System Consortium, an alliance of 95 academic medical centers, recently published guidelines on how best to comply with the Joint Commission standards, including using programs such as SBAR. This fall, the consortium will offer its members an online training program for residents, "Do No Harm", which will include strategies for improving hand-off communication. The SBAR "quick briefing" model can help overcome differing communication styles such as nurses who might give long, descriptive reports and physicians who might say, "just give me the headlines" and don't want a nurse's opinion.

Some large medical centers with electronic medical records, such as Brigham and Women's Hospital have used a computerized sign-out system so a standard set of information can be exchanged every time. Kaiser, again, has developed a Nurse Knowledge exchange computer program which allows departing nurses to create customized electronic reports on patients for the incoming nurses, such as lab results or medication changes. Mercury MD, the producers of M Data that many of us are using, has developed a hand-off module for the PDA, which includes care team, summary of relevant patient information and a shared task list.

In almost all serious avoidable episodes of patient harm, communication failures play a central role, which is why teaching caregivers "structured communication" is of the utmost importance.

# How technology fits in your office:

## GRIPA Connect™ Clinical Integration takes a customized approach

by Eric Nielsen, M.D., CMO, GRIPA

### Our technology fits your practice, not the other way around

We understand that the details of our technology implementation will be critical to the usability and success of the GRIPA Connect™ web portal. Our Director of Information Technology, Vicky Viglucci, is overseeing a customized approach to each doctor's office implementation so that the technology will, as Vicky says, "make your life easier, not harder."

**Vicky Viglucci, Director Information Technology, GRIPA**

### First step: understanding where you are on the technology continuum

Does your office already have an Electronic Medical Records system? Are you using computers just for billing and paper records for patients? Do you use email to communicate with other practices or rely strictly on fax and phone calls?

These are the kind of questions we'll be asking when your GRIPA Connect Technology Team first calls on your office staff. We'll conduct a hardware assessment to understand what computer equipment and networks are already in use at your practice. We'll also conduct a technology readiness assessment, a more broad-ranging survey of issues such as your staff's level of computer and Internet expertise; your use of computers during the average day and for regular, repeating tasks; the systems (paper or electronic) that you currently use.

On the basis of our findings, we will develop a customized plan for implementing the GRIPA Connect web portal in your office. "This is not a mass rollout," says Vicky. "We are going to treat each office as a unique implementation, and help our physicians with individual solutions to their issues."

### A dedicated team of professionals will provide guidance and support

Each office will have a Technology Team consisting of an Account Manager (who will oversee your implementation and be your single point of contact), a Technology Trainer (who will get you and your office staff up and running), and a Technologist, who will be sure that your computers, your wires, and your wireless network all work together.

This multidisciplinary team will come to understand your office, your staff, your network, and your use of the web portal.

"Any sufficiently advanced technology is indistinguishable from magic."
—Arthur C. Clarke, "Profiles of The Future," (Clarke's third law)

"We want physicians and their staffs to be so delighted with the ease and usefulness of the portal," says Vicky, "that they're calling us up to say: 'What's next? When can we get the next new feature?' We understand that generating that level of excitement is going to require a lot of care and effort on our part to make the transition seamless and easy."

### The basics: a computer and a connection to the Internet

For each GRIPA Connect participating physician who is a member of the Rochester General Physicians Organization (RGPO) or the Wayne County Physicians Organization (WCPO), GRIPA will provide a tablet computer free of charge. The tablet will be an IBM ThinkPad X41, with a value of approximately $1900. You can use it as a laptop computer with a keyboard, or as a "writing" or touch-sensitive tablet. It will include a long-life battery and a year of anti-virus protection.

GRIPA Connect Clinical Integration

### Physicians coming together for all the right reasons

Clinical integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care.

"The great thing about a computer notebook is that no matter how much you stuff into it, it doesn't get bigger or heavier."
—Bill Gates, "Business @ The Speed of Thought"

We will also set up a wireless network in any office in which you see patients. Although each office will be responsible for connecting to the Internet, we will be happy to provide guidance.

"We are not going to set up the portal, plug you in, and walk away," says Vicky. "Our model is one of complete, true customer support. We understand that technology, and GRIPA, are here to serve our physicians and their patients."

"Computers are incredibly fast, accurate, and stupid. Human beings are incredibly slow, inaccurate, and brilliant. Together they are powerful beyond imagination."
—Albert Einstein

SEPTEMBER 2006

# Forum

A NEWSLETTER FOR THE MEDICAL AND DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL



24/7 PHYSICIAN HOTLINE NUMBER:
**922-4414**

DIRECT ADMISSION NUMBER:
**922-7333**

**IMPORTANT REQUIREMENTS**

**Please refer to the Medical Records article on page 4.**

## A Message from Sam Huston, President & CEO ViaHealth

For some time now, I have found myself reflecting on how fortunate I am to culminate my career in Rochester. When you work in the healthcare field as long as I have, you are certain to meet and work with a number of talented and gifted professionals....and that has been especially true during my tenure at Rochester General Hospital and ViaHealth. To sum it up in a word, I can describe our Medical and Dental staff as *outstanding*.

A very recognized leader, Vince Lombardi, once said that "the achievements of an organization are the results of the combined effort of every individual." That quote - as simple as it is stated - quite accurately sums up my feelings related to our Medical and Dental staff. Together, we have achieved much, and though I will miss working with you on a day to day basis, it will be a unique and rewarding experience for me to see the new levels of achievement that are attained in the future..

Thank you for all you have done over the years... and for providing me the pleasure and good fortune to be able to be associated with all of you.. You represent an invaluable asset to the greater Rochester community and I wish you continued success in all that you do.

Sincerely,

Sam

## Greetings from Cindy Christy, MD

As fall approaches we are saying goodbye to Sam Huston who has served admirably as our CEO for the past 6 years. I would like to express my thanks for the resuscitation and rejuvenation of our hospital and ViaHealth. He will be missed, but will continue to stay involved with the Foundation. Thanks Sam for a job well done.

We also welcome Mark C. Clement as our new CEO. He comes to us from Boston where he led Caritas St. Elizabeth's Medical Center, a 500-bed medical center with major teaching and research programs and an academic affiliation with Tufts University Medical School. He brings more than 25 years of experience in hospital administration with him and has already met with members of the MDS Executive Committee to learn about our issues and insights.

# Construction Update from Safety and Security

*By Gary S. Smith, Senior Director, Support Services*


On Sunday, August 20, 2006, Construction Services closed the ground floor connector coming in from the Portland Avenue ramp garage. The "Lobby Connector" is now the only way in from the garage for the duration of the Polisenni Pavilion construction project. This entrance will be locked at 8:00 pm daily and opened by 5:00 am. To gain entrance after hours, you will need to have an ID card that is programmed. If you presently have an ID, we just need to hear your request to have access. Please provide this information to Mary Lou in the Medical Staff Office. If you do not have an ID, please go to the Carter Street Ramp Garage office located on Level 1. They will also be able to program your ID for any access that is needed at that time.

Physicians that are coming into the hospital after hours on emergencies can go directly to the Emergency Department to park. See the Safety and Security officer working in the area, who will direct you to a space. If for some reason, there is no space available and an overrun of vehicles, you may be directed to park in the garage and walk in through ED.

# Wayfinders

The hospital has employed contract "Wayfinders" during the construction project to assist patrons coming into the hospital in getting to their destination, with all barriers and redirected routes that have been put up. These individuals work for American Valet Parking and are on duty from 6:30 am until 6:30 pm Monday through Friday and 9:30 am until 6:00 pm on weekends. They can be found all around the construction project, specifically in the POB, and the upper and lower levels of the ramp. We have also increased our valet service extensively to accommodate patient parking from the POB. Valet runs from 7:00 am until 5:30 Monday through Friday. Starting on August 21st, the service will be available right in front of the POB. For any questions regarding parking, way finding or safety and security, please call Gary Smith at 922-4251

# ROM THE EDITOR

*y Michael L. Jacobs, MD*

This will be the last edition to be produced under my supervision. Over the last several years, oth at Genesee and Rochester General Hospitals, FORUM has been a vehicle for the Medical & )ental Staff to communicate with its members.

In both settings, the hospital has either contributed to or completely sponsored the production f this news communication. For the most part, both administrations have maintained a "hands-ff" attitude to the content, for which I heartily thank them all.

Changes to content and style over the years has been remarkable, and the most remarkable of ll is the decreased need for political comment. In no small measure, the lowered level of contro-ersy in the last few years can be attributed to the good work of Sam Huston. Thank you Sam, we ope your successor can carry on in the same manner.

Dr. Pam Sullivan has worked with me from early on at RGH, and her insight has been most aluable. Of course, we all know that Mary Lou McKeown actually is the impetus for this produc-ion. Thank you, Mary Lou.

To my great satisfaction, Dr. Peter Van Brunt has agreed to join Dr. Sullivan in producing this ewspaper. His experience as President of the Medical & Dental Staff, and all that entails, will allow im greater understanding of the nuances of the FORUM.

FORUM was conceived as an independent vehicle for Medical & Dental Staff communication nd has maintained that independence through several administrations. I anticipate that the new edi-orial staff will carry on that tradition.

With thanks for the privilege of serving in this position.

# In Case You Haven't Heard!!

**Diagnostic Imaging** is celebra two years of RIS/PACS! We have cessfully moved from hard copy film softcopy viewing. During our transit time several things have occurred wh makes the viewing of images faster, si pler and easier for our Referring phy cians. Let me explain.....

Images may be viewed in one of tv ways. **First, is via the DirectView ico located on the Desktop of a Clinic Viewing Station.** These stations a located in ED, all ICUs, 4400, OPD, th Physicians Lounge and Radiology. Thi will take you directly into the PACS Wel product. After you access the PACS Web the fastest way to view a patient's image is by inputting the medical record num-ber. However, of course you can alway query the system by patient name.

The RIS/PACS administrative tear is supporting the OR's efforts to brin PACS images to the OR. We are awar that 'COWS' or Computers on Wheel have been placed in the OR so that sur-geons may view images during surgery either from RGH or via a cd-rom from another facility. We understand that there are additional plans to add wall-mounted monitors. The RIS/PACS infrastructure is capable of supporting whichever view-ing options are selected.

**Method Two is via CCS.** Within the CCS application, under Clinical Reports, a User will notice an icon that resembles a Rib Cage. When a report has been generated and signed for a study, selection of this icon will take you into the PACS Web for image viewing.

On Monday, August 7th, the depart-ment finally went completely softcopy: i.e. film or paper will be printed "on demand"; otherwise images are available either on cd-rom or via one of the meth-ods described above.

To gain access into either method, one need only have a ViaHealth acc ount and permissions from the RIS/PACS Office (**922-5922**/2987/5151). Training and/or instructions on how to use either application may be arranged by calling these numbers as well. We're here to HELP!

Micha
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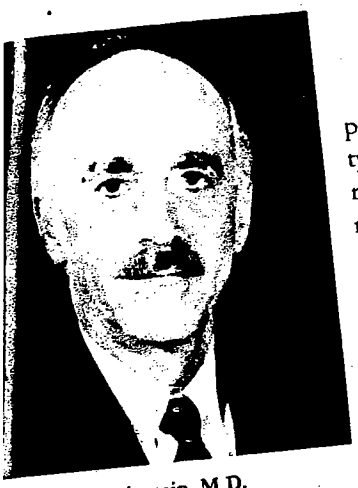
# CCHIT ANNOUNCES CERTIFICATION OF EHRS



**Michael J. Feinstein, M.D.**
*Medical Director, Informatics*
ViaHealth-Rochester General Hospital
Voice: 585.922.1642 (Humboldt);
585.922.2932 (RGH)
Fax: 585.922.1655
Email: michael.feinstein@viahealth.org

CCHIT (Certification Commission for Healthcare Information Technology) announced recently at a press conference with Michael Leavitt, U.S. Secretary of Health and Human Services, the first group of twenty certified EHR products. CCHIT is the recognized authority in the U.S. for certifying electronic health records. Sec. Leavitt endorsed the certification process and emphasized the importance of electronic health records to improve healthcare delivery. Since the initial announcement, four additional products have been certified.

Mark Leavitt, MD, chair of CCHIT, said that "physicians who purchase certified products have the assurance that they have been reviewed by a panel of judges, including practicing physicians, and that they are being evaluated against standards set by professionals in the field and successfully piloted with products from large and small companies". The goals of CCHIT product certification are to reduce the risk of HIT investment by physicians and other providers; to ensure interoperability of HIT products: to enhance the availability of HIT adoption incentives from purchasers and payers; and to protect the privacy of personal health information All CCHIT products are tested and pass inspection of 100 percent of a comprehensive set of criteria for:

**Functionality:** (ability to create and manage electronic records for all patients as well as automating workflow in a physician's office.

**Interoperability:** (ability to receive and send electronic data to other entities such as laboratories, etc.).

**Security:** (ability to keep patient's information safe).

CCHIT's compliance criteria have been thoroughly researched taking into account state of the art EHRs and available standards and comparing certification processes in other industries and other countries. The inspection process is based on real life medical scenarios designed to rigorously test products against the clinical needs of providers. CCHIT EHRs are also tested against criteria that deal with the coming new reimbursement environment with requirements for quality and safety indicators.

Rather than list the initial group of vendors who have received CCHIT certification, it is recommended that physicians contact CCHIT by email at: info@cchit.org to allow your query to be directed to the appropriate source. However, the telephone number is: (312) 233-1582.

# EMR USE BY DOCTORS ON THE RISE

A new report from the CDC's National Center for Health Statistics claims that the electronic medical record usage by office based physicians in the United States is increasing. They looked at 2005 data and concluded that almost 23.9 percent are using full or partial EMRs. This represents an increase of 31 percent from the 18.2 percent reported in 2001. However, many physicians are not using the systems to their full potential.

Some of the key findings included:

Physicians working in the Midwest (26.9 percent) and West (33.4 percent) were more frequently making use of EMRs compared to those in the Northeast (14.4 percent).

Not all physicians are using all the capabilities offered by an EMR. Just 9.3 percent were using the system for all of the four basic functions offered: computerized orders for prescriptions, computerized orders for tests, reporting of tests and physician notes.

# Midlevel Coverage for Medical Patients

*By Richard Sterns, MD - Chief of Medicine*

**The Department of Medicine now provides midlevel providers to see all newly admitted patients** to make sure that admission orders are written and a brief history and physical is on the chart as soon as possible. Our goal is that every patient admitted from the ED and every patient who is direct admitted is seen and evaluated. Follow-up coverage by midlevels is optional and must be requested by the attending physician. Coverage arrangements should be discussed when the midlevel provider calls to discuss admission orders. If, later in the patient's course an attending wants follow-up coverage, there are two ways to get it:

Call the Call Center (922-7333). That's the same number to for direct admissions. The Call Center will contact the PA and arr for the PA to call you back.

Call the Administrative PA (Pager #194).

The Department of Medicine would like to hear from you ever this process fails to work properly. If you experience any lems, please call the Departmental office (922-4894) or send an (richard.sterns@viahealth.org) with the name of the patient a date of the occurrence. We want this to work for attendings ar patients. Your feedback will help make that happen.

# anges to the Medical Record Suspension Process and How They Effect Yo

The Medical Board of the RGH Medical & Dental Staff recently oved some very important changes to the Medical Record ension process that you must be aware of. One example of the ge is that when you are placed on suspension, **you must complete nedical records, not just reduce the number of delinquent med- records to below 30.** The changes to the process are indicated w and will be put into place starting August 10, 2006.

The weekly notification of incomplete medical records that is mailed each Tuesday will now state the **number of deficiencies** as well as continue to state the **number of medical records**. This letter will also indicate to call the HIM Clerk at 922-4232 to have your records pulled prior to you coming in to HIM.

When incomplete records are pulled for physicians prior to them coming into HIM, they will be organized into 3 categories: Unbilled/ROI, Delinquent/Warning, and Incomplete. The categories will be marked by labeled laminated sheets.

The HIM department will e-mail to the Department Chiefs a list of all RGH MDS Members that receive a warning letter.

The Medical Staff Office will contact the Member's office when the warning letter is signed notifying the physician of the potential suspension.

When HIM receives the certified receipt of delivery from the suspension letter mailed to the RGH MDS Member, HIM will contact their office.

The suspension letter will now include the following statements:

- **Suspensions in place for greater than 3 months are subject to RGH MDS Corrective Action.**
- **$50 is payable to the RGH MDS for each 30 days the suspension is in place – not to exceed 90 days.**
- **Suspended MDS Members may not admit patients and or perform surgery or procedures. In addition, scheduling of admissions and/or surgery will not be permitted.**

Two days prior to suspension, the Chief will contact the Member as a reminder of impending suspension.

ED will be included in the communication to the departments of current suspensions.


- Any **suspended RGH MDS Member will be notified each week** of their suspension status.
- On the day the suspension occurs, HIM will contact the Member to notify them they are suspended.
- The RGH MDS Member **will remain suspended until all available medical records are complete.**
- A letter signed by the RGH Medical and Dental Staff President and RGH CEO Representative will be issued to the suspended Member notifying them that the suspension was lifted and the effective date.
- Names of those RGH MDS Members suspended for medical records will be posted in a prominent spot in the Medical Staff Office and HIM Department.

**Access to CCS** is important for you to assure your ability to keep your medical records updated. If you have not secured CCS access through your home or office, please contact Mary Lou McKeown, in the Medical Staff Office and she will arrange this for you. Mary Lou maybe reached at 922-4259 or marylou.mckeown@viahealth.org. For Medical Records completion, CCS allows you to electronically edit and/or sign all transcribed reports typed by HIM and electronically sign the Patient Visit Summary (PVS) (coding summary). You can also view your list of incomplete records in CCS (those that are delinquent are highlighted in red).

**Reminder #1:** All entries to a medical record must include a legible signature and contact number. This continues to be monitored by RGH MDS for compliance and you are asked to keep up the good work.

**Reminder #2:** When progress notes are written in Hospital charts, they shall be dated on the date and time that they are actually written, and may contain by date within the note instances of previous visits by the practitioner on days when no note was written.

If you have any questions or concerns regarding these changes please contact one of the RGH MDS Elected Representatives.

# The 2006 Resident Class

*Karen Balta and Anthony J. Fedullo, M.D.*

The Medical and Dental Staff and the training programs all look rward to another year of resident education which is such an essential rt of the mission of Rochester General Hospital. The number of plications to RGH residency programs increased over last year and the ograms all continue to attract very high quality individuals. We should be pleased to know that RGH filled all available positions in all of our n training programs in the Departments of Dentistry, Internal edicine, Obstetrics & Gynecology and Diagnostic Radiology. In July 06, we welcome 35 new residents to these RGH programs. In addion to our four residency programs, we also participate in the education residents in programs sponsored by Strong Memorial Hospital in diatrics, Surgery, Plastic Surgery, Urology and Ophthalmology, among hers.

Of the large number of applicants, only a select few are invited to terview. The interview process consists of a half day visit to RGH th some programs supplementing the visit with social activities the ght before. After the interview season, the programs make their final termination about each applicant, ranking them in order of priority. alysis of the statistics shows that the programs continue to match those applicants that they have ranked very high.

The Department of Medicine has a three year training program which has recently expanded to nineteen positions per year. Of the recent graduating class, five stayed at RGH as hospitalists and five went into highly competitive University fellowships.

The Obstetrics and Gynecology program recruited a full complement of three first year residents to their four year program, and one second year resident. All three of their graduates joined private practices with one resident remaining in Rochester.

The Department of Radiology four year program recruited three new residents and recruited two of their graduates to remain on as Attendings in the Department.

The Department of Dentistry recruited five residents to their program for the coming year.

Those involved in graduate medical education value our residency programs and welcome these young doctors to RGH. They provide intellectual stimulation and an academic environment for the members of the Medical and Dental Staff and highly skilled coverage for our patients.

# Passing the Neurology Baton

*rd Sterns, MD - Chief of Medicine*

irty-seven years ago, Josh Hollander came ester General Hospital as its first full-time of Neurology. Jerry Honch joined him ars later. And, since 1972, RGH has been by the "Josh and Jerry" show. Their tire- votion to the hospital and its patients and henomenal understanding of Neurology ver be matched. Generations of medical ts and Neurology, Neurosurgery, istry, Physical Medicine and Internal ne residents will be forever indebted to r their teaching. RGH has been an essen- p for Neurology trainees; here they have posed to an extraordinarily rare resource: nted clinicians who combine an academic gist's knowledge of the literature with an us wealth of practical clinical experience. dical staff has benefited enormously from esence. Few, if any, hospitals in the coun- been graced with the on-site presence of gists of this caliber.

lly, all good things must come to an end. d Jerry, though still teaching, and still con- their Neurology practice believe it is time down. After thirty-six years of service, pped down as Head of the service last d Jerry has been graciously serving as Head. They have both been eagerly await- eone to take the helm and continue their That time has finally come.

should all be pleased that Dr. Michael Meyer has accepted the position of of Neurology at Rochester General l. Dr. Meyer earned his Bachelor of Arts t Columbia University and his M.D. from Medical College. On completion of his gy training at the Mayo Clinic, he pur- lowships in Nuclear Medicine and Brain naging at the University of Pennsylvania University of Michigan. Dr. Meyer has culty appointments at the University of see, Louisiana State University, The ity of Missouri, and, most recently, at the ity of Buffalo, where he served as the gy Residency Program Director. Dr. as an academic interest in stroke, neu- erative diseases, and neuro-imaging and ublished extensively in these fields.

ase join me in thanking Drs. Hollander ach for their long devoted service to the and to the medical staff and in welcom- Meyer as he takes the baton from them.

# Hospitalist Program at RGH: Fall 2006 Update

*By Walter Polashenski, MD, Head, General Medicine Unit*

The Division of Hospital Medicine in the General Medicine Unit has continued to grow rapidly, expanding to cover more than sixty RGH affiliated primary care physicians while maintaining the traditional coverage for unassigned patients. The Division has continued to recruit to keep up with growing interest in coverage of hospitalized patients. There are currently 21 hospitalists and 6 physician assistants in the DHM, including fourteen new additions (twelve physicians and six physician assistants) that have started during the summer of 2006. In addition to the expanding role of coverage for community physicians, the DHM provides twenty-four hour consultations for the surgical and cardiology services, is present in-house twenty-four hours a day for newly admitted patients and continues to play an important role in resident education.

**This fall the Division will expand services again to community physicians who expressed interest in hospital coverage during our information sessions last winter. We plan another enrollment session for interested primary care providers in the spring of 2007.** At this time the Division is enrolling practices interested in full time coverage only (i.e. no weekend or vacation only coverage). Although the Division has grown rapidly in response to interest in hospital coverage, the Department of Medicine supports physicians who would like to continue to care for their hospitalized patients and encourage them to do so.

In addition, the Division has been giving clinical direction to Information Services for refinements of the electronic discharge instructions and the coverage information system available on CCS. In the Emergency Department, the Division has been active in collaborating with the ED staff to design safer and more efficient patient flow and as well quality initiatives with respect to newly admitted patients.

The Division of Hospital Medicine has seen tremendous growth over the past two years. There are still challenges to meet, but we are very excited to look beyond our rapid growth to the institution of important quality initiatives and educational activities. If you have questions, or are interested in utilizing the hospitalist service during the 2007 expansion please contact Dr. Balazs Zsenits, Director, Division of Hospital Medicine; or Dr. Walter Polashenski, Head, General Medicine Unit at 922-5067.

**NEW HOSPITALISTS**

| June 2006 | July 2006 | September 2006 |
|---|---|---|
| Amir Moheet MD | Zubair Ahmad MD | Rochan Ali MD |
| Pamela Polashenski MD | Vamsi Garikipati MD | Salima Sadruddin MD |
| | Parham Gharagozlou MD | Margot Searles RPAC |
| | Valerie Hamann RPAC | |
| | Satyarth Kulshrestha MD | |
| | Leon Kurtz MD | |
| | Tanya Nikolova MD | |
| | Chris Reynolds MD | |
| | Daniel Tanase MD | |

# Have You Applied for Your NPI Numbers Yet?

All healthcare professionals who bill for services are encouraged to obtain their national provider identifier (NPI) as soon as possible. As the volume of health care professionals across the country apply for their NPI's, it is anticipated that the waiting time for an NPI could lengthen. When implemented, your NPI will replace all other payer provider numbers and will be required for the submission of electronic claims, referrals, authorizations, and inquiries. Failure to secure an NPI by May 23, 200~ will prevent you from billing for all your services.

To apply for an NPI:

On-line:

Go to https://nppes.cms.hhs.gov. It takes less than 20 minutes to complete.

To request a paper application:

Call the NPI Enumerator at 1-800-465-3203 (or TTY at 1-800-692-2326)

**When you have received your NPI number, please be sure to register it with all your payors and IPA's etc.**

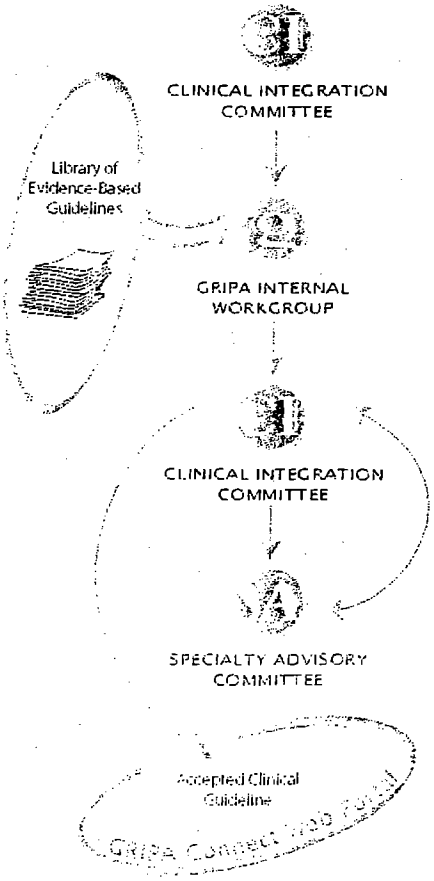
# Clinical Integration Guidelines for Patient Care

## GRIPA Connect™ uses a committee-based process to write recommendations

### A commitment to evidence-based care required for Clinical Integration

The creation and adoption of Clinical Care Guidelines is one of the elements essential to establishment of a Clinically Integrated Network. The process of creating these Guidelines for GRIPA Connect is well underway; we began with the most common—and difficult—disease states.

Guidelines for Diabetes, Hypertension, and Coronary Artery Disease were approved by the GRIPA Board of Directors in early August. Congestive Heart Failure and Hyperlipidemia Guidelines are being finalized by the GRIPA Connect Clinical Integration Committee and are slated for Board approval in early September. Meanwhile, Guidelines for Preventive Services, Low Back Pain, and Osteoporosis are under review by the Clinical Integration Committee. GRIPA staff members are currently researching CVA/TIA, Migraine and Depression recommendations.




### First step: thorough research leading to recommendations

The Clinical Integration Committee (CIC) comprised of physicians, GRIPA staff members and myself, makes the initial decision on which disease states should have a GRIPA-developed Guideline. An internal GRIPA staff workgroup then begins the process of researching literature on evidence-based studies and guidelines available from national and local sources.

That workgroup consists of Deborah Lange, Director, Analysis; Jeanette Altavela, PharmD, BCPS, Consulting Clinical Pharmacist; Jane Dean, Manager, Care Management Services; Kathryn Gardner, RN, EdD, Director, Analysis/Evaluation & Nursing Research; and myself.

We also look for measures within these guidelines for which GRIPA has available patient-specific data. These measures are reviewed against the current literature and local standards to verify clinical acceptability and determine a relevant benchmark. Then we recommend measures relevant to as many patients of GRIPA members as possible and touching one or several practice specialties.

### Next up: physician committee review

The Clinical Integration Committee, meeting monthly, is the first to see recommendations from GRIPA staff. We solicit input and suggestions from Specialty Advisory Committees, comprised of physicians from the relevant specialty and subspecialty areas.

The CIC then makes final revisions and formally approves the Guideline for release to the physician community. It is then approved by the GRIPA Board.

### Accessing the Guidelines

We are posting the Guidelines on our web site: www.GRIPAconnect.com, as they are approved. We encourage physicians and their staff to download them. Once the GRIPA Connect Web Portal is operational, we will post the Guidelines there as well for convenient access during patient visits.

GRIPA

Clinical Integration

**Physicians coming together for all the right reasons**

Clinical integration delivers higher quality patient care by creating a connected community of physicians, hospitals, labs and imaging facilities with electronic access to complete patient information, support from patient care managers and assistance to fulfill a commitment to evidence-based clinical care.

You can also find a complete list of Clinical Integration Committee members on our web site.

### CONTRACT UPDATE: Addressing concerns about billing and patient data

We heard from a number of physicians who questioned the need for GRIPA to be collecting billing data under the recently distributed GRIPA Connect Physician Participation Contracts. Our purpose in requesting that data is to cull from it diagnostic information that we can use to look for opportunities to improve Guideline compliance and thereby quality of care. But we recognize the concern of some physicians that this data could potentially be used to compare physician fees. Our purpose is to help physicians and their patients. We have no interest in that information, but to allay those concerns, we have adopted a policy whereby we will not store the charge information. GRIPA does not receive information on actual payments to physicians except for patients who are enrolled in GRIPA products.

**Miscellaneous**

2. Please provide any pre-existing reports, studies, or analyses of physician or health care competition, or pricing or payment levels to providers, in the geographic area (or any part thereof) within which GRIPA proposes to operate its program. Please include the 2005 strategic study that GRIPA undertook, and which is referred to on page 2 of your request letter, as well as any subsequent strategic or market reports or studies.

# GRIPA Board of Directors Strategic Planning Retreat

## August 18, 2004

GRIPA

# RETREAT OBJECTIVES

- Review GRIPA's current status and core competencies
- Review results of current Strategic Initiatives
- Review "Focus Issues" and assess opportunities and challenges
- Identify Strategic Initiatives for 2004/2005

GRIPA

# FOCUS ISSUES

GRIPA

# Focus Issues

- Both operating and structure challenges hinder the financial success of GRIPA
-

# Focus Issues (continued)

- Tremendous pressure to hold down medical expenses => FROM ALL QUARTERS
- Inability, to date, to move more market share to our owners
-

GRIPA

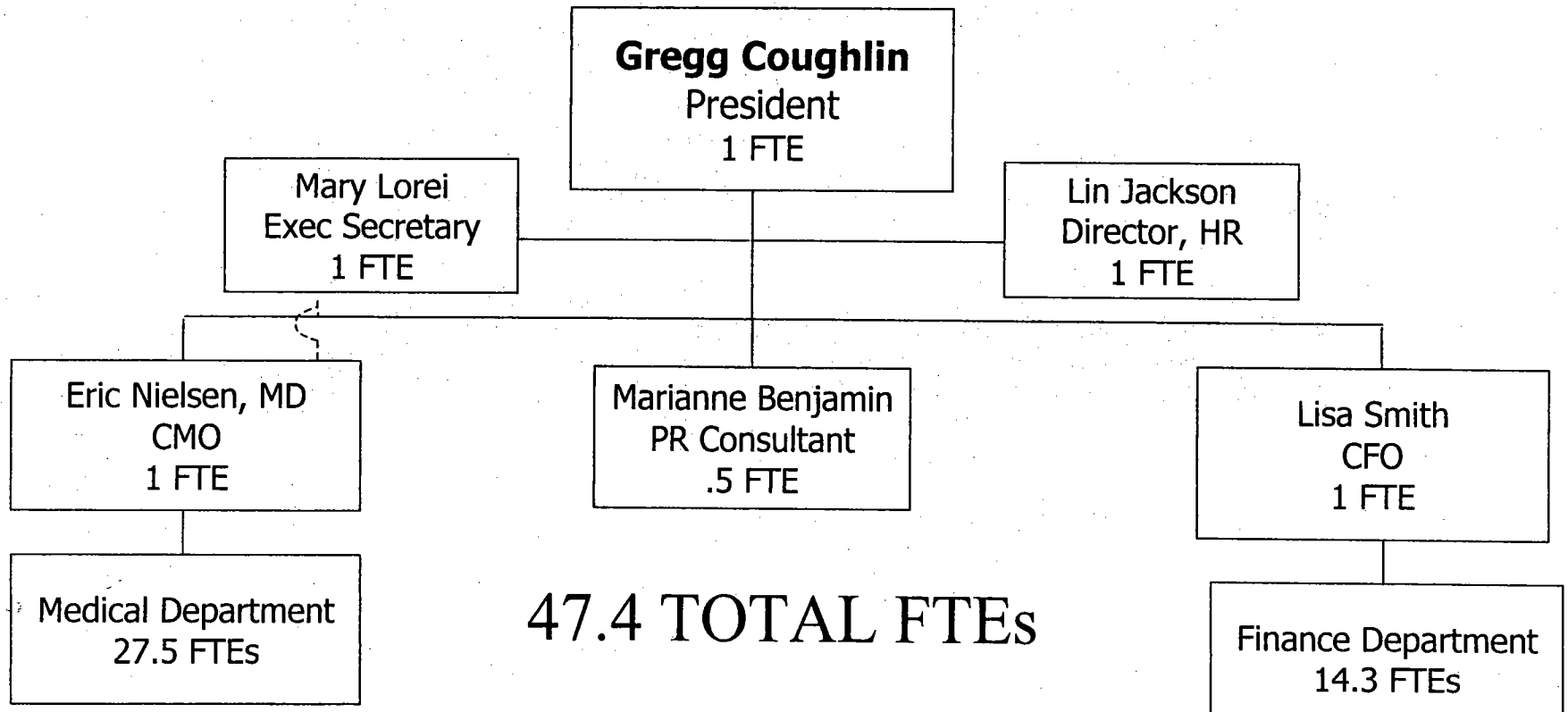
# Focus Issues (continued)

In light of these issues, our owners must reasses their expectations and commitment to GRIPA

GRIPA

# GRIPA OVERVIEW

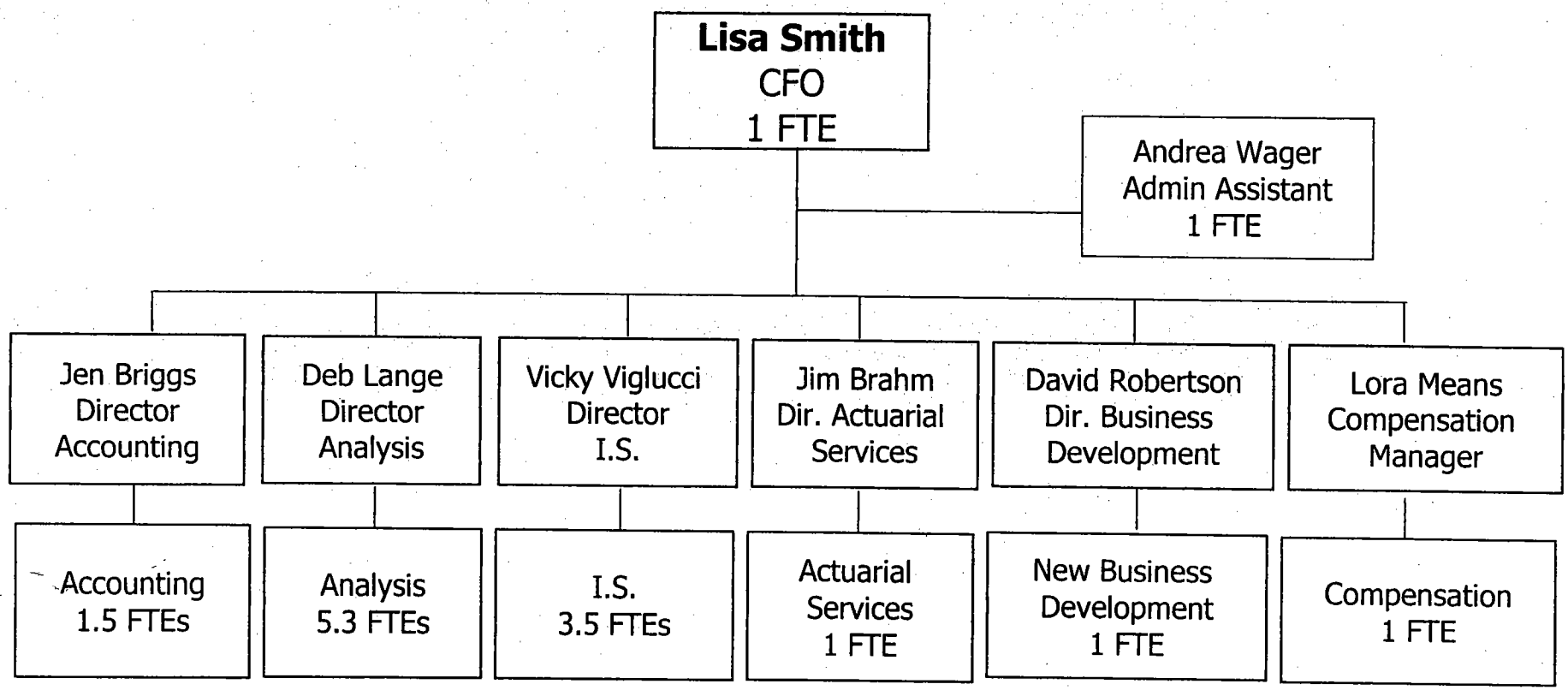
# GRIPA Administration




47.4 TOTAL FTEs

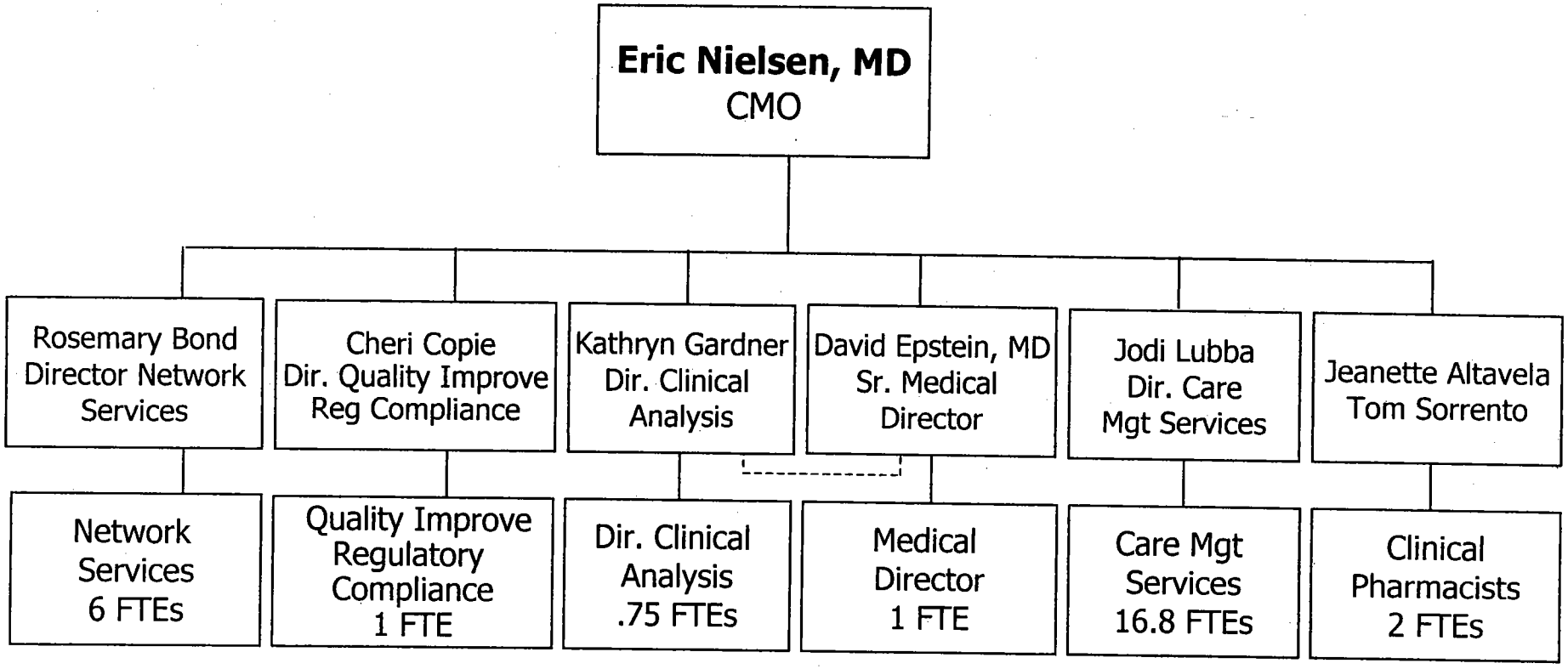
GRIPA

# GRIPA Finance Department



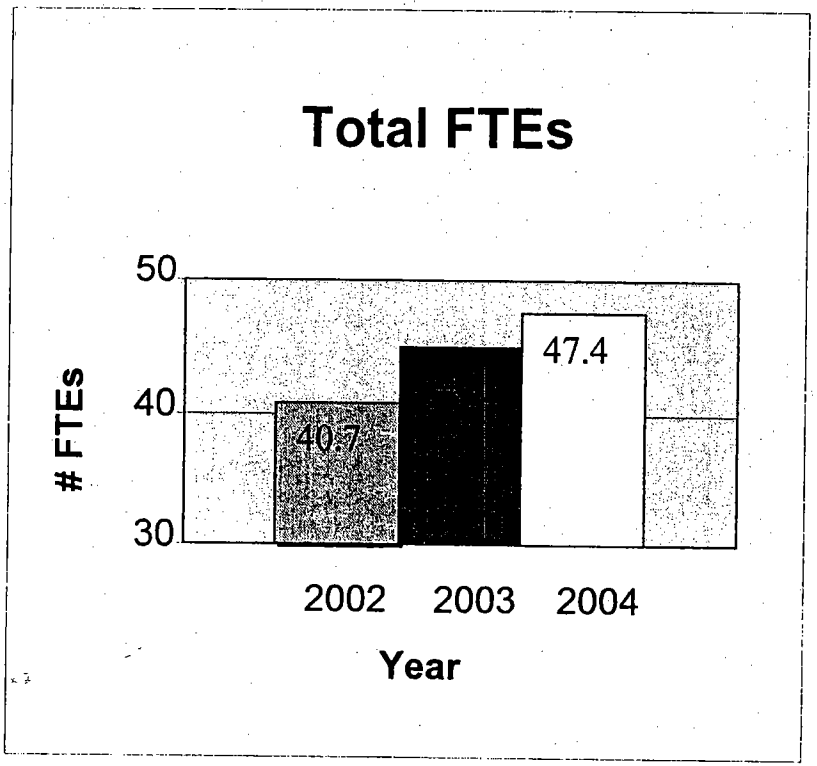

GRIPA

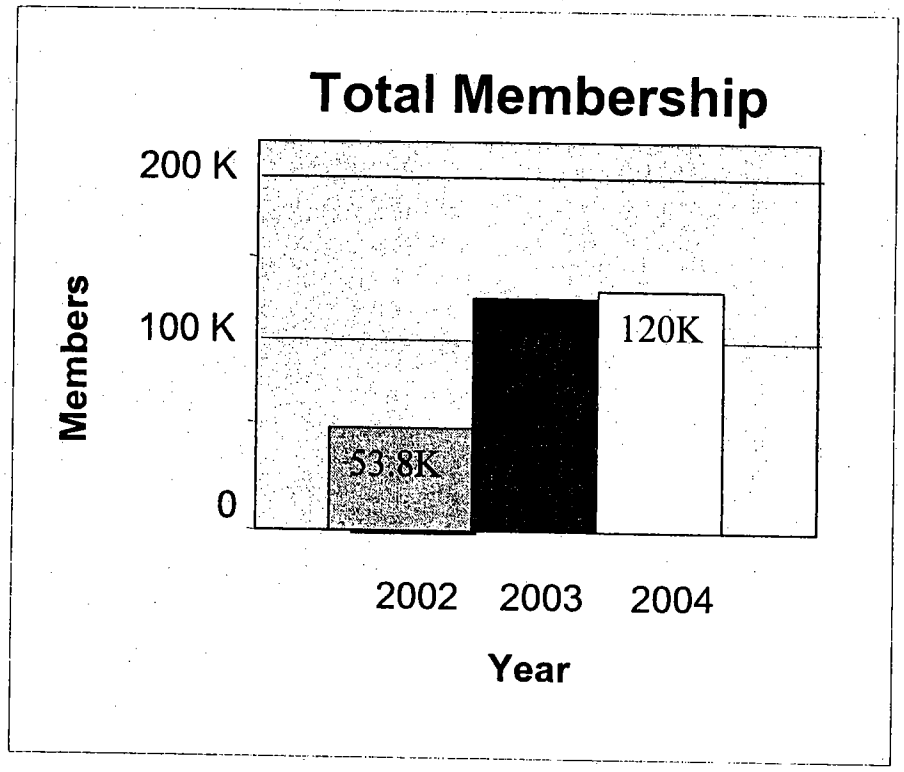
# GRIPA Medical Department




GRIPA

# FTE : Membership Ratio




**FTE:Membership Ratio**

**2002 1 : 1,324**

**2004 1 : 2,533**

GRIPA

# Administrative Expenses Compared to Revenue

**Total Administrative Expenses**

# Financial Data Summary

**(in millions)**

# REPORT CARD

GRIPA

# 2004 Strategic Initiatives

1. Successful Choice-Choice Implementation
2. Demonstrating value to Owners
3. Network Development/Partner Alliances
4. Business Development/new products

GRIPA

# SCORE CARD

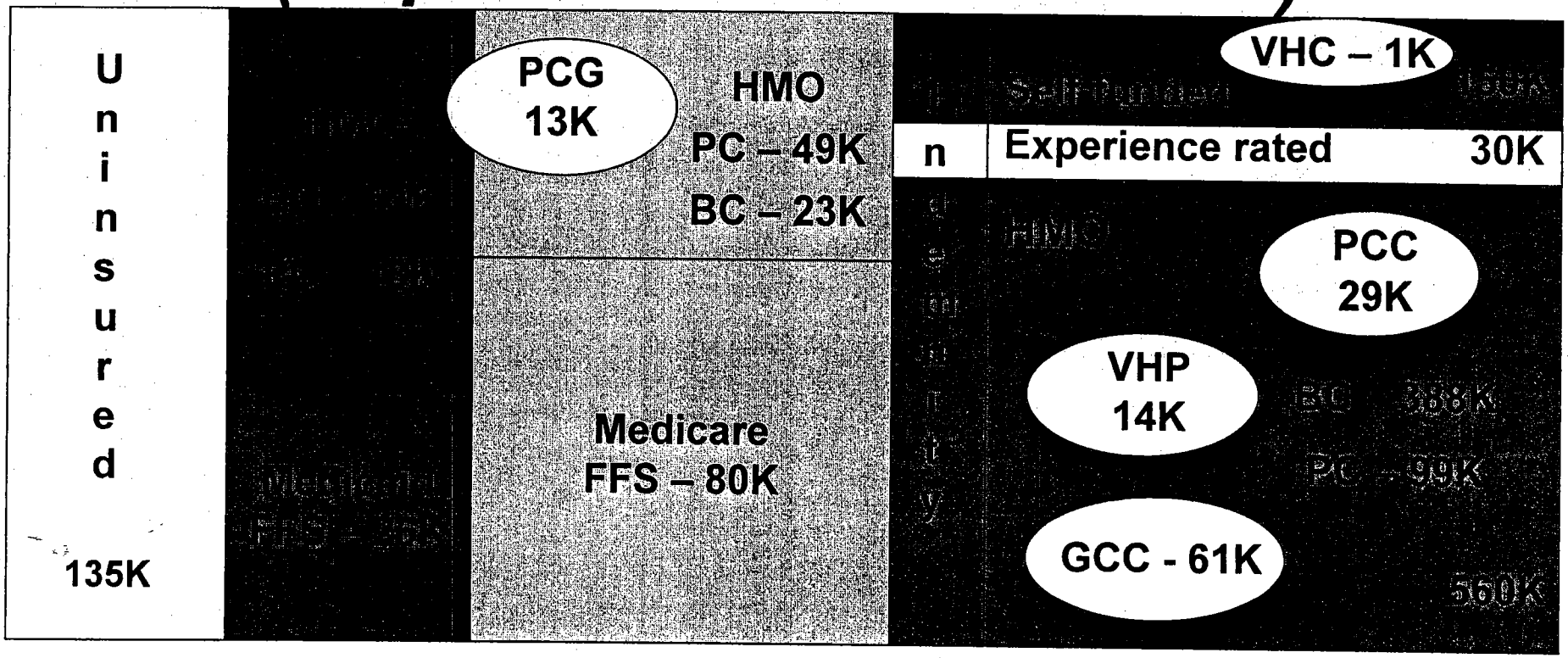
**Strategic Initiative**

| | |
|---|---|
| Choice Choice | Operationalized in 2003<br>Initial financial success but faltering |
| Value to Owners | Above market returns in 2003; no significant change in market share |
| Network /Partner | No significant change |
| Business Development | Kodak in 2004<br>Need Board direction |

GRIPA

# Rochester Healthcare Benefits Marketplace – Today

## *(Population stated in 000s)*




| Medicaid | Medicare | Commercial Market |
|---|---|---|
| N = 105 | N = 150 | N = 740 |

# MARKETPLACE

- Preferred Care
  - Buyer?
- Blue Cross
- Aetna
- Monroe County Medical Society
- Rochester Health Commission
- Regulatory

GRIPA

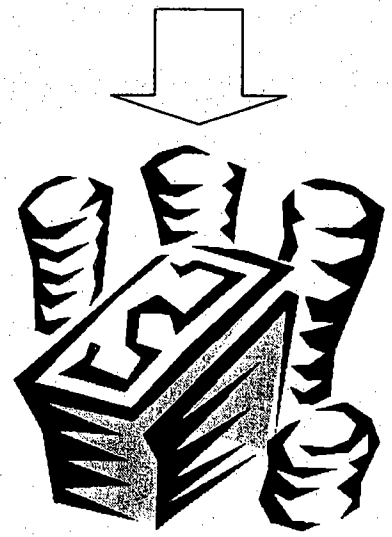
# CAPITATION

A method of paying for healthcare services on the basis of:

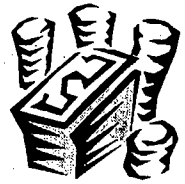
- Number of members covered rather than the number of services provided
- Monthly payments per member regardless of how often (if at all) the member receives care during the month and regardless of the actual cost of that care

GRIPA

# INSURER

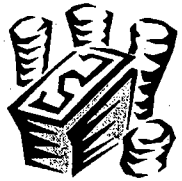


**Capitation to GRIPA**



**Hospital/Physician Claims Less Withhold**

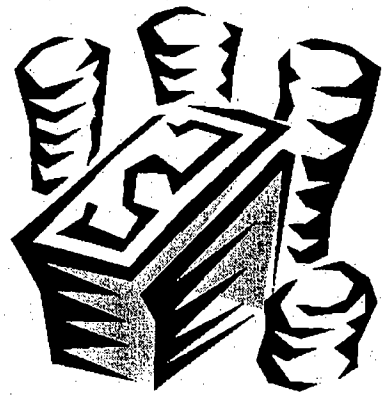
**Admin**



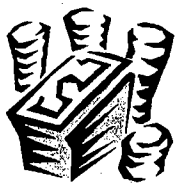
**Risk Withhold**

**+Gainshare**

# Self Funded Employer/ TPA



**MEDICAL CLAIMS**



**Payments directly to Providers**

**GRIPA**

# Capitation/Risk

Accounting & Reporting
Contracting (Joint hospital/physician)
Analysis
Actuarial
IT
Medical Directors
Pharmacist
Medical Management
Network Services
Quality – Compliance
General Administration

# Non – Risk Self Insured

Medical Directors
Contracting
Network Staff

GRIRA

# Capitation

## PRO

- Gain Share
- Move Market Share
- Interface with Payors
- Significant Form of Insurance
- "Control" Own Destiny

GRIPA

# Capitation (continued)

## CON

- More difficult to get fair cap rate
- More difficult to forecast hospital rates
- Compression of physician fees make volume projections more unpredictable
- What is considered a "win"
- Have not moved market share

GRIPA

# Non – Risk
# Self Insured

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GRIPA

# Risk
# Self Insured

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GRIPA

# CAPITATION SUMMARY

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GRIPA

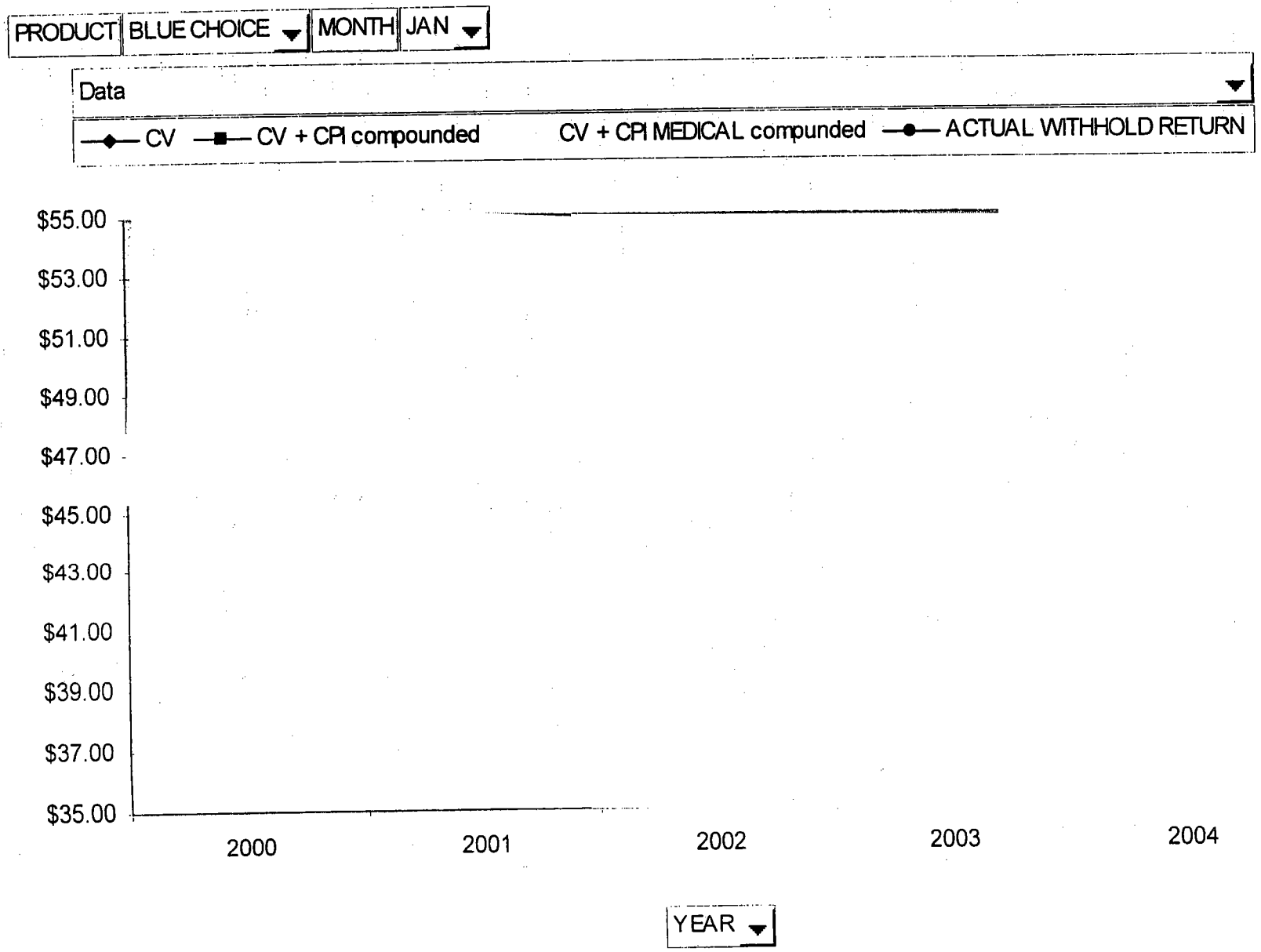
# PHYSICIAN COMPENSATION

GRIPA

# BLUE CHOICE MEDICAL CPI AND CPI BASED ON 12-MONTH COMPARISONS ENDING IN JANUARY

| YEAR | INSURANCE RATE INCREASE | BCBS PROFITS | CV | CPI + CV COMPOUNDED | Medical CPI +CV COMPOUNDED | ACTUAL RETURN WITH WH RETURN |
|---|---|---|---|---|---|---|
| 2000 | | | | | | |
| 2001 | | | | | | |
| 2002 | | | | | | |
| 2003 | | | | | | |
| 2004 | | | | | | |

# Blue Choice

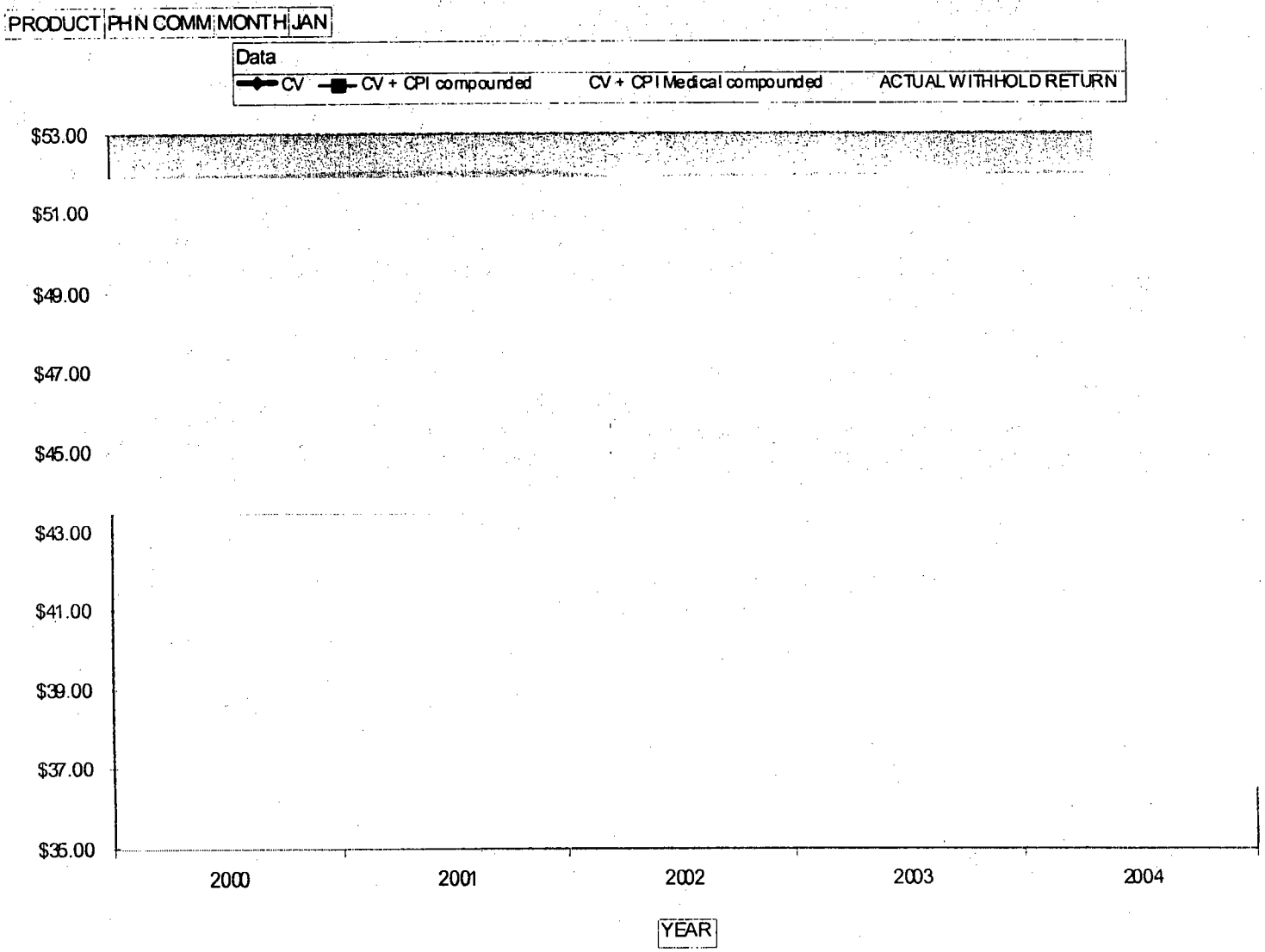



RGPO/R. Pennino 2004

# PREFERRED CARE MEDICAL CPI AND CPI BASED ON 12-MONTH COMPARISONS ENDING IN JANUARY

| YEAR | RATE INCREASE | PREFERRED CARE PROFITS | CV | CPI + CV COMPOUNDED | Medical CPI +CV COMPOUNDED | ACTUAL RETURN WITH WH RETURN |
|---|---|---|---|---|---|---|
| 2000 | | | | | | |
| 2001 | | | | | | |
| 2002 | | | | | | |
| 2003 | | | | | | |
| 2004 | | | | | | |

# Preferred Care Commercial




RGPO/R. Pennino 2004

# American Medical Group Association's

## 2004 Medical Group Compensation & Financial Survey

- 30,500 physicians caring for 50 million patients in 42 states
- 15 million capitated lives
- Median compensation & productivity has increased over 4 yrs
- Most specialties saw modest increases in compensation in 2003
- Certain high demand specialties saw major increases over 1 & 4 yrs
- For 2003: Cardiology 12%, Dermatology 17%, GI 12%, Path.14%
- For 2003: Neurology 7%, General Surgery 0%, Orthopedic 1%
- For 2003: Internal Medicine -2%, Emergency Medicine -1%
- Physicians in Northern Region had a loss of $3,477 in 2003
- Southern: +$570, Eastern +$2080, Western +$1530
- Trends continue

GRIPA

# Strong Health Flexes Its Muscles

- ?2003 Excellus started giving ? mgmt fee to only SMH neurosurgeons
- ?1/2004 RIPA found out and insisted all RIPA neurosurgeons included
- RIPA developed a protocol for mgmt fee $200-$2000 based on CPT
- This is an HMO expense (not in IPA cap.) (new money for some docs)
- To start in early Sept. '04 to replace what Excellus is presently doing
- No formal communication yet but presumably will only go to neurosurg
- RIPA has warned Excellus that other specialties will be standing in line

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# Strong Health Flexes Its Muscles (continued)

- Preferred Care is giving enhanced fees to several specialties at SMH
- Various conversion factors up $70 (
- As PHN has no structure, PC gives this to some groups and not others
- One of our (non-SMH) spinal orthopedists called PC to complain
- He was offered for surgical charges to PHN 9/04-12/31/05
- GRIPA was asked by PC if it would follow suit, for this surgeon alone
- This money would come from the IPA
- Whatever happens to the PCP's, patients and risk $ follow.

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# PHYSICIAN SUMMARY

- Physician fees in Rochester and throughout the Northeast have been relatively stagnant, especially compared to premium increases
- Strong Health and certain specialties have been able to negotiate more favorable terms. Can a single conversion factor survive?
- Physicians will seek out the organization (s) that can best negotiate higher fees. Will specialist de-par from GRIPA?

GRIPA

# EMR

GRIPA

# Update On EMR Efforts

GRIPA staff has challenged itself to convert its provider network to electronic medical records in the next 2-3 years.

GRIPA

# Update On EMR Effort

- Why?
- What are the costs?
- Benefits for providers and the IPA?
- What are the barriers?
- Do stakeholders agree?

GRIPA

# Why?

- Executive Order 4/27/04:

  "By the authority vested in me as President by the Constitution and the laws of the United States of America, and to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure **to improve the quality and efficiency of health care**, it is hereby ordered as follows…

  The Secretary of Health and Human Services shall establish the position of National Health Information Technology Coordinator…appointed by the Secretary in consultation with the President…. begins operations within 90 days of the date of this order."

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# Why?

- Improve quality
- Reduce medical errors
- Reduce costs
- Reduce inappropriate care
- Improve information capture, accuracy, security, exchange between providers, and availability at the point and time of care

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# Benefits for Providers/Practices

- Improved patient care by adherence to preventive care and disease management guidelines
- Improved work environment from reduced paper shuffling, transcription
- Reduced potential for human errors
- Reduced physical space requirements
- Reduced FTE requirements
- Increased provider efficiency/satisfaction

GRIPA

# Benefits to IPA

- More efficient use of specialty care resources
- Improved in-network referral
- Improved adherence to tier drug formularies
- Improved compliance with NCQA standards
- Potential for disease management in offices
- Extend reach of care management staff
- Improve marketability to employers, insurers, patients, and physicians due to measurable improvements

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# Benefits to Insurers/Employers

- Improved quality of care
- Improved coding accuracy
- Boost disease management efforts
- Satisfy NCQA requirements, etc.
- Share in cost savings

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# EMR Can Save On Drug Costs:

- 
- 
- There are several other commonly prescribed classes of medications for which this applies including anti-inflammatories, antidepressants and antihypertensives.

GRIPA

# EMR Can Save On Drug Costs:
## (continued)

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- 
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GRIPA

# EMR Can Save On Drug Costs:
## (continued)

- 
- 

GRIPA

# Business Case for EMR for Small-to-Medium PCP Practices
# Annual Cost/Benefit Per Primary Care Physician

Estimates from a 5-year survey of primary care physicians in the Partners Healthcare System
Wang S. J. et al (2003). A cost-benefit analysis of electronic medical records in primary care. *American Journal of Medicine,* 114,397-403.

| Description | Benefit Category | Mean Benefit | Low End | High End |
|---|---|---|---|---|
| Savings from converting to paperless record | Chart pulls | $3,000 | $1,500 | $6,000 |
| | Transcription | $2,700 | $1,900 | $9,600 |
| Savings on capitated patients (17% of pts) | Adverse drug events | $2,200 | $600 | $4,500 |
| | Drug utilization | $16,400 | $5,400 | $21,800 |
| | Laboratory utilization | $2,400 | $300 | $3600 |
| | Radiology utilization | $8300 | $2,900 | $11,800 |
| Gains on fee-for-service Patients(83% of pts) | Charge capture | $7,700 | $5,700 | $19,100 |
| | Billing errors | $7,600 | $3,500 | $9,200 |
| **Total (annual benefits)** | | **$50,300** | **$21,800** | **$85,600** |

GRIPA

| Cost Category | Mean Cost | Low End | High End |
|---|---|---|---|
| Implementation (yr1) | $3,400 | $3,400 | $3,400 |
| Hardware (yr1) | $4,400 | $2,200 | $6,600 |
| Productivity Loss (yr1) | $11,200 | $5,500 | $16,500 |
| Software License | $1,600 | $800 | $3,200 |
| Support | $1,500 | $700 | $3,000 |
| Hardware Updates | $2,200 | $1,100 | $3,300 |
| **Total Costs, Year 1** | **$22,100** | **$13,700** | **$36,000** |
| **Total Costs, Year 2+** | **$5,300** | **$2,600** | **$9,500** |
| **Total Return on Investment Year 1** | **$28,200** | **$8,000** | **$49,600** |
| **Total Return on Investment Year 2+** | **$45,000** | **$19,000** | **$76,100** |

# Barriers to Implementation

- Real and perceived financial cost
- Vendor selection
- Downtime for implementation & training
- Decreased productivity until providers are familiar with new systems/procedures
- Lack of technical knowledge
- Inertia, "Too busy"
- Changing Technology

GRIPA

# Do Stakeholders Agree?

- 60% of physicians are thinking about EMR
- Less than 10% have converted
- Physicians will need help in vendor selection, financing, and implementation.
- GRIPA, as a provider organization, is well positioned to help and, as it takes risk, to benefit financially
- **Should GRIPA make the investment?**

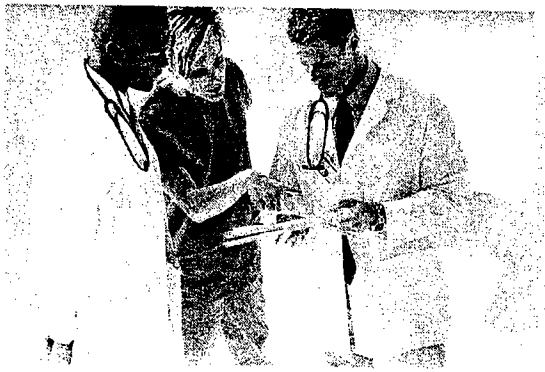
GRIPA

THE Coker GROUP

*National Consultants to Healthcare Providers*

*11660 Alpharetta Highway ◆ Suite 710 ◆ Roswell, Georgia 30076 ◆ (678) 832.2000*

# About The Coker Group



# The Coker Group

***The Coker Group,*** through principled professional consulting, assists healthcare providers in their pursuit of a sound business model and an enhanced patient experience.

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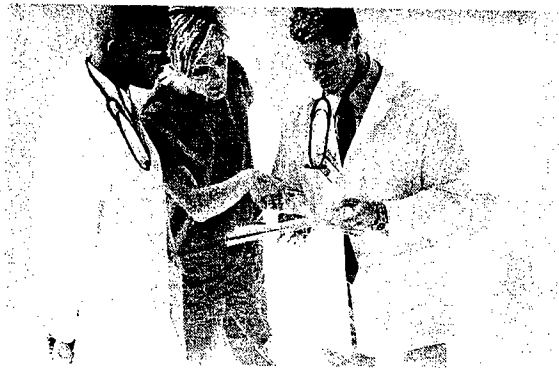

# The Coker Group

- Providing strategic consulting assistance to healthcare providers since 1987.
- Primary focus
  - Strategic
  - Operational
  - Financial
  - Technological
- Day-to-Day Management
- Special Projects Assistance
- Interim Management

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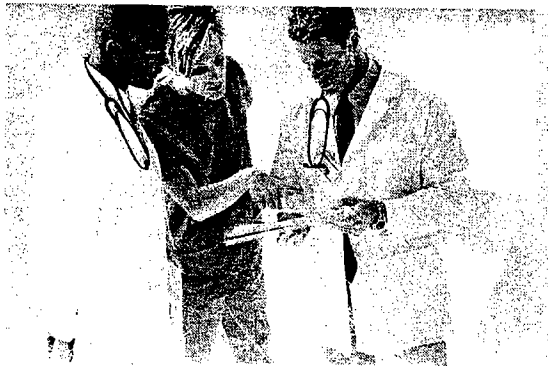
*National Consultants to Healthcare Providers*



# The Coker Group

## Location:

Base of Operations – Atlanta, Georgia

## National Presence:

- Worked in 49 states since inception
- Worked in 45 states in 2004

## Clients:

- Hospitals
- Medical Groups
- Strategic Alliances
- Private Businesses/Associations (AMA, AMEX, MicroSoft)

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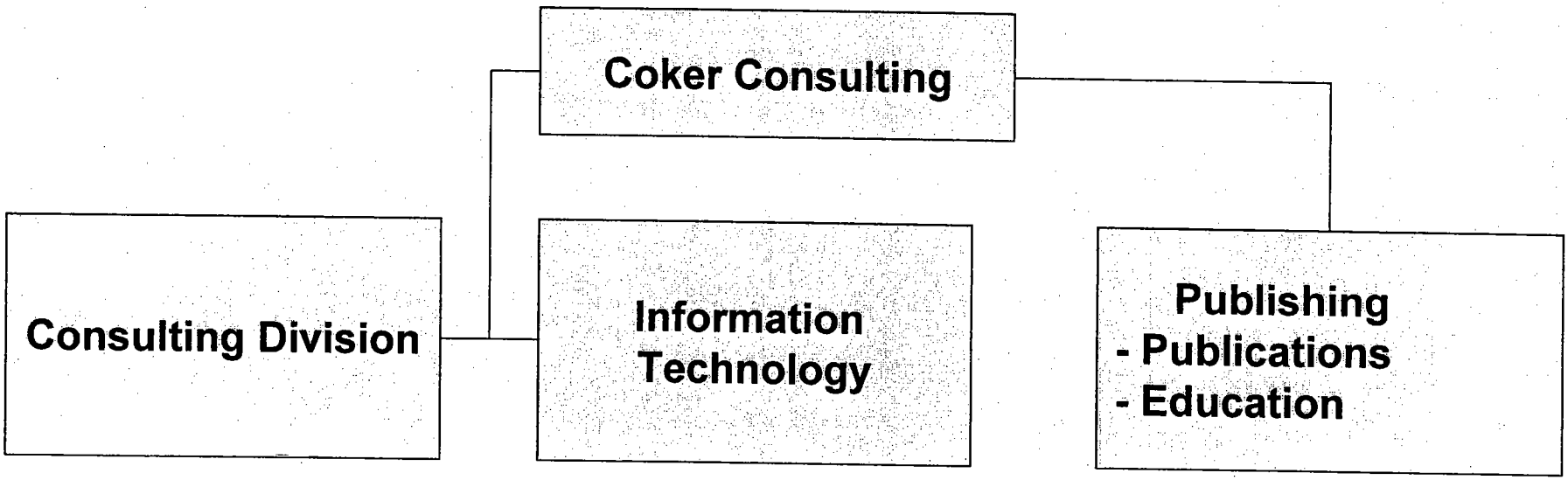
# Structure

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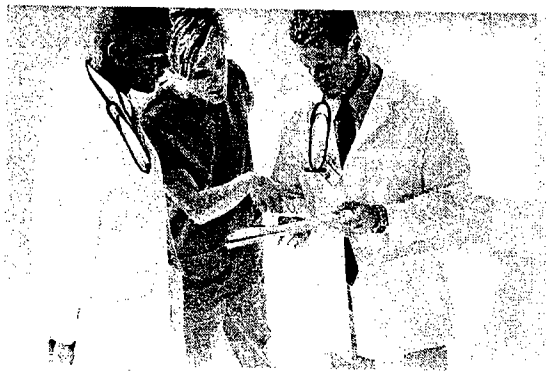


# Consulting Division

## Operational Consulting

- Coding and Compliance
- Supply/Demand Analysis
- Revenue Cycle Analysis and Audits
- Interim Management
- New Entity Start-up
- Business Plans
- Expense Analysis
- Managed Care Negotiations/Contracting

## Financial Consulting

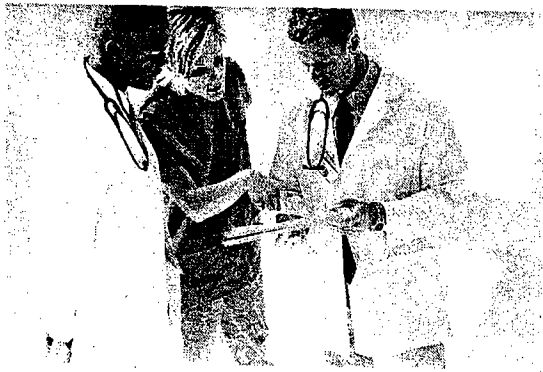
- Feasibility Analysis
- Business Valuation
- Fairness Opinions
- Debt Analysis/ Restructuring/ Turnaround
- Compensation Plan Development
- Mergers and Acquisitions
- Strategic Financing
- Buy/Sell Agreements

## Strategic Consulting

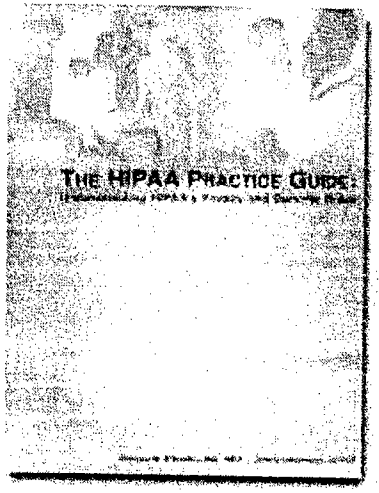
- Groups
- Health Systems
- IPAs
- Joint Ventures
- Ancillary Services

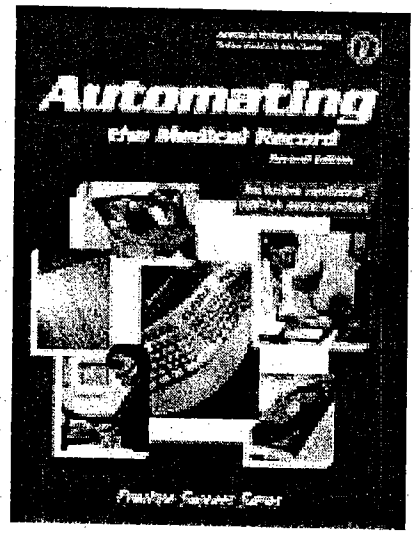
# Information Technology

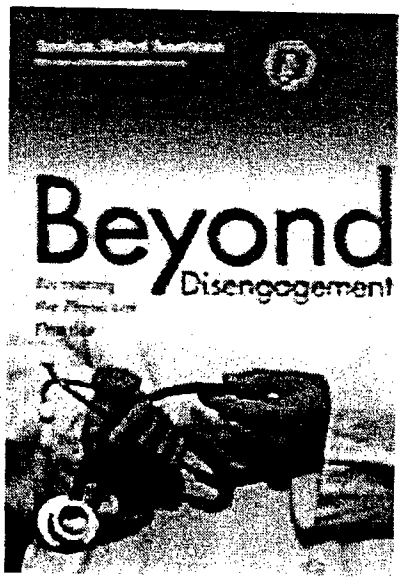
- EMR/PM Readiness
- EMR/PM Evaluations
- EMR/PM Installation Support
- EMR/PM De-installation Support
- Hardware Needs Analysis
- White Paper Analysis
- Vendor Analysis

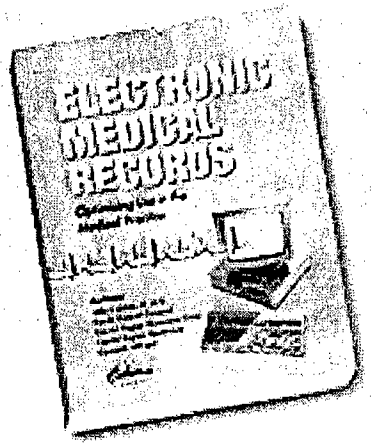


# Media/Publishing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# Education

- American Medical Association (AMA)
- Healthcare Financial Management Association (HFMA)
- American Association of Medical Management (AAMM)
- National Medical Group Management Association (MGMA)
- Regional MGMA
- Healthcare Information and Management Systems Society (HIMSS)
- Toward an Electronic Patient Record (TEPR)
- Southern Medical Association (SMA)
- American Medical Group Association (AMGA)
- Specialty Academies
- *Coker Connection* Monthly Newsletter

# Coker Team

- **Approximately 30 consultants.**
- **All clients work directly with Managing Partner or Associate Partners.**
- **Consultants specialize in multiple issues:**
  - Strategic
  - Financial
  - IT
  - Operational
  - Management
  - Coding and Compliance
  - Billing and Collections
  - Compensation
  - Valuation

**When using the Coker Group you get access to ALL of our consultants and ALL of our expertise.**

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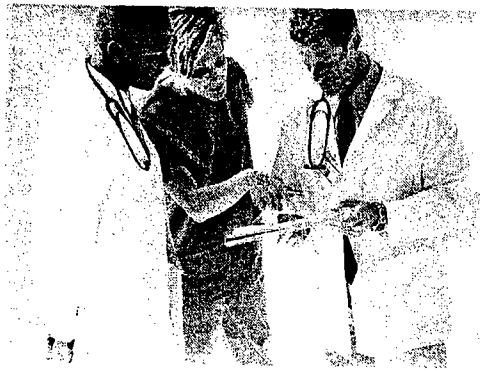

# Coker Representative

J. Max Reiboldt, CPA, Managing Partner/CEO*

- 32 years of management experience in various areas and types of businesses
- Extensive experience in negotiations and facilitation among various business/initiatives
- Currently: Managing Partner/Chief Executive Officer and principal owner of successful national healthcare consulting firm

*Biographical summary has been provided.

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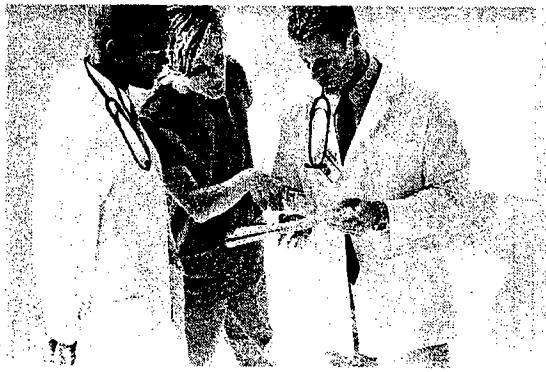
*1000 Mansell Exchange West ◆ Suite 310 ◆ Alpharetta, Georgia 30022 ◆ (678) 832.2000*

# Greater Rochester IPA
# Strategic Planning Meeting Agenda
# June 23, 2005

## Agenda



# Agenda (Outline)

| | | |
|---|---|---|
| I. | Introduction | Mike Kukfa, M.D., GRIPA Chairman |
| II. | Overview of Strategic Planning Process | Max Reiboldt, CPA, Managing Partner/CEO<br>The Coker Group |
| | •Summary of Interviews<br>–Issues Identified | Max Reiboldt |
| | –Strategic Plan Assumptions | Greg Meredith, Managing Partner,<br>Mededith Consulting |
| | •Legal Summary | Isman, Cunningham, Riester & Hyde |
| | •GRIPA Alternatives | Max Reiboldt, CPA |
| III. | Workgroup Conclusions/Recommendations | Max Reiboldt, CPA<br>Greg Meredith<br>Gregg Coughlin, GRIPA, President<br>Eric Nielsen, M.D., GRIPA CMO |
| IV. | Strategic Plan Process Conclusions | To Be Completed |

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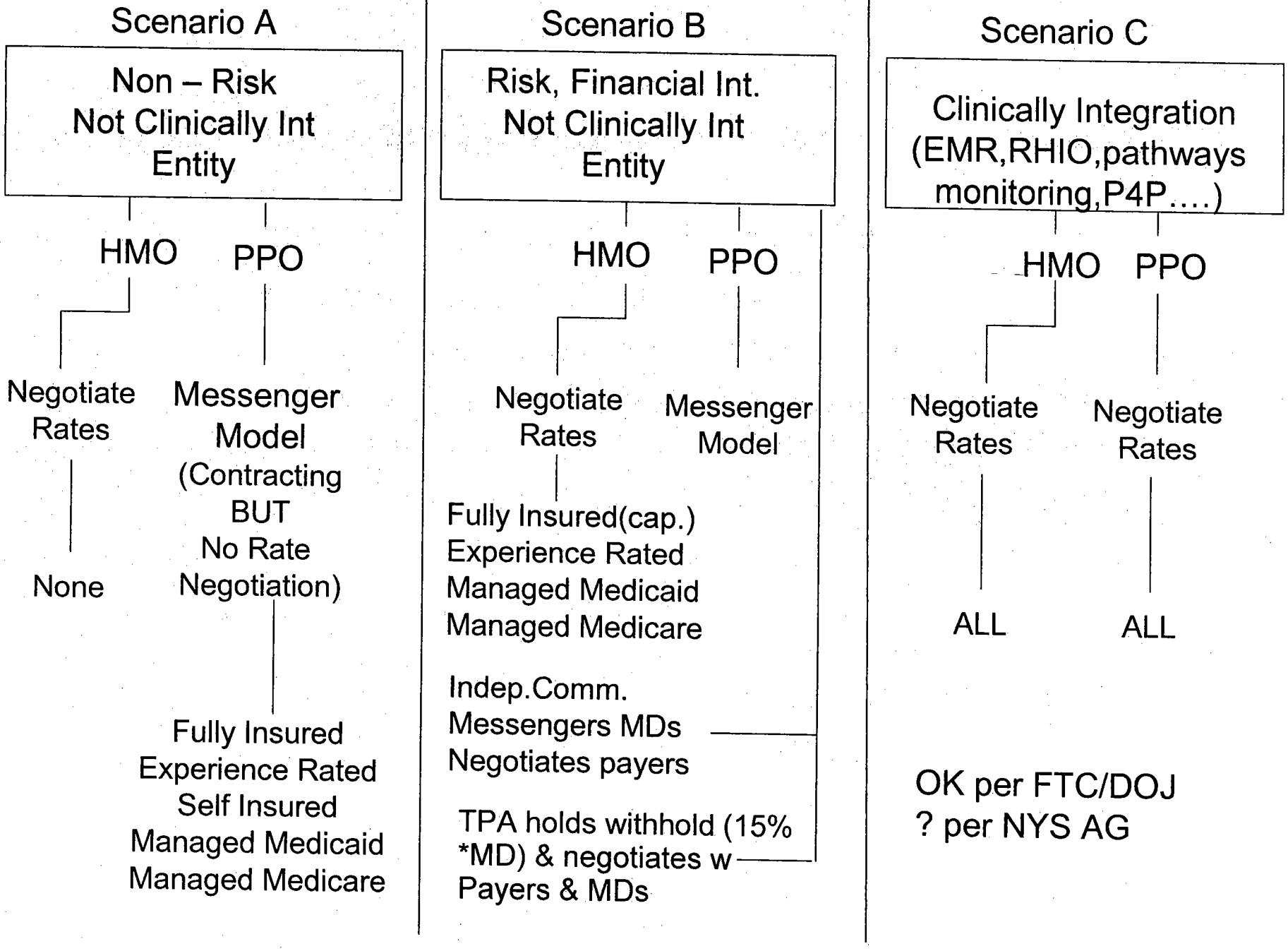
# GRIPA STRATEGIC PLANNING MEETING



# Strategic Planning Meeting

June 23, 2005

GRIPA

# Introduction

- Welcome
- Retreat Leaders
  - Max Reiboldt
  - Bob Iseman & Paul Gillan
  - Greg Meredith
  - Missing Chris White from McDermott Will & Emery

GRIPA

# Introduction

**2004 was a rough and challenging year**

a)

b)

c)

d)

e)

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# Greater Rochester IPA
# Strategic Planning Meeting Agenda
# June 23, 2005

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# CLINICAL INTEGRATION

Health Care Statement 8 notes that clinical integration can be evidenced by a "network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."

Statements of Antitrust Enforcement Policy in Health Care, Issued by U.S. DOJ and the FTC August 1996

# THREE KEY ELEMENTS A CLINICAL INTEGRATION PROGRAM MUST INCLUDE

*(Health Care Statement 8)*

1. "Establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care"
2. "Selectively choosing network physicians who are likely to further these efficiency objectives of clinical integration"
   - Monitor performance to improve outcomes and control costs
3. "The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies."
   - Common software, electronic medical records systems, and data warehousing to permit shared access to patient records

# Society Perspective

- Costs of health care are rising faster than inflation
- Patients shouldering larger share of costs
- Quality and patient safety lag known remedies
- Providers resistant to disclosure, measurement and change

# Physician Perspective

- Rarely rewarded (often penalized) for better value: IT, disease management
- Difficulty demonstrating value
- Difficulty winning P4P income
- Inadequate infrastructure to sustain value
- Need integration across specialties (and with hospital) to deliver value continuously

# PHO/IPA Perspective

- Risk contracts are flat or shrinking
- Messenger model for FFS contracts is difficult to implement & unsatisfactory
- Value of IPAs and PHOs often not perceived by market place
  - Insurers trying to direct contract with MDs
- Each payer develops own P4P
- Regulators aggressively scrutinize functions

# Challenge for Hospitals

- Traditional medical staff structure does not engage doctors in hospital performance
- Employed practices difficult to manage and incomplete strategy
- Regulators disallow payment to MDs for admissions, referrals, or share of savings
- Gain-sharing arrangements limit compensation to physicians and have regulatory hurdles

# Market Realities

- Risk contracts are flat or declining
- Large multi-specialty groups do not dominate physician practice positions
- Instead, solo and small groups dominate physician practice positions
- Independent practices must demonstrate clinical integration and/or financial integration to be able to jointly contract
- Organizational forms are needed to deliver the advantages of both multi-specialty and single-specialty groups to the public

# Clinical Integration

- Independent practices come together:
  - To add value to the market place
    - Better quality
    - More efficient
    - More responsive to patients
  - With or without hospital integration
- Shared commitment:
  - Clinical improvement
    - IT
    - Staff
    - Materials
    - Financial incentives
  - Stable network of MDs
    - Contract through 1 IPA
  - Common product to the outside world (branding)
  - Contracting for risk and FFS

# Clinical Integration…

Aligns physicians and other health care providers through:

- Data collection and analysis
- Collaboration in clinical quality initiatives and disease state management programs
- Establishment of clinical protocols and shared best clinical practices
- Financial incentives
  - Increased Clinical Quality = Better Financial Position for Hospitals, Physicians, & Payers (per HFMA)

# Clinical Integration

*cont'd*

This alignment creates systems that:

- minimize variations in care
- improve patient care outcomes
- reduce medical errors
- provide care more efficiently

In order to:

- demonstrate better value to employers/insurers
- deliver better health to consumers

# Impact of Clinical Integration

- Patient safety/risk reduction
- Decrease practice variation
- Customer satisfaction
- Operational efficiency
- Staff/Physician competency
- Satisfy regulatory/purchaser requirements
- Reduce costs
- Focus on the health status of community

# MEDSOUTH RECEIVED FAVORABLE FTC ADVISORY OPINION 2/19/2002

- MedSouth, Inc. is an IPA in Denver that partially integrated its 432 member physicians in 216 practices (101 PCPs, 331 SCPs)
- Requested an FTC advisory opinion about their proposal before entering into FFS contracts with third-party payers
- First written guidance addressing the amount and nature of clinical integration necessary to permit independent physicians to collectively negotiate fees without violating federal price fixing prohibitions
  - Statements of Antitrust Enforcement Policy in Health Care by FTC/DOJ August 1996
- This opinion remains the "gold standard"

# MEDSOUTH

*cont'd*

- Intended to adopt and implement 100-150 practice guidelines (covering 80-90% of diagnoses of its physicians' patients)
- Participating providers would invest in common software, clinical data record systems and data warehousing to permit the electronic sharing of patient records
  - E.g., patient charts, office visit notes, lab reports, radiographic reports, treatment plans and Rx information
- MedSouth would monitor physician performance on a routine basis
  - Provide ongoing education and training to promote individual provider compliance
  - Impose sanctions, including expulsion, for non-compliance

# INTEGRATION PLANNING

from "Improving Healthcare: A Dose of Competition", FTC/DOJ 7/23/04
(Chap.2, p.36-)

## The Agencies (FTC & DOJ)

- **Are committed to eliminating unlawful restraints on vigorous price and non-price competition in physician markets**
- **Do not suggest particular structures with which to achieve clinical integration**
- **Questions they are likely to ask when analyzing the competitive implications of a physician network joint venture (not exhaustive):**

# INTEGRATION PLANNING

*cont'd*

- **What do the physicians plan to do together from a clinical standpoint?**
  - What specific activities will (and should) be undertaken?
  - How does this differ from what each physician already does individually?
  - What ends are these collective activities designed to achieve?
- **How do the physicians expect actually accomplish these goals?**
  - What infrastructure and investment is needed?
  - What specific mechanisms will be put in place to make the program work?
  - What specific mechanisms will there be to determine whether the program is working?

# INTEGRATION PLANNING

*cont'd*

- **What basis is there to think that the individual physicians will actually attempt to accomplish these goals?**
  - How are individual incentives being changed and re-aligned?
  - What specific mechanisms will be used to change and re-align the individual incentives?
- **What results can reasonably be expected from undertaking these goals?**
  - Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?
  - To what extent is the potential for success related to the group's size and range of specialties?

# INTEGRATION PLANNING

*cont'd*

- **How does joint contracting with payors contribute to accomplishing the program's clinical goals?**
  - Is joint pricing reasonably necessary to accomplish these goals?
  - In what ways?
- **To accomplish the group's goals, is it necessary (or desirable) for physicians to affiliate exclusively with one IPA or can they effectively participate in multiple entities and continue to contract outside the group?**
  - Why or why not?

# Clinical Integration: Example Components
## from FTC/DOJ Statements

- Establish quality and utilization goals
- Monitor and evaluate each participant's and the group's aggregate performance
- Work with individual providers to modify practice patterns where necessary
- Measure the individual provider and group performance against cost and quality benchmarks
- Monitor patient satisfaction

# Components
## *cont'd*

- Develop practice standards and protocols
  - Actively monitor and review each physician's compliance with standards and protocols
  - Case management, preadmission authorization of some services, and concurrent and retrospective review of inpatient stays
- Invest in the information systems and software necessary to monitor the cost, quantity and nature of services provided by participating providers
  - Provide payors with detailed reports on the cost and quantity of services provided, and on the integrated group's success in meeting its goals

# Components
*cont'd*

- Medical director and support staff to assist the physicians in achieving integration and to coordinate patient care in specific cases
- Sanction (and expel, if necessary) physicians who fail to adhere to standards and protocols

# NEXT STEPS

# Strategic Planning Meeting

June 23, 2005

GRIPA

# Introduction

- Welcome
- Retreat Leaders
  - Max Reiboldt
  - Bob Iseman & Paul Gillan
  - Greg Meredith
  - Missing Chris White from McDermott Will & Emery

GRIPA

# Introduction

**2004 was a rough and challenging year**

a)

b)

c)

d)

e)

GRIPA

# GRIPA STRATEGIC PLANNING MEETING

## Scenario A

Non – Risk
Not Clinically Int
Entity

HMO

Negotiate Rates

None

PPO

Messenger Model
(Contracting BUT No Rate Negotiation)

Fully Insured
Experience Rated
Self Insured
Managed Medicaid
Managed Medicare

## Scenario B

Risk, Financial Int.
Not Clinically Int
Entity

HMO

Negotiate Rates

Fully Insured(cap.)
Experience Rated
Managed Medicaid
Managed Medicare

PPO

Messenger Model

Indep.Comm.
Messengers MDs
Negotiates payers

TPA holds withhold (15% *MD) & negotiates w Payers & MDs

## Scenario C

Clinically Integration
(EMR,RHIO,pathways monitoring,P4P….)

HMO

Negotiate Rates

ALL

PPO

Negotiate Rates

ALL

OK per FTC/DOJ
? per NYS AG

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# Summary of Interviews *

* Not necessarily the opinion of Coker

# Individuals Interviewed

John Genier, M.D.
Internal Medicine
Member, RGPO Board of Directors

Robert Wayland-Smith
Member, GRIPA Board of Directors
Chase Bank

Michael Kukfa, M.D.
Chairman, GRIPA Board of Directors

Linda Rice, M.D.
ViaHealth
President, Medical and Dental Staff

Joseph Rube, M.D.
ViaHealth – General Surgeon
Member, Medical Management Committee

Nancy Adams
President, Monroe County Medical Society

Patrick Riggs, M.D.
ViaHealth – Vascular Surgeon
Member, GRIPA Board of Directors

David Hannan, M.D.
ViaHealth of Wayne
Past President, Wayne County Physician Organization
Member, GRIPA Board of Directors

Richard Endres, M.D.
ViaHealth of Wayne
Member, GRIPA Board of Directors

Joseph DiPoala, M.D.
President, Rochester General
Physician Organization
Member, GRIPA Board of Directors

# Individuals Interviewed *(continued)*

John Oberlies
President, Rochester Health Commission

Tom Mahoney, M.D.
President, Rochester Independent
Practice Association

Lisa Brubaker
Preferred Care
Chief Operating Officer

Greg Heeb, M.D.
President, Newark – Wayne Physician Organization
Member, GRIPA Finance Committee

Jack Biemiller
Chairman, GRIPA Finance Committee
Member, GRIPA Board of Directors

Daniel Meyers
President, Al Sigl Center
Vice Chairman, GRIPA Board of Directors
Member, ViaHealth Board of Directors
Chairman, ViaHealth Health Care Services
Board of Directors

Richard Hogg
ViaHealth Chief Financial Officer
Member, GRIPA Finance Committee
Member, GRIPA Board of Directors

Richard Gangemi, M.D.
ViaHealth, SVP Academic & Medical Affairs
Member, GRIPA Board of Directors
Former Chairman, GRIPA Board of Directors

Samuel R. Huston
ViaHealth Chief Executive Officer
Member, GRIPA Board of Directors

# Individuals Interviewed *(continued)*

Ralph Pennino, M.D.
Plastic Surgeon
Past President, RGPO (Rochester General Physicians Organization)
Member, GRIPA Board of Directors

Gary Wahl, M.D.
ViaHealth
Pulmonary Medicine

Chris O'Donnell
VP Network Management
Blue Cross – Blue Shield Rochester Region

Lisa Smith
CFO, GRIPA

Eric Nielsen, MD
Chief Medical Officer, GRIPA

# Questions Asked and Summary of Comments

## Questions Asked

- Major Issues (Strategic and Operational)
- GRIPA Vision
- Management/Board Effectiveness
- Future Products and Services
- Current Operational Challenges/Concerns

## Summary of Comments

- Commonalities
- Differences of Opinion

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# Workgroup Summary

# Workgroup Members

**Workgroup Facilitator**

**Max Reiboldt,** CPA, Managing Partner/CEO, The Coker Group

**Workgroup Members**

**Michael Kukfa, MD** - Chairman GRIPA Board of Directors, Community Physician
**Mr. Samuel Huston** - Member of the GRIPA Board, President/CEO ViaHealth,
**Joseph DiPoala, MD** - Member of the GRIPA Board, President Rochester General Physicians Organization,
**Mr. Daniel Meyers** - Vice Chairman of the GRIPA Board
**Patrick Riggs, MD** - Member of the GRIPA Board, Community Physician (vascular surgeon)
**David Hannan, MD** - Member of the GRIPA Board, Community Physician
**John Genier, MD** - Community Physician, Member of the Rochester General Physicians Organization

**GRIPA Staff**

**Gregg Coughlin**, President, GRIPA
**Eric Nielsen, MD**, Chief Medical Officer, GRIPA

**Also Present**

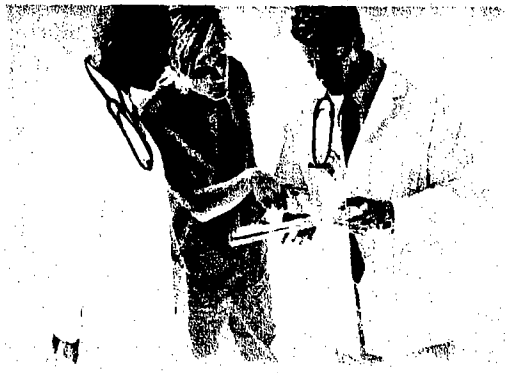
**Greg Meredith,** Managing Partner, Meredith Consulting
**Paul Gillan**, Attorney, Iseman, Cunningham, Riester & Hyde

# Workgroup Goals/Objectives

1. Serve as the intermediary body
2. Openly discuss issues with candor and respect
3. Bring forward, discuss, resolve difficult issues
4. Identify the best outcomes for GRIPA
5. Define the vision of GRIPA
6. Submit recommended strategic plan decisions to rest of GRIPA owners
7. Meet objectives of both owners
8. Build consensus of GRIPA's future make-up/structure

# Workgroup Protocols

- Coker's role – facilitator, independent party
- Efficient turnaround time re: analysis
- Discussion/analyses time limitations
- Communications among members
- Specific next steps (assignments, next meetings)
- Frank, open discussion



# Workgroup Covenants

- Protection of interests, but with respect and priority of GRIPA's existence
- Must make tough decisions to assure GRIPA's future success, viability
- GRIPA must be reviewed and decisions made for the good of the macro-entity, not just a segment(s)
- Employees of GRIPA must be considered but not unduly protected
- Fair mechanism, functionalized that will allow GRIPA to sustain
- Sense of fair play to allow difficult-to-resolve problems being resolved
- Consideration of an unwinding process, if decided

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# Issues Identified

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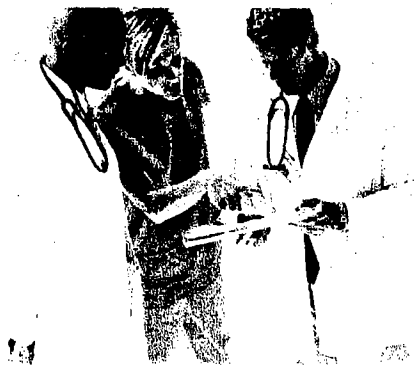
# GRIPA Strategic Planning Assumptions– Executive Summary

# GRIPA Strategic Planning Assumptions-Executive Summary

- An initial undertaking of the strategic planning process was the development of the Strategic Planning Assumptions.
- These assumptions were the basis for discussion at the planning meetings.
- The initial list of assumptions was developed by management and related to Insurers, IPA's, Physicians, Hospitals, and GRIPA.



# GRIPA Strategic Planning Assumptions-Executive Summary

- The list was modified and supplemented during the interview process and planning meetings.
- These assumptions represent our understanding of the Rochester Health Care Community as it exists, as well as a vision of the future.

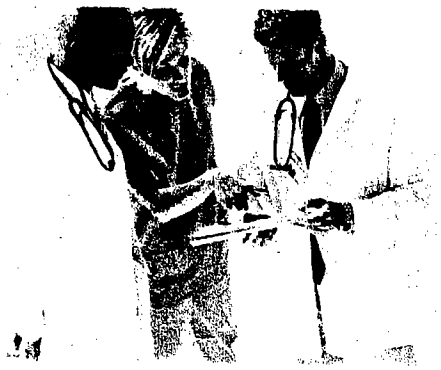
# GRIPA Strategic Planning Assumptions-Executive Summary

- The assumptions became the basis for addressing the basic questions related to why does GRIPA exist, is there value in the existing relationship moving forward and what steps need to be taken to benefit the Physicians as well as the Hospitals in this relationship?

# GRIPA Strategic Planning Assumptions-Executive Summary

***Insurers:***

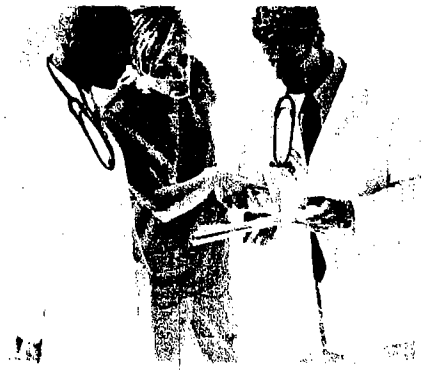
- Blue Cross will maintain its existing dominant market share in the commercial business and will leverage their dominant market position to obtain favorable rates from the providers.
- Preferred Care will have a more difficult time competing in the self insured market due to price gouging and increased competition.
- Community rated plans still represent 60 percent of the commercial market but will steadily decline to about 35 to 40 percent in three to five years.



# GRIPA Strategic Planning Assumptions-Executive Summary

***Insurers (Continued):***

- Employers will pay a decreasing share of employee insurance costs; as a result almost all new benefit plans will offer fewer benefits and higher co-payments.
- Employers will demand insurers hold the line on premium increases, which will result in little or no rate increases for providers.
- The employment market will continue to struggle.
- The uninsured population will increase.



# GRIPA Strategic Planning Assumptions-Executive Summary

***IPA's:***

- Community IPA's will become totally ineffective; if RIPA survives it will be controlled by Strong.
- It is reasonable and prudent to assume that the FTC will review all contracting entities in the future.

# GRIPA Strategic Planning Assumptions-Executive Summary

***Physicians:***

- Medicare and Medicaid rates will not keep up with inflation unless political intervention is successful; commercial insurers will try to follow Medicare rates.
- Physician reimbursement faces significant downward pressure from both employers and insurers.

# GRIPA Strategic Planning Assumptions-Executive Summary

***Physicians (Continued):***

- Physicians are not well-prepared to deal with the next five years contracting environment, and they are certainly less organized than hospitals and insurers for contracting purposes.
- Physicians will probably not succeed financially, regardless of the caliber of their clinical expertise, without an EMR or comparable system.

# GRIPA Strategic Planning Assumptions-Executive Summary

***Physicians (Continued):***

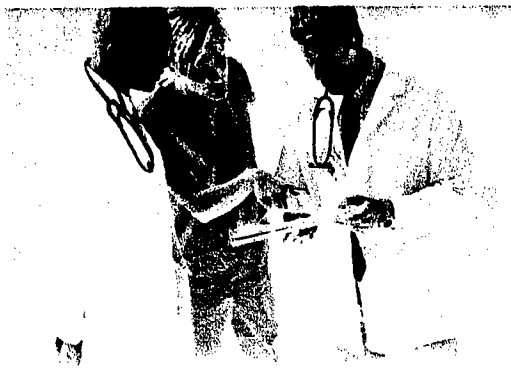
- Recruitment, retention, aging and relocation of the physician workforce will continue to be a problem in the Rochester market.

# GRIPA Strategic Planning Assumptions-Executive Summary

***Hospitals:***

- All hospitals will suffer due to physician recruitment issues,

- As physician income deteriorates, other competing systems will try to buy key practice groups.



# GRIPA Strategic Planning Assumptions-Executive Summary

***GRIPA:***

- GRIPA is best positioned to meet the needs of ViaHealth and the PO's moving into the future.
- Most PO physicians have a sense of loyalty to and are invested in the success of their hospital.

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# GRIPA Strategic Planning Assumptions

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# Insurers Assumptions

- Blue Cross will maintain its existing dominant market share in the fully insured commercial business and expand its market share in the experience rated market.

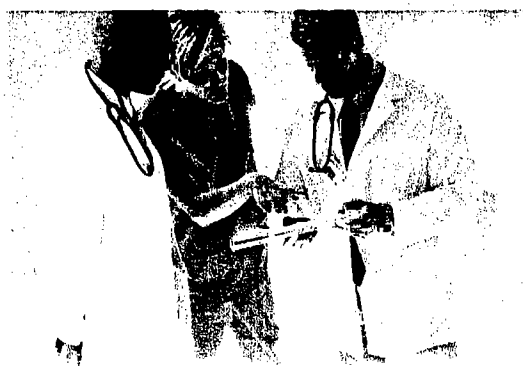
- Blue Cross will discontinue capitation payment to community IPA's within the next two years.
  Blue Cross will continue to leverage their dominant market position to obtain favorable rates from the providers.

- Blue Cross and Preferred Care will likely attempt to switch to direct contracting with physician groups.

# Insurers Assumptions - Continued

- Preferred Care will maintain its existing position in both commercial fully insured and Medicare markets for the next year or two; after that, the commercial business will erode.

- Preferred Care will have a more difficult time competing in the self insured market due to price gouging and increased competition.



# Insurers Assumptions - Continued

- Aetna will probably lose the University contract and may leave the region. We may have the opportunity to help maintain Aetna in the area.

- Several other insurers will enter the market but not gain significant market share unless they purchase Preferred Care.

# Insurer Assumptions - Continued

- Community rated plans still represent 60 percent of the commercial market but will steadily decline to about 35 to 40 percent in three to five years.

- Insurers make "side deals" to maintain the physician panel. If multiple conversion factors are introduced, the Primary Care conversion factor will probably decrease.

- Pay for performance payment models will be the predominant physician compensation model in two to three years for commercial and Medicare business; it is doubtful that any additional monies will be invested to fund the programs.

# Insurer Assumptions - Continued

- Local insurers and employers show no willingness to invest in EMR and RHIO.
- Employers will pay a decreasing share of employee insurance costs; as a result almost all new benefit plans will offer fewer benefits and higher co-payments.
- Employers will demand insurers hold the line on premium increases, which will produce little or no rate increase for providers.

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# Insurers – Assumptions Continued

- The employment market will continue to struggle.
- The uninsured population will increase.
- Excellus may merge or sell.

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# IPA Assumptions

- Preferred Care will maintain its' "community IPA" PHN.
- Either Strong Health or the Blues will eventually cause RIPA to close or make it totally ineffective; if RIPA survives it will be controlled by Strong.
- Unity may form its own IPA if RIPA discontinues services.

# IPA Assumptions - Continued

- It is reasonable and prudent to assume that the FTC will review all contracting entities in the future.
- A Community Panel IPA might work if the major hospital systems merge into one entity.
- Preferred Care and the Blues will continue to offer one time payment to PO's and ViaHealth to close GRIPA.

# Physician Assumptions

- Medicare and Medicaid rates are projected to decrease and not keep up with inflation unless political intervention is successful.
- Commercial insurers will try to follow Medicare rates.
- In general, insurers only respond to leverage.
- It is most likely that community IPA's will cease functioning, forcing physician groups to direct contract with the insurers.

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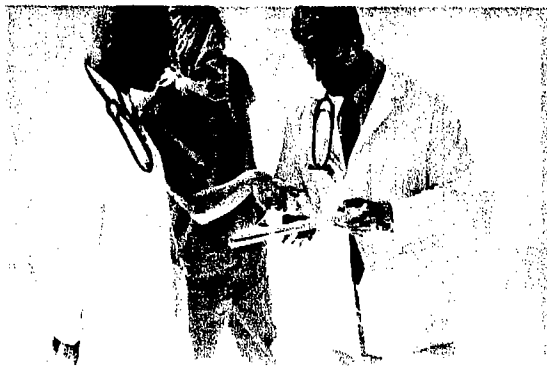
# Physician Assumptions - Continued

- Currently 52 percent of all local practicing physicians are employed by hospital systems.
- Over 70 percent of GRIPA owners, excluding the hospital employed physicians, are in groups of four or less.
- Physician reimbursement faces significant downward pressure due to industry wide and local influences.
- Physicians are not well organized for contracting purposes.



# Physician Assumptions - Continued

- Physicians are not well-prepared to deal with the next five years contracting environment, and they are certainly less organized than hospitals and insurers for contracting purposes.

- Physicians will probably not succeed financially, regardless of the caliber of their clinical expertise without an EMR or comparable system.

# Physician Assumptions - Continued

- Recruitment, retention, aging and relocation of the physician workforce will continue to be a problem in the Rochester market.

- New physicians will have a preference for the employed model as it provides a guaranteed income and an EMR connection with a larger entity.

# Physician Assumptions - Continued

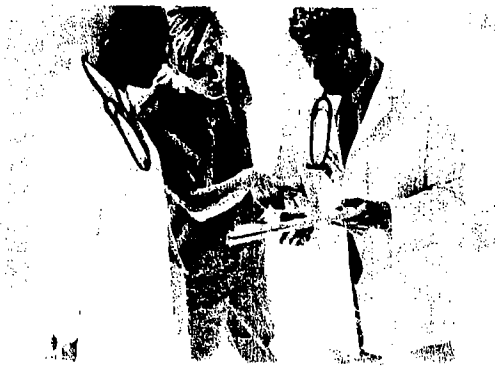
- Physician Extenders will increase penetration as they are less expensive, in greater supply, and do not expect a seat at the table.
- Private physicians will be less connected to the hospital due to the presence of hospitalists.
- Physicians will provide additional ancillary support services in their office to maintain income.
- Almost all physicians should be concerned about their future earning capacity in Rochester.

# Hospitals

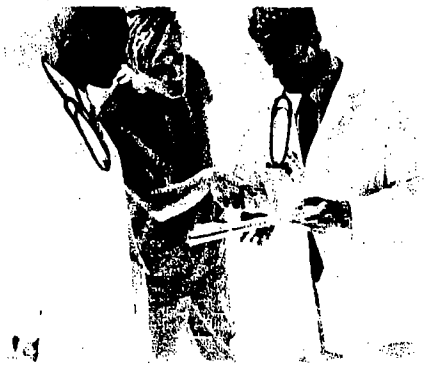
- All hospitals will suffer due to physician recruitment issues,
- 
- As physician income deteriorates, other competing systems will try to buy key practice groups.
- RGH must develop an IT strategy that deals with connectivity among private practice physicians. The success of this strategy is more important than who controls the systems.

# Hospitals (Continued)

- Ambulatory surgery centers will be increasingly attractive to patients and providers.
- It appears that Strong has almost an inexhaustible "war chest".



# GRIPA



# GRIPA - Continued

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# GRIPA Alternatives

# GRIPA Decision Tree

- Continuance
  - Contracting Entity Only
    - As Is
    - As Is, plus FFS
    - Captive PC
  - Services Entity Only
    - I.T.
    - Captive PC
    - Mgmt. Services
    - Group Purchases
  - Contracting and Services Entity
    - Contracting
    - Services
    - Captive PC
    - Clinical Integration
- Discontinuance
  - Sell
    - Payer
    - Another IPA
  - Dissolve
    - Liquidate
    - Distribute Proceeds
  - De-Merge
    - Hospital or POs survive

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# Points of Consideration

1. "As is" is likely untenable
2. Continuing the current capitated contracts, then moving to a messenger model FFS/PPO contracting arm is probably possible, though disadvantages the physicians
3. A services entity would require much planning, buy-in (both physician and hospital), capital and some time to develop and mature; time is not something that GRIPA has a lot of
4. A combination of both contracting and services might be viable as the contracting would continue to give GRIPA a "purpose" near-term; once the services are developed, GRIPA could better decide its future business plan
5. Selling GRIPA to a competitor or to a payer could be possible; the proceeds could be significant
6. Dissolving GRIPA would be regrettable, giving up all the time, effort and investment to develop it to the still viable entity it is today
7. De-merging would likely work though it would disconnect the physicians and the Hospital and would eliminate any possibilities of joint contracting in the future
8. Continuing as a contracting entity and providing services through achieving clinical integration.

ALL OF THE ABOVE SCENARIOS MUST BE REVIEWED, VALIDATED AND THEN STRUCTURED FOR LEGAL COMPLIANCE

# GRIPA Discontinuance Three Channels

1. Sell – To a payer; to another IPA
2. Dissolve – Liquidate, distribute proceeds
3. De-Merge – POS assume ownership

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# GRIPA Discontinuance

- To sell or merge GRIPA would largely admit that it no longer has a function or purpose
- The elimination of GRIPA as a viable entity would strengthen the payers even more than they already are
- De-merging would create a disconnect between the two owner groups
- The Hospital would have to locate other sources of partnering and developing goodwill with its medical staff

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# GRIPA Continuance
# Three Channels

1. Continue as a Contracting Entity Only
2. Become a Service Entity Only
3. Combination of 1. & 2.
    - Captive PC
    - Clinical Integration

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# Contracting Entity Only

1. As Is
2. Take on non-capitated contracting
3. Captive PC
4. Clinical Integration

# Service Entity Only

1. Information Technology (RHIO)
2. Create Super Group (Captive PC)
3. Management Services
4. Group Purchasing

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# Combination Contracting and Service Entity

1. Contracting regardless of payment form
2. Identify and provide needed services
3. Captive PC may be an option
4. Clinical integration may be the preferred function

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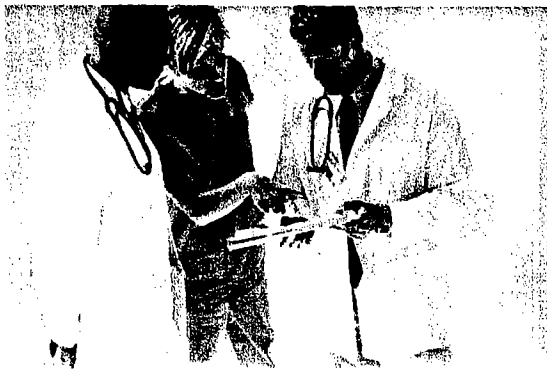
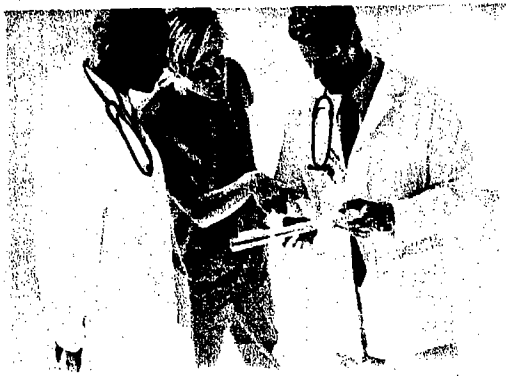


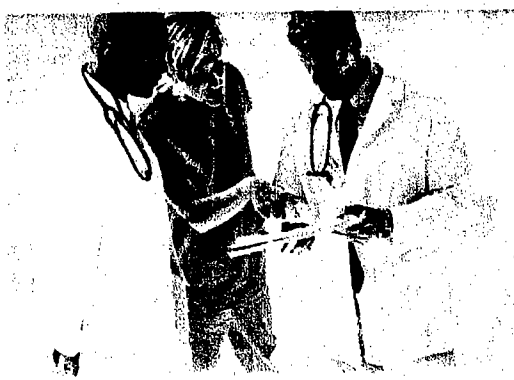
# GRIPA Continuance

1. Continue as a Contracting Entity
   a) Continue as is
      - Medical management company
      - Risk contracts only
      - Proactively extend current contracts
   b) Continue as a contracting entity, regardless of reimbursement
      - Continue/finish current capitated contracts
      - Transition to fee-for-service reimbursement
   c) Create a Captive PC
      - Vehicle for contracting
      - Vehicle for physician/hospital connectivity
   d) Clinical Integration
      - Information interface
      - Clinical efficiency



# GRIPA Continuance

2. Become a Service Entity Only
   - Provide one or more of the menu of competencies
   - Generate revenue via some fee assessment plus subsidy from Via Health (until self-sustaining)
   - In essence, become an MSO



# Continue as a Contracting Entity Only

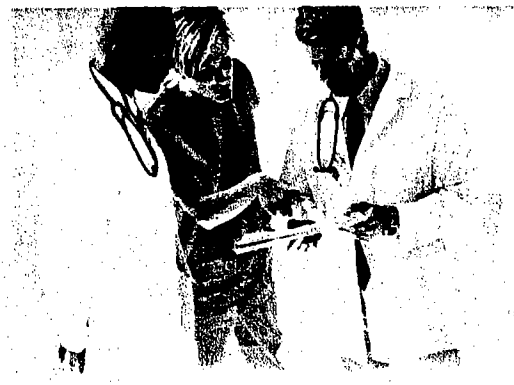
- Partner exclusively with either the Blues or Preferred Care
- Consider capitation for as long as it will last
- Move to fee-for-service, likely utilizing messenger model PPO contracts
- Without capitation (or whenever it runs out) significant staff reductions will be required
- Develop clinically integrated entity

# Continue as a Contracting Entity Only

- Determine the Viability of the Ownership Structure
  - Would the Hospital be interested in continuing as a partner?
  - Consider the functionality of only one owner (likely the POs)

# Continue as a Contracting Entity Only

- Consider joint contracting with the Hospital
- Consider partnering with other practitioners (Unity, Strong)
- Consider moving toward becoming an insurer through a TPA
- Consider forming a Captive PC
  - Hospital and practices as a foundation
  - Utilize for contracting and services strategies
  - Consider development of a clinically integrated model



# Become a Service Entity Only

- Continue to support the contracts until they expire
- Create an MSO
- Retool competencies
  - Staff
  - Equipment
  - Management
  - Governance
- Determine viability of partnership continuing

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# Become a Service Entity Only

- Determine competencies to deliver
  - Demand
  - Product mix
- Establish new infrastructure
  - Recruit competent staff
  - Determine subscribers
  - Raise capital
- Complete business plan
  - Determine services
  - Define delivery
  - Ascertain market and feasibility
  - Determine capital needs
  - Define revenue sources and sustainability

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# GRIPA Continuance

Combination of Contracting and Service Entity

- Continue contracting (both capitated, then fee-for-service)
- Develop additional competencies/services and sources of revenue
- Consider captive PC
- Develop clinical integration initiative

# Become a Service Entity Only

- Consider the possible services
  - Information technology (Practice management, EHR)
  - Management services (Billing, staffing, coding, compliance, etc.)
  - Group purchasing (Supplies, malpractice, etc.)
  - Education (Training for practice management, etc.)
  - Captive PC (Super group)

# Continue as a Contracting Entity While Developing Services

- All issues of contracting noted above must be considered
- All issues of providing services must be considered
- Determining the resources and capital for such dual competencies must be completed/evaluated
- Consider clinical integration as a GRIPA competency

# Continue as a Contracting Entity While Developing Services

- Develop the Captive PC
  - Consider joint contracting
  - Consider forming from the current Hospital-owned practices
  - Consider non-par relationship within the new group
  - Consider providing management services through the Captive PC

# Continue as a Contracting Entity While Developing Services

- Consider a "partnering" relationship with either the Blues or Preferred Care
- Consider moving toward becoming an insurer through a TPA
- Value of such an entity to both of the current owner groups must be measured and determined
- Capital investment may be prohibitive
- Timing of developing services could be extended
- GRIPA could be the vehicle for future "pay-for-performance" reimbursement structures
- Clinical integration could be functional

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# Conclusions and Recommendations

## Scenario A

Non – Risk
Not Clinically Int
Entity

HMO

Negotiate Rates

None

PPO

Messenger Model
(Contracting BUT No Rate Negotiation)

Fully Insured
Experience Rated
Self Insured
Managed Medicaid
Managed Medicare

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## Scenario B

Risk, Financial Int.
Not Clinically Int
Entity

HMO

Negotiate Rates

Fully Insured (cap.)
Experience Rated
Managed Medicaid
Managed Medicare

PPO

Messenger Model

Indep.Comm. messengers MDs negotiates payers

TPA holds withhold (15% *MD) and negotiates w payers & MDs

## Scenario C

Clinically Integration
(EMR,RHIO,pathways monitoring,P4P….)

HMO

Negotiate Rates

ALL

PPO

Negotiate Rates

ALL

OK per FTC/DOJ
? per NYS AG