LOYOLA MEDICINE

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October 1, 2013

Julie Hamos, Director
Illinois Department of Healthcare and Family Services (HFS)
Prescott Bloom Building
201 South Grand Avenue, East
Springfield, Illinois 62763

RE: Solicitation for Accountable Care Entities, ACE program-2014-24-002

Dear Director Hamos,

Loyola University Health System (LUHS) is pleased to submit this Letter of Intent in response to the Solicitation for Accountable Care Entities (ACEs). Rooted in the Jesuit tradition of knowledge in the service of humanity, Loyola offers compassionate, knowledgeable care from healthcare professionals who treat the human spirit as well as the human body. LUHS has reviewed the RFP in detail and we think that LUHS has the necessary resources and experience to provide integrated and accountable care, improved health outcomes, and enhanced patient access, as described in the RFP.

Section A: Contact Information

Name of Accountable Care Entity: Loyola University Health System Accountable Care Entity

Primary Contact Information:
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Section B: Proposal Outline/Self-Assessment

LUHS has performed a self-assessment and provides the following responses to the questions posed in Section B of the Attachment D in the ACE RFP.

1. **Geography and Population**: As a quaternary health center, LUHS serves patients from several counties across northern Illinois, southern Wisconsin and even western Indiana. LUHS has a network of outpatient clinics throughout Cook, DuPage and Will counties and anticipates that these counties will represent the primary catchment area for the LUHS ACE.

   LUHS anticipates serving 40,000 clients primarily from the Cook, DuPage and Will counties. Because of LUHS' fundamental belief in the Patient-Centered Medical Home (PCMH) model, LUHS will recruit potential enrollees working with the primary care providers in the network. All of the existing patients of the participating network PCPs will be informed of the potential benefits of joining the LUHS ACE including care coordination and access to a range of health services. These patients will be invited to enroll in the newly-formed ACE. LUHS also intends to provide information about the LUHS ACE to patients who use emergency or urgent care and appear to be "medically homeless", especially frequent ED users.

   LUHS is requesting data for the following counties: Cook, DuPage and Will.

2. **Organization/Governance**: LUHS' premier strength in applying to become an ACE is that LUHS already represents a comprehensive, integrated delivery system (IDS) with expansive clinical services including primary, specialty and tertiary care, urgent care, behavioral health services, home health services, skilled nursing facility and rehabilitation. LUHS has contracted with Blue Cross Blue Shield of Illinois to manage a large cohort of HMO Illinois clients and has built the necessary infrastructure to successfully manage both clinical care and financial risk.

   As an IDS, LUHS has already established a board that includes representation from three Clinical Faculty Directors and members from both Loyola University Medical Center and Gottlieb Memorial Hospital. Dr. Keith Veselik, LUHS Director of Primary Care, is serving as the provisional Medical Director for the ACE development.

   LUHS is evaluating whether this board meets the necessary requirements outlined in Section 3.1.2.3, or can be adapted, or a new board strictly for the administration of the LUHS ACE needs to be constructed. Since LUHS is pursuing multiple accountable care initiatives with other payers, LUHS prefers to integrate the administration of all programs into a single entity so that there is no fragmentation of any care processes.

3. **Network**: *Academic Medical Center:* The Loyola University Medical Center (LUMC) is a quaternary-care system with main medical center campus located in Maywood, Illinois. The

heart of the medical center campus, Loyola University Hospital, is a 569-bed facility. It houses a Level I Trauma Center, and the Ronald McDonald Children's Hospital. Also on campus are the Joseph Cardinal Bernardin Cancer Center, Loyola Outpatient Center, Center for Heart and Vascular Medicine, and Loyola Oral Health Center. Dedicated to educating the next generation of healthcare professionals, the LUHS also supports the Loyola University Chicago Stritch School of Medicine and Loyola University Chicago Marcella Niehoff School of Nursing.

Community Hospital: Loyola Gottlieb Memorial Hospital is a 250-bed, community hospital located in Melrose Park three miles from the Loyola University Medical Center.
The Melrose Park campus features a full range of diagnostic and specialty care services including a Level II Trauma Center with heliport, Birth Center with private labor/delivery/recovery rooms and a professional office building (connected to the hospital) that is home to nearly 100 physician offices, simplifying access to a wide range of healthcare services. Gottlieb Memorial Hospital has nearly 400 community-based physicians on staff.

Primary Care: Currently, LUHS employs 100 PCPs and all of them will be participating in the ACE network. As a teaching facility, LUHS also operates three primary care residency programs which include 90 internal medicine residents, 30 pediatric residents and 16 combined IM/pediatric residents. None of the current PCPs or resident clinics is at full capacity so LUHS could rapidly expand primary care capacity. In addition, LUHS already has plans to grow the primary care capacity and has targeted recruiting 50 more PCPs over the next 3 years. In addition to the employed physicians, approximately 100 community-based PCPs also on staff on Gottlieb Memorial Hospital and they will be recruited to join the ACE. LUHS enjoys a collaborative relationship with the community-based medical staff at Gottlieb Memorial Hospital and projects that many of these physicians will welcome the opportunity to improve care for Medicaid clients through participation in the LUHS ACE. LUHS is also reviewing current physician relationships to identify non-affiliated PCPs who refer frequently to LUHS for specialty care and recruit those providers into the ACE. LUHS works closely with several FQHCs by providing specialty care to their patients and is evaluating the possibility of working with FQHCs both in Cook and DuPage counties as part of the ACE network. Finally, LUHS will analyze the MPARK data to assess patterns of care in the catchment area and target additional PCPs for recruitment into the ACE.

Obstetrical Care: Based on the birth rate predictions provided in section 3.1.3.5 of the RFP, LUHS estimates that there is excess clinical capacity to cover 1300 births.
Specialty Care: LUHS employs over 450 specialty physicians representing a diverse array of specialties. Access to specialty care is traditionally difficult for many Medicaid patients in Illinois. As a fully-formed IDS, LUHS can guarantee access to needed specialty care for all of the anticipated 40,000 enrollees. Since LUHS also houses the Ronald McDonald Children's Hospital, access to specialty and tertiary children's services is readily available, which will be a critical factor in caring for the Family Health population anticipated to be enrolled in the ACE.

Behavioral Health: LUHS houses a wide-array of behavioral health services and also collaborates with community-based providers for additional behavioral health services. A major initiative for LUHS in the next 18 months is to recruit an additional 18 behavioral health providers including six psychiatrists and 12 psychologists and licensed clinical social workers. Some of the referral patterns for behavioral health services for HFS clients are constrained by the limitation on providers who can provide services outside of a Community Mental Health Center. LUHS will identify the local Community Mental Health Centers to recruit them for participation in the LUHS ACE. Some of the FQHCs with which LUHS already has a relationship also provide behavioral health services and LUHS will evaluate the opportunity to recruit these providers and provide integrated primary care and behavioral health services. LUHS will also review the MPARK data to assess patterns of care for behavioral health services and use that information to guide network development.

4. **Financial**: LUHS is part of the Catholic Health East/Trinity Health System and has adequate financial reserves to support the development of an ACE and the eventual transition to a Managed Care Community Network (MCCN) as required in the RFP.

5. **Care Model**: *Overview and Financial Reimbursement Model:* As a fully-developed IDS LUHS encompasses two hospitals, 550 employed physicians and an array of support services. LUHS is working towards developing an internal compensation and bonus structure to reward high-value providers. LUHS participates in a Physician-Hospital Organization (PHO) to organize community-based providers around risk-based contracts. For over twenty years, the PHO has worked with MCOs and internally distributed funds to participating providers using a variety of compensation formulae including fee-for-service, capitation and pay-for-performance. LUHS will be able to build on this experience to create financial incentives to support the integrated care model envisioned by the ACE.

   Patient-Centered Medical Home: LUHS' care model embodies the Jesuit tradition of promoting health and healing the mind, body and spirit. The primary care network as described above represents the cornerstone of care delivery within LUHS. LUHS is committed to the PCMH model and has begun the application process for NCQA PCMH Recognition with plans to achieve Level 3 Recognition for all primary care practices within the next 18 months. As part of that initiative, care coordinators will work within each primary care practice to assist high-needs patients in managing their care.

   Chronic Disease Management: Through a suite of products from Phytel (as described more fully below), LUHS identifies twenty common chronic disease conditions such as diabetes and asthma, mines data from the EHR, compares the care that patients have received to evidence-based recommendations, and then reaches out to patients to address any gaps in care. The system creates disease registries that can be used by clinicians to monitor care patterns and target appropriate services for high-risk individuals.

Transitions of care: Recognizing that transitions in care can be difficult for patients to navigate and pose risks for potential gaps in care, LUHS employs a variety of strategies to manage transitions. As an IDS, the majority of patients who are discharged from an LUHS hospital have a follow-up appointment with an LUHS employed physician. All of the 550 employed physicians share the same EHR (Epic) as well as the two hospitals, LUMC and Loyola Gottlieb Memorial Hospital, providing a seamless record as the patient receives services through a variety of care settings and providers. LUHS provides a Transition of Care summary for patients according to Meaningful Use standards. In order to augment transition services, LUHS has recently hired a Director of Post-Acute Care. Many patients now receive post-discharge phone calls to ensure that they have filed their prescriptions and made a follow-up appointment.

Test and Referral Tracking: LUHS has sophisticated systems for both test and referral tracking. At the point of ordering, all diagnostic tests are assigned an expected due date. If a test is not completed by the due date, a notice appears in the provider's EHR inbox prompting the provider to evaluate why the test has not been completed and outreach to the patient if necessary. Completed tests are returned to the provider and time stamped when reviewed and patients are notified of the results through a phone call, letter, follow-up appointment, or secure email messaging. Referrals are tracked in a similar manner. If a referral is ordered but the patient fails to schedule an appointment, an automated notice is generated and task delivered to the work queue of the ordering provider or care coordinator so that they can outreach to the client and assist with scheduling the appointment. Completed referrals are provided back to the primary care physician or ordering provider to ensure coordination among all of the providers involved with a patient's care. "No shows" and cancelled appointments are similarly tracked to ensure appropriate clinical follow-up and continuity of care.

Patient Engagement and Education: Educational materials, written at a sixth-grade literacy level and available in English and Spanish, regarding a wide variety of clinical conditions are available through the EHR and provided to patients as clinically appropriate. LUHS hosts a range of patient support and education groups ranging from groups to support patients battling cancer to pediatric obesity groups focusing on peer support and education. LUHS employs dedicated diabetes educators and has also employed asthma educators in the past and may evaluate the opportunity to recreate those services depending on the MPARK data analysis.

Quality Assurance: LUHS has developed the Center for Clinical Effectiveness (CCE) whose mission is to catalyze improvement in the quality and value of health care services provided at LUHS. The CCE coordinates performance improvement activities across LUHS, identifies and implements state of the art quality and safety monitoring, analytic, and improvement tools, and communicates results of performance improvement work within LUHS. Supported by the CCE, LUHS has a robust system to monitor clinical performance and provide feedback to providers. This includes tracking such metrics as chronic disease measures and client satisfaction. Each provider is presented with a dashboard of preventive health measures such as rates of mammography, colon cancer screening, pneumococcal and influenza vaccination rates, and

objective, pediatric developmental screening rates. Based on previous experience with managed care contracts, LUHS has also developed processes for utilization management to ensure that resources are appropriately managed while ensuring high-quality care.

6. **Health Information Technology (HIT):** All of the care management functions described above are supported by sophisticated HIT systems. All LUHS-employed physicians work on the same EHR, Epic. Epic is also used for all hospital care provided at LUMC and Gottlieb Memorial Hospital. LUHS has offered to include community-based providers in their Epic network and has plans for FY 2015 to establish interoperability functionality for community-based physicians who continue to use different EHRs.
LUHS employs a suite of products provided by Phytel to better manage quality and proactively improve chronic and preventive care across the population. The Phytel systems are fully integrated with the EHR and provide gap analysis with evidence-based preventive care and chronic disease management protocols, automated outreach, disease registries, risk stratification and appointment management.
Physicians who refer patients to LUHS and do not share the Epic system can directly access their patients' electronic health records at Loyola through a system called Loyola Connect. This allows a referring provider access to the comprehensive EHR record for three months after the initial referral. In addition, for a period of up to two years after the initial referral, using Loyola Connect, referring physicians can choose to receive an e-mail alert when there is a significant event in the patient's care, such as a doctor's appointment, test result, emergency room visit or hospitalization. The referring physician then can log on to a secure account and read physician notes, see lab and radiology results or view the entire chart. This innovative system was developed specifically recognizing the need to enhance communication and care coordination among all providers. LUHS recognizes the need for even greater connectivity with providers outside the LUHS system and is evaluating participation in either the ILHIE or regional HIE with plans to join one of these systems in the next six months.

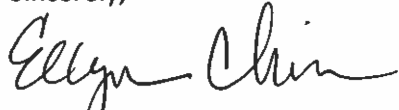
   As a member of Catholic Health East/Trinity Health System, LUHS can draw on a national pool of IT resources. As LUHS works toward developing the ACE, the widely-shared EHR, array of population management tools, quality assessment tools, and Loyola Connect, coupled with the LUHS expertise in systems-development and data management, will provide the building blocks necessary to securely pass clinical information among the ACE network, aggregate and analyze data, and coordinate care as described in the ACE RFP.

Section C: HIPAA Limited Data Set Agreement

See Attached

Loyola University Health System is delighted to work with HFS towards the shared goal of providing more highly integrated care to HFS clients through the establishment of an Accountable Care Entity. Thank you for your consideration of this Letter of Intent.

Sincerely,



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