ANNUAL CONFERENCE ISSUE

AMERICA’S PHYSICIAN GROUPS

COVER STORY:
Lessons for Looking Upstream, p.16

Making the Leap to Global Risk, p.48

Regional Focus: Midwest, p.31
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Eliminating Low-Value Care: A New Model
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From the President

A MESSAGE FROM DON CRANE, PRESIDENT AND CEO
AMERICA’S PHYSICIAN GROUPS

Members and friends,

Welcome to America’s Physician Groups Annual Conference 2019 and to the beautiful city of San Diego! We’re proud to present the premier conference for those engaged in coordinated and accountable care. And with our outstanding speakers, unparalleled networking opportunities, and lots of fun, I’m sure our first-timers will see why people make this the one conference they cannot miss!

As we close out the first quarter of the year, in many ways it seems like our nation is a house divided. Democrats control the House, while Republicans control the Senate. The legislative gridlock in Congress mirrors the actual gridlock on the streets of the nation’s capital. And bipartisanship is a dirty word on Capitol Hill.

Even in the midst of so much uncertainty, one thing is clear—our work doesn’t stop.

Every day, our three pillars of excellence—advocacy, education, and leadership—drive what we do. We continue to promote our Third Option—a better ACO model that includes both robust quality measures and prospective, capitated payments—to Congress, the administration, and other stakeholders as a common-sense solution to today’s broken healthcare system.

We maintain strong relationships with national health policy leadership. So far in 2019, I have met with the Secretary of the U.S. Department of Health and Human Services, the Administrator for the Centers for Medicare & Medicaid Services, and dozens of congressional offices. The message is simple: There’s a better way to deliver high-quality, low-cost healthcare.

But leadership is more than meetings; it requires action and innovation. And with that in mind, I was pleased to see the launch of our Risk Evolution Task Force earlier this year. With one meeting under its belt, this task force is already helping APG members find success in today’s risk models and prepare for the risk models of tomorrow. The group will be reviewing initial findings during a breakout session at this conference.

I truly believe that our conferences offer something for everyone, no matter where you are on the value-based care continuum. And I think you’ll see that when you talk to the person next to you, visit the Exhibit Fair, or attend an educational program that challenges your thinking.

So again, welcome to our Annual Conference 2019, and thank you for joining us on this journey. But make sure you buckle up, folks! The value movement is moving fast!

Don Crane, President and CEO
America’s Physician Groups

HCP Studies™ mobile platform easily connects you and your patients to internal or external clinical trials, observational studies and patient experience surveys. Patients want to be involved with studies and they want to have a voice about how their healthcare is delivered. Their healthcare professional (HCP) is the trusted source!

TRANSFORM PATIENT ENGAGEMENT WITH CLINICAL STUDIES AND SURVEYS

Simple
• Minimal work from your team to maintain
• Easy access via mobile, PC or tablet

Timely
• Instant access to studies/surveys for HCPs and patients
• Nimble use – add studies or surveys within one business day

Results
• Generate meaningful data to address quality measures
• Enroll studies at your group or within your preferred network

“HCP Studies enables us to gain feedback from patients efficiently to support our quality initiatives”
– Marc Hoffing MD, Medical Director, Desert Oasis Healthcare

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– Gary Pien MD/PhD, Director of Research, Summit Medical Group

“Fox Insight is an online Parkinson’s study that contributes to research by providing real-world information. HCP Studies enables providers to invite their patients to join in an easy way.”
– Lindsey Riley, Senior Associate Director, Michael J Fox Foundation

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41% say HCPs are the desired source for study info (more than double the second highest source).
Source: A Research!America poll of U.S. adults conducted in partnership with Zogby Analytics in May 2017.

60% of top loyalty drivers are related to engagement rather than cost or quality
Source: Transforming Care for Patients as Consumers, December 2018.
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~ Marc Hoffing MD, Medical Director, Desert Oasis Healthcare

With our large portfolio of clinical trials, HCP Studies helps our providers, staff and patients gain easy access to our studies which helps with engagement and enrollment”
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~ Lindsey Riley, Senior Associate Director, Michael J Fox Foundation

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NEWS AND EXPANSIONS AT IORA

In March, Iora announced expansions into Texas and North Carolina. Building off of the company’s success in seven states across the country, the new Houston, Charlotte, Winston-Salem, and Greensboro practices will change everything about care: the team, outcome-focused payment, and the technology that supports care.

Tyler Jung, MD, joined Iora in January as Chief Medical Officer. Jung has more than 20 years of experience at HealthCare Partners and Molina Healthcare. His experience aligning care decisions with patient goals and coordinating care to reduce unnecessary and harmful events makes him a perfect fit for the company.

Finally, Iora has been named one of Fast Company’s Most Innovative Companies in the health category for 2019. The distinction demonstrates the impact Iora makes far beyond the walls of its practices.

CEDARS-SINAI APPOINTS NEW CHIEF NURSING EXECUTIVE

Following an extensive national search, Cedars-Sinai appointed David R. Marshall, JD, DNP, RN, CENP, NEA-BC, NHDP-BC, FAAN, as Senior Vice President and Chief Nursing Executive. Marshall brings more than three decades of healthcare experience, from bedside nurse to nursing-leadership proficiency, and a reputation for enhancing innovation and emphasizing compassionate care. Most recently, he served as system chief nursing and patient care services executive at the University of Texas Medical Branch at Galveston.

Marshall succeeds Linda Burns Bolton, DrPH, RN, FAAN, Cedars-Sinai’s widely respected nursing leader who has been with the institution for 48 years. Burns Bolton will become Cedars-Sinai’s inaugural Chief Health Equity Officer, steering the health system’s efforts to improve the health and healthcare outcomes for all members of the community.

APG COLLOQUIUM 2019
Washington, DC
November 11-13, 2019
Gain hands-on knowledge and best practices from physician groups with successful track records in value-based care delivery

CLINICAL QUALITY LEADERSHIP COMMITTEE
April 11, 2019
APG Annual Conference 2019

COLORADO REGIONAL MEETING
April 30, 2019
Denver, CO

CONTRACTS COMMITTEE
May 7, 2019
Los Angeles, CA/WebEx

WEBINAR WEDNESDAYS
May 8, 2019
June 12, 2019
July 10, 2019

PHARMACEUTICAL CARE COMMITTEE
May 15, 2019
Los Angeles, CA/WebEx

FEDERAL POLICY COMMITTEE
May 16, 2019
WebEx

CALIFORNIA POLICY COMMITTEE
May 23, 2019
Los Angeles, CA/WebEx

MIDWEST REGIONAL MEETING
June 4, 2019
Columbus, OH

NORTHEAST REGIONAL MEETING
June 6, 2019
Boston, MA

I AM APG ADVOCACY COMMITTEE
June 11, 2019
WebEx

APM COMMITTEE
June 18, 2019
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PATIENT-CENTRIC.
PHYSICIAN-DRIVEN.
TEAM-BASED CARE.

For nearly 40 years, Compassus has led the transformation of health care delivery by continuously and measurably improving the quality of community-based hospice, palliative, and home health care services.

With more than 150 locations in over 30 states across the country, we partner with health care providers, as an extension of their teams, to expand value-based care. This results in improved quality of care, an enriched patient and family experience, and a cost-saving solution.
The 116th Congress began in January, kicking off the 2019 political season. As a reminder, after the marathon midterm elections, the House of Representatives is now controlled by a Democrat majority, while Republicans maintained their control of the Senate. With President Trump in the White House, Washington is potentially more divided than ever.

Further, 2018 ended with a cliffhanger when U.S. District Court Judge Reed O’Connor ruled that the Affordable Care Act (ACA) was unconstitutional due to the lack of an individual mandate penalty. This ruling, in addition to several other healthcare priorities, will be high on the agenda this year. The continued ACA debate will incent lawmakers on both sides of the aisle to respond to the Texas ruling and discuss a host of other ACA issues—including preexisting conditions, individual insurance market rules and stabilization, and Medicaid expansion.

After eight years in the minority, House Democrats have a number of healthcare priorities on their agenda, including ACA stabilization, prescription drug pricing, and some sort of Medicare-for-All or public insurance option legislation. Democrats have also pledged to ramp up congressional oversight of the Trump administration—not only on the President himself (tax returns, Russia, etc.), but perhaps more importantly on the actions of federal agencies in the executive branch, including Health and Human Services (HHS), the Food and Drug Administration, and the Centers for Medicare & Medicaid Services (CMS).

House Democrats have already called numerous administration officials to testify before their committees on things like the Trump administration’s family separation policy and national drug control efforts. Expect a revolving door on administration staff coming to the Hill to defend President Trump’s healthcare policies through the 116th Congress.

This not only poses potential political problems for the President, but also has a chilling effect on the work those agencies turn out. If staff are consumed by prepping testimony and ensuring leadership is equipped to handle the dozens of congressional inquiries, there is less time to devote to advancing new priorities or strengthening existing programs.

Importantly, it will be challenging for Speaker Nancy Pelosi (D-CA) to keep the Democratic Caucus united. The legislative agenda will likely be influenced by wide-ranging ideological factions, including far-left progressives like Rep. Alexandria Ocasio-Cortez (D-NY). Democratic leadership will face difficulty reconciling competing factions of the caucus, which gained a significant number of moderate New Democrats and Blue Dogs in the midterm elections.

However, the nearly 80 existing members of the Progressive Caucus are expected to push for consideration of more liberal items on the agenda, including Medicare-for-All, which may alienate more moderate Democrats. This is a very similar dynamic to the one that House Republican leadership faced for the last eight years with the rise of the Tea Party, and it demonstrates how polarization within
each political party has sharply increased over the past decade.

On the Senate side, the agenda will likely focus more on “must-pass” items, like raising the national debt ceiling, as well as judicial and Cabinet-level nominations. Republicans actually picked up a few seats in the midterms, extending their slim majority to 53 seats. Don’t expect Senate Majority Leader Mitch McConnell (R-KY) to take up any partisan bills that the House may pass.

However, Sen. Chuck Grassley (R-IA)—now president pro tempore and chairman of the influential Senate Finance Committee—is one member of the Republican leadership who just might. Sen. Grassley has already indicated that his top priority for 2019 is reducing healthcare costs by addressing prescription drug costs, increasing transparency, boosting oversight of elder care, and ensuring hospital payment programs are effective and working as Congress intended.

The senator has a long history of bipartisan work, so expect him to team up with his colleagues across the aisle to address some of these priorities. However, he is still a Republican, so don’t let expectations get carried away: He won’t be supporting Medicare-for-All anytime soon.

On the administration front, expect HHS and its delineated agencies to continue their fast-paced efforts to reform healthcare in the United States. Last year, the administration proposed some pretty bold changes (not all of which were implemented), including systemic changes to the Medicare Physician Fee Schedule and overhauling the Medicare ACO program. This year, look for CMS’ Innovation Center (CMMI) to continue to crank out new demonstration programs expanding payment and delivery options for providers across the nation.

Last year’s Christmas shutdown, which lasted 35 days through January 25, 2019 (longest shutdown in history), significantly delayed CMMI’s work this year due to the mandatory review by the Office of Management and Budget (OMB). With OMB shut down for over a month, CMMI isn’t the only agency feeling the lag time. America’s Physician Groups and others were expecting a plethora of new models, including the highly anticipated Direct Contracting model, early this year. Instead, it has been more like a trickle. While the forthcoming CMMI models are expected to be released, the longer they are held up, the more opportunities there are for revisions or even cancellations.

And of course, spring is the start of payment rule season, with the final Medicare Advantage Rate Notice and proposed Medicare Physician Fee Schedule, Inpatient Prospective Payment System, and Outpatient Prospective Payment System rules due.

Despite the divisiveness and delays in Washington, the value movement marches on. Momentum is building, and while it may be slower than many would like, the evolution of our nation’s healthcare system from volume to value continues. ☀
New legislation sponsored by America’s Physician Groups and California Schools VEBA, a voluntary employee benefits association purchaser, would pave the way for expanding integrated delivery systems under a global risk model in the California self-funded employer market.

The bill, AB 1249, is authored by Assembly member Brian Maienschein, a San Diego legislator with close ties to the education and healthcare communities. It would change existing California insurance regulations to allow two five-year pilot programs. Under these pilots, self-funded employer health plans and union trusts could contract directly with provider groups in global risk-bearing contracts.

Currently, self-funded employer plans and union trusts are limited to fee-for-service provider payment mechanisms. Many people argue that this contributes to and even encourages rising healthcare costs. California Schools VEBA, which purchases and manages health benefits for 150,000 school district employees across Southern California, would operate the pilot in the southern part of the state. The bill identifies another potential pilot for Northern California, which could be operated by a similar union trust purchaser, along with providers from the northern portion of the state.

The bill would exempt plans from certain insurance licensing requirements to encourage experimentation with innovative direct contracting arrangements—designed to facilitate cost control while incentivizing improved quality measures. The risk-bearing providers would be subject to the existing financial solvency oversight of the California Department of Managed Health Care. At the end of the five-year period, a report would be issued to the Legislature on the pilots’ success in controlling cost trends and improving quality.

California has one of the highest rates of participation in integrated healthcare delivery in the nation—around 40 percent of residents, according to the Kaiser Family Foundation. Still, approximately 8 million people, or 1 in 5 Californians, are covered under a self-funded employer plan or union trust. The ability for these entities to enter into risk-based contracts, even on a pilot basis, could be an important move forward for capitated payment systems.

A recently released study in *Health Affairs*, authored by professors Stephen Shortell and Richard Scheffler, found that utilization of health services and per-capita spending in California have historically been lower than in the rest of the country. The authors correlate this to California’s greater prevalence of integrated care.1

While the study also found that market concentration plays a key role in cost increases, it determined that more tightly integrated delivery systems that function under HMO networks have commercial risk-adjusted costs that are nearly 9 percent lower than the less-integrated PPO networks ($4,529 per person for the HMOs, versus $4,912 per person for the PPOs). In addition, PPO members paid an average of $769 more in out-of-pocket costs than HMO members.
The underlying data for the study were generated by the Integrated Healthcare Association (IHA) under its California Regional Cost and Quality Atlas 2 database, which gathers cost and quality data for care provided to 29 million patients in the state. IHA’s data indicate that, in addition to lowering costs, financial arrangements with higher levels of risk are associated with better quality and cost of care. As stated in the Shortell and Scheffler white paper:

“In other words, a full risk financial arrangement achieves the best value-based performance—low cost and high quality. Thus, proposals to encourage more Californians to receive their care from groups providing more integrated care through risk-based capitated payments would likely result in both lower costs and better quality of care.”

AB 1249 provides a way for the Legislature to evaluate the advantages of allowing more integrated care delivery in combination with risk-based provider payment. The concurrent operation of the two pilots in Northern and Southern California would also provide data on whether more highly integrated care delivery, based on globally capitated payment, can address the differences in healthcare costs at both ends of the state. In a prior study, Professor Scheffler provided data showing that healthcare costs in Northern California are 30 percent higher on average than in Southern California.

The bill will now progress through the Assembly Health Committee and then to the Assembly Appropriations Committee. The 2019 legislative session will run through the first week of September. If the bill is passed and signed into law, the two pilots would be organized prior to the 2020 open enrollment periods and commence on January 1, 2021.

School district employees could then choose the new pilot coverage models from among a range of offerings currently offered by California Schools VEBA and the other purchaser. Employees would have the opportunity to renew their participation over the course of four subsequent open enrollment periods.

References:
1Scheffler and Shortell, California Dreamin’: Integrating Health Care, Containing Costs, and Financing Universal Coverage.

The Symphony Provider Directory streamlines how providers and health plans share, reconcile and validate provider data. As the statewide utility in California, Symphony helps reduce the administrative burden on provider organizations and supports compliance with state and federal regulatory requirements including SB 137.

California’s Centralized Platform for Provider Data Management

Driven by Collaboration

IHA is bringing health plans, provider organizations, regulators, and other stakeholders across California together to improve the information that consumers access in health plan directories.

Support at Every Step

No matter how you currently manage provider data, we connect to what works and partner with you to figure out how to streamline what doesn’t. From roster management to formal multi-plan attestation, we simplify the provider data management every step of the way.

Enhanced Data Quality

Symphony enables plans and providers to confidently meet state and federal regulatory requirements—improving data quality and driving industry standardization. We also facilitate a transparent process so plans and providers can hold each other accountable and achieve better results together.

Did you know?

- $2.1 billion is spent per year by commercial health insurers to maintain provider databases
- 48% of online provider directories for Medicare Advantage were inaccurate
- $25,000 is the fine per error per physician that plans face for inaccurate directories
- State & federal regulations require providers to participate in 1-4+ attestation cycles a year
- Providers who fail to validate data may see delayed payments or removal from health plan member directories.

For Plans

Instead of juggling multiple data files and calling providers, plans can access all provider information in one place to more easily update member directories, create efficiencies, and drive industry data standardization.

For Providers

Providers can make real-time updates and validate information through a single portal or via FTP and are notified when information is accepted by all participating plans.

For Consumers

When plans and providers use Symphony, they can more easily make updates to their internal systems and ultimately provide consumers and patients with the most up-to-date information.

To help encourage participation, the Symphony Provider Directory will be fully subsidized for the duration of 2019. Learn how you can join now at www.symphony.iha.org
“Symphony is an industry-wide movement to make a positive impact in the California healthcare system by driving alignment around provider data management—supporting health plans, practice, providers, and ultimately healthcare consumers.”

IHA President and CEO, Jeffrey Rideout MD, MA, FACP

Current Provider Data Challenges

Frequent, duplicative outreach efforts to update and validate provider information leading to plan and provider fatigue

High administrative burden from manual roster management for each health plan with varying data format requirements

Attestation requests from health plans are disparate and occur frequently, with information often not updated correctly in member directories

Lack of access to information to easily cross-check data with validated sources and data conflict loops are frequently never closed

Inaccurate health plan directories that cause frustration and financial burden for consumers

How the Symphony Provider Directory Supports

Centralizes provider directory updates in one place and streamlines the data exchange and validation process between plans and providers

Replaces manual roster management process and works with data in any format to help plans and providers quickly integrate into the utility

Facilitates a centralized, multi-plan attestation process on quarterly basis in compliance with SB137 and CMS requirements for Medi-cal and Medicare.

Leverages contract-level information and encourages market collaboration to give providers and plans the tools they need to validate their information or mitigate data conflicts as needed

Provides health plans the tools they need to maintain more up-to-date and accurate member directories

The Symphony Provider Directory streamlines provider information updates and attestations and enables health plans to improve the quality of information their member directories while reducing the administrative burden for all involved.

About the Symphony Provider Directory

The Symphony Provider Directory is the statewide platform that enables plans and providers in California to come together in one place to share and reconcile provider information—streamlining the way provider data is managed and decreasing the time and resources needed for provider outreach, data reconciliation, validation, and processing changes.

Join the Movement

www.symphony.iha.org

Are signs of a deeper trend, one that is now challenging many physicians and medical groups to consider their role in addressing these so-called “social determinants of health”—the social and environmental factors that play a major role in shaping health outcomes for patients and communities.

While the shift to value-based payment models is a primary driver for this new focus, it is not the only one. Other factors include the expansion of Medicaid, the spread of state-led delivery system reforms, the expansion of supplemental benefits in Medicare Advantage plans, and updated patient-centered medical home and health plan accreditation standards.

The convergence of these policy and payment reforms with a growing movement of community-led and public health initiatives has led to a flurry of activity to help tackle sickness at its source. This highlights a key fact: Addressing social determinants of health is integral to healthcare transformation. It’s an idea whose time has come.

For physician groups, this moment raises many questions. What is our role in addressing upstream social determinants of health? How do we do this in the context of our current priorities and pressures?

These questions are not new for my colleagues and me at HealthBegins. Founded by physicians in 2012,
HealthBegins now works with healthcare leaders across the country, helping them to design and implement strategies that result in demonstrable improvements in care and social determinants of health for patients and communities.

As you might imagine, we engage with physicians who have a range of perspectives about these efforts, even within a single organization. Some are innovators and early adopters, while others are late adopters. Regardless of where you fall on that spectrum, our experience has taught us some key lessons for physician groups entering this space.

THE QUADRUPLE AIM AND CULTURE

Thirty years of accumulated research on social determinants of health is now definitive. The social and environmental conditions that shape where we live, eat, sleep, work, and learn also play a major role in shaping health outcomes for us all—from the burden and distribution of disease to how long we live.

In fact, as the National Academies of Medicine and others have documented, the science tells us that social and environmental factors have nearly five times more impact on morbidity and mortality outcomes than clinical interventions alone.

Acknowledging the science about social determinants is necessary, but insufficient. Medical groups exploring upstream changes—like integrating social needs screening into clinical practice or leveraging social data for better risk stratification—perform better when these changes are clearly aligned with organizational goals and priorities. This starts with a change management strategy that leverages a growing body of research to link social determinants of health-related efforts with the quadruple aim: improving patient experience, driving better population health outcomes, lowering per-capita costs, and improving physician joy and resilience.

This is also where organizational culture comes in. We’re supporting many healthcare organizations to develop change management strategies for upstream interventions. The successful ones don’t just focus on getting the technical pieces in place for new workflows, data systems, and community partnerships. They also recognize that upstream work requires a change in organizational culture.

To that end, physician groups seeking to address social determinants of health must be strategic, proactive, and open in engaging not only community partners, but also their own physicians, care teams, and operations and administrative staff. We recommend becoming familiar with the research outlining the relationship between physician burnout and a lack of clinic capacity to address patients’ social needs. We have found it powerful in our change management efforts to ask physicians and care team members to share their own perceptions about this relationship.

This is where clinical experience is key. The irony of this “new” focus on social determinants of health in medicine is that it is not actually new. Those who have spent their careers caring for geriatric patients, for children and adolescents, for patients with HIV, and other vulnerable populations have long known that the best standard of care requires us to assess and address social risk factors like housing, food, and social isolation.

In one respect, the challenge now is how to bring that existing clinical experience and expertise to scale in the era of value-based payments.

A PATH FORWARD

As physician groups adopt risk-based payment models, helping patients stay healthy and avoid unnecessary hospitalizations becomes a higher priority. But how can we do this? A key first step is getting clear on terms, especially because all effective upstream strategies rely on strong partnerships.

As a term originally defined by experts in public health and international development, “social determinants of health” refers to broad, community-level resources for living, like affordable housing, access to healthy food, and the physical design of neighborhoods. Public health advocates and policymakers go further to distinguish these factors from “social determinants of health equity”—the way these resources are distributed within and across populations and the political and structural forces that shape them.

These days, when healthcare leaders use the term “social determinants of health,” we are actually referring to what may be better defined as “health-related social needs”—how the broader phenomena of social determinants of health and health equity manifest in the lives of individual patients.

Improving the precision of communication and planning is an essential next step as physician groups engage community partners to address health-related social needs for patients. This is not only true for defining basic terms, but also for defining shared goals, developing screening and referral workflows, refining strategies for data collection and sharing, and setting partner roles and expectations.

With input from clinical leaders around the country, HealthBegins has developed a “Levels of SDH Integration Framework” to help care delivery systems improve the precision of their communication and planning efforts as they engage social service partners.

continued on next page
Once physician groups convene these partners, they can proceed to the next step of strategic planning and develop a portfolio of upstream strategies. In HealthBegins’ experience, this works best when partners:

- Focus on defined populations and target social determinants of health
- Map out barriers and potential solutions across different levels of prevention and intervention, using a 3x3 matrix called the Upstream Strategy Compass (see chart)
- Select early win opportunities for both clinical and community partners

To help achieve early wins, vanguard healthcare organizations are leveraging their internal performance improvement experience and resources to launch what we call “Upstream Quality Improvement” campaigns. Time and again, we’re seeing healthcare and community partners use the power of continuous learning and improvement methods to drive demonstrable improvements in care by addressing health-related social needs.

More than ever before, healthcare stakeholders and community partners are looking upstream, searching for ways to not only provide a clinical remedy, but also to address the forces that are making people sick in the first place. This raises many important questions for physician groups, and these changes to organizational culture and practice won’t be easy. The good news is that across the country, we’re now seeing that moving upstream is not only necessary—it’s possible.

Rishi Manchanda, MD, MPH, is President & CEO of HealthBegins.

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### The Upstream Strategy Compass

<table>
<thead>
<tr>
<th>Level of Intervention</th>
<th>Patient/Client</th>
<th>Organization</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Prevention</td>
<td>Financial literacy, support, &amp; nutrition programs for low-income families with family history of DM</td>
<td>Provide on-site farmers’ Market, gym, walking trails, or financial counseling for employees and dependents</td>
<td>Support ban on trans fats or a tax on refined grain products with added sugar, with subsidy support for healthier foods</td>
</tr>
<tr>
<td>Secondary Prevention</td>
<td>Poverty screening &amp; financial assistance for DM patients at risk of end-of-month hypoglycemia</td>
<td>Subsidize vouchers to a farmer’s market, incorporate the DPP into benefits plan for prediabetic employees</td>
<td>Change timing and content WIC &amp; school food programs to avoid food insecurity among DM</td>
</tr>
<tr>
<td>Tertiary Prevention</td>
<td>Reduce hospital use among high-utilizer diabetics using medically-tailored meals</td>
<td>Coordinate with local banks, collectors, lenders, to reduce debt burden for utilizer diabetics</td>
<td>Support legislation/regulations to provide financial and “hotspotter” services to severe diabetics</td>
</tr>
</tbody>
</table>

The Upstream Strategy Compass uses levels of prevention and intervention to help healthcare systems and their community partners improve specific social determinants of health for priority populations. Here, DM indicates diabetes mellitus, and DPP refers to Diabetes Prevention Program. Gray boxes represent “early wins.” Copyright 2018 by HealthBegins. Reprinted with permission.

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**Integrated Healthcare Association**

Join us at our APG Super Session to learn how financial risk sharing relates to healthcare quality and cost in California

**Atlas 3 – Does Integrated Care Continue to Shine?**

Friday, April 12, 10:00 am - 11:30 am

**Dolores Yanagihara, MPH**
VP, Analytics & Performance Information, IHA

**Jeffrey Rideout MD, MA, FACP**
President and CEO, IHA

Stop by our booth at the APG Annual Meeting or visit iha.org to learn more.

The Integrated Healthcare Association (IHA) is non-profit organization committed to advancing high-value integrated care that improves access, quality and affordability for patients.
In a competitive marketplace, operational excellence is a key driver of strategic advantage and profitability. To achieve this, management must first assess their organization's business strategy, systems, processes and people—identify their weaknesses, then take strategic steps to maximize the value of their organization.

As one of the nation’s leading professional service firms, Mazars USA provides the resources, experience and expertise to help you adapt in a dynamically changing healthcare landscape. Navigating today’s turbulent environment demands expert insight and flexible solutions. As an unparalleled change facilitator in this era of sweeping reform, the Mazars USA Healthcare Consulting Group provides a wide range of service offerings that helps meet your organizational goals and realize the maximum value from investments. Based on our strategic service model, you will be able to:

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Mazars USA gives you the expertise and deep resources of a firm with national reach, paired with the ongoing client service and feel of a boutique. We are a nimble partner, delivering actionable strategies that address your specific challenges. When choosing Mazars, you can be confident in your decision knowing that we have delivered success to other companies and can help you achieve similar results.

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Drive bottom line revenue improvement to help meet increasing demands and lower margins.

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Navigate and implement state and federal regulations by increasing awareness and reducing risk.

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Advanced analytics for critical decision making.

**DUE DILIGENCE**
Provide market-based reviews and feedback to address issues before a transaction is finalized.
ADOPTING VALUE AND RISK-BASED MODELS

Industry-wide adoption of the value-based payment model has begun and will ultimately shape the future of healthcare in a way that will be mutually beneficial to patients, providers, and payers. As with many visionary endeavors, risk-based payment sharing can require heavy collaboration, strategic planning, complex contracts, and uncertainty in the near term.

Today's healthcare industry faces increasing pressure to shift reimbursement models to some form of value-based payments due, in part, to patients wanting to be more involved in their care decisions and burdened with a greater cost-share responsibility. In addition, CMS has set aggressive targets for transitioning to a value-based payment model. The value-based train has left the station but will ultimately prove to make a significant impact on every stakeholder in the industry. For example, it will enable acquiring extensive data analytics to better utilize population health management programs, resulting in truly meaningful improvements in health.

Consider the example of Medicare. Over the last 50 years, Medicare took the lead on reforming the delivery of healthcare. Some of its initiatives have already succeeded, while others are a work in progress. Medicare introduced diagnostic related groupings (DRGs) to control costs and better manage the episode of care in a hospital by paying a set amount per diagnosis. This reduced a hospital’s incentive to extend stays and encouraged providing efficient care. More recently, Medicare introduced bundled payments to manage the cost of a case from pre-admission through discharge and follow up.

Commercial payers are also implementing risk-based payments, but a major drawback of following the Medicare Advantage model is that commercial membership rapidly changes due in no small part to the high levels of competition. There is less incentive to heavily invest in the long-term health of an enrollee when they can and do often switch plans.

All these factors can make sharing risk appear complicated and intimidating, but it’s a step in the right direction for the industry as a whole. With extensive experience and expertise in strategic planning, contract management, regulatory compliance and data analytics, Mazars USA can help your organization embrace the shift from fee-for-service to value-based care by proactively engaging these challenges and opportunities.

HOW WE HELP OUR CLIENTS

**Physician Groups, IPAs, MSOs & Ancillaries**

Mazars USA has extensive experience delivering tailored services to physician groups, independent practice associations (IPAs), management services organizations (MSOs), skilled nursing and rehabilitation facilities, urgent care centers, ambulatory surgery centers, home care agencies and social services organizations, helping to firmly position them within the changing healthcare landscape. Our goal is to provide support in contracting initiatives, compliance, financial modeling, clinical and operational process improvement and strategic planning for payer and provider alignments.

**Hospitals & Health Systems**

We help drive long term financial, operational and market success for hospitals and health systems through revenue maximization, technology implementation, system alignment, process improvement, data analytics and payer contracting. Our focus is on delivering sustainable outcomes for hospital executives facing transformational change.

**Payers**

We provide full-service consulting to national and local payers; Managed Medicare and Medicaid, Public and Private Exchanges, Workers’ Compensation/No Fault and Commercial Plans. We guide payers through end-to-end regulatory reviews, network expansion, reimbursement transformation, unit cost reduction and clinical/operational process improvements.

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Unprecedented consolidation in the healthcare market means that many companies will become part of a private equity portfolio. Our team understands both the buy and sell side of the transaction, giving us the ability to provide effective transactional support in valuations, financial modeling, integration and market based due diligence.
CASE STUDIES

INDEPENDENT PRACTICE ASSOCIATION AND MEDICAL GROUP:
Making an informed move to risk-based contracting and managing new licensing requirements
- Collaborated with multiple stakeholders to, based on informed assumptions, develop financial modeling and pro forma projections in order to contract for global risk with risk bearing organizations and payers in Medicare, Medi-Cal, and commercial lines of business
- Advised on new licensing requirements for entities taking risk

RISK BEARING ORGANIZATIONS:
Building a more robust network
- Worked with multiple stakeholders to determine provider gaps
- Assisted in updating contracts
- Negotiated on behalf of and with network team for favorable terms
- Completed geo-mapping to verify compliant network adequacy
- Provided interim credentialing services

INDEPENDENT PRACTICE ASSOCIATION & MANAGEMENT SERVICE ORGANIZATION:
Utilization management excellence
- Provided experienced clinical and compliance staff to assess Utilization Management workflow
- Worked with multiple stakeholders to improve processes and communications leading to efficiencies and increased compliance in documentation and turn-around time
- Management coaching to improve staff accountability

MANAGEMENT SERVICES ORGANIZATION:
Claims analysis and process improvement
- Performed a comprehensive analysis of the claims process from receipt of mail to EDI to payment of claims
- Revamped all policies and procedures, modernized performance metrics, updated job descriptions and performance review criteria
- Assisted with implementation of controls and new processes
- Provided team and one-on-one training and coaching regarding both regulatory requirements and managerial skills

CONCLUSION
Mazars USA LLP provides insight and specialized experience in accounting, tax and consulting services. Since 1921, our skilled professionals have leveraged technical expertise and industry familiarity to create customized solutions to overcome client challenges. As the independent U.S. member firm of Mazars Group, we have a global reach of 23,000 professionals in 89 countries. For more information about the solutions Mazars can offer your business, visit mazarsusa.com/hc.

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Mazars USA LLP is an independent member firm of Mazars Group.
This is the second in a two-part series on physician recruitment and retention. Part 1, “Recruiting Providers: Get the Right People on the Bus,” was published in the Fall 2018 issue of the Journal of America’s Physician Groups.

The right physicians bring long-term value to a medical group and flourish in their environment. In Part 1 of this series, we discussed “getting the right people on the bus”: how to effectively recruit and select the “right” clinicians who will fit well into your group.

But once you’ve made the expensive and challenging decision to hire a new physician, how do you offer that new clinician the best chance to succeed? How do you ensure that your organization will utilize this valuable new resource in the best possible way? In other words, once the right people are on the bus, how do you keep them there?

The keys to success in this area include:

• **Orientation.** Clearly communicate performance expectations based on the mission, vision, and values of the group, as well as the group-physician compact.

• **Feedback.** Give timely, frequent feedback about performance, with effective coaching.

• **Patient focus.** Emphasize patient satisfaction—and how both the group and the individual contribute to a good patient experience.

• **Communication.** Provide two-way communication about how things are going.

**ORIENTATION: COMMUNICATING EXPECTATIONS**

The first key to success is to clearly communicate your expectations of the new group member.

Most organizations use fairly standard employment (groups) and provider (IPA) contracts. These legal documents contain all the regulatory and HR-required language—including specifics about hours worked, productivity, and bonuses. This information reflects the financial status and culture of the organization, but just scratches the surface of real performance expectations.

The organization’s statements of principles—its mission, vision, and values—are much more important. These are infrequently used in conversations with new physicians, but they can help them develop accurate expectations of their work, as well as a deeper understanding of what your group values. They can also help you build a strong relationship with new personnel.

Your vision is what your organization hopes to accomplish if it is wildly successful over the long term. This statement can be used as a test for whether your new
clinician understands the destination and is willing to commit to the journey.

My favorite medical group vision is from Sharp Healthcare: “to become the best health system in the universe.” This may be overly dramatic, but it leaves little doubt about the expectations for the group and all its employees.

One independent practice association (IPA) describes its vision as a “virtual group of interdependent physicians who share a common vision” and includes that “each physician will be held accountable for providing the best possible care without being wasteful.” This vision clearly lays the groundwork for what the IPA expects of its contracted providers—and why.

The IPA included its vision statement as an exhibit in every provider contract and “recited” the vision at virtually every physician meeting. Essentially, the message was: “This is where we are going. Do you want to go with us and help us get there?”

Many groups’ values include items such as putting patients first, providing the highest quality evidence-based care, and practicing in a cost-efficient manner. Feedback about patient communication, tardiness, timeliness of results review and charting, and appropriate use of imaging and consultation can all be given using the framework of the group’s mission, vision, and values.

Another key statement of principles is the group-physician compact. This reflects the critical, but less tangible, expectations for both the group and its clinicians. The compact addresses what the physicians expect to give to the group—and what they can expect to get from the group in return. It should clearly list the commitments that allow the organization and the clinicians to hold each other accountable for specific actions.

Examples of the “Give”:

- Adopt evidence-based best practices
- Adopt new technologies
- Be an advocate for the organization in the community
- Participate in organizational events and meetings

Examples of the “Get”:

- Assistance and support with implementing new technologies
- Fair and competitive compensation
- Share in performance-based incentives

Developing and committing to a compact helps to clarify the behaviors necessary for the organization to achieve its goals, and serves as a reminder to both the organization and the clinician of what is expected of each.

Recruiting high-potential clinicians is hard, but helping them to succeed requires equally hard work around orientation and education. Large and mature organizations have a long history and deeply held principles, and they may already have a strong program for orientation and education.

However, their programs may no longer be as effective in the current state of complex, multidimensional healthcare systems and new millennial clinicians. Younger organizations, meanwhile, may not have developed the infrastructure and systems to accomplish these vital tasks.

A successful program starts with organizational self-evaluation: Who is responsible for the orientation, education, and mentoring of new recruits? If it’s “everyone,” it’s probably no one. Effective physician onboarding requires both a formal orientation program—with clear identification of responsible individuals—and formal assessment and evaluation processes. Developing these programs is a core responsibility of the organization’s leadership.

THE IMPORTANCE OF EARLY FEEDBACK

Once physicians start practicing in the group, it is crucial that they receive frequent, timely feedback about performance issues as soon as possible. A strong understanding of the group’s mission, vision, and values can help frame these early conversations, with both positive and negative feedback.

For our risk-managing organizations, it is important to remember that no clinician is born with expertise in providing value-based coordinated care—and this subject is often not addressed in residency programs. Experience is essential, but so is a system of education, feedback, and accountability. Not every clinician wants to practice value-based care, but for those who do, the organization must take responsibility for providing accurate and effective learnings.

Historically, many of us hoped that issuing denials would change physician behavior. This is probably not the case; denials just frustrate clinicians, especially when responses are inconsistent and depend on the reviewer. Helping new clinicians develop a satisfying, coherent, and sustainable practice requires effective feedback and a long-term commitment to education about best practices.

FOCUSING ON PATIENT SATISFACTION

The successful orientation and long-term retention of new clinicians requires a rational and effective approach

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How Smart Leaders Stay Out of Harm’s Way

BY RUSSELL FOSTER AND SHEILA STEPHENS

This is the first in a three-part series on how to overcome compliance and operational deficiencies in a time of expanding government oversight.

With the recent rapid growth in Medicaid and Medicare Advantage membership, the infrastructures of many health plans and downstream entities have been stretched to the breaking point.

Changes in federal and state policies and related rules and regulations have often been accompanied by short implementation timelines and more frequent audits and regulatory oversight. The pace of change has made it extremely difficult for health plans and their delegates to operate in full compliance and at optimal levels of efficiency and effectiveness.

At our firm, we find that compliance and operational assessments often yield similar findings, regardless of an organization's size or complexity. Below, we highlight the 10 most common compliance and operational deficiencies we see during an audit or assessment, which is increasingly the focus of the Centers for Medicare & Medicaid Services (CMS) and state regulators.

These deficiencies reduce a health plan's efficiency, effectiveness, and profitability—exposing the enterprise to:

- Unnecessary regulatory risks (e.g. fines, cease and desist orders, and increased oversight)
- Member, provider, and stakeholder dissatisfaction
- Loss of competitive advantage

TOP 10 COMPLIANCE AND OPERATIONAL DEFICIENCIES

Based on our experience, here are 10 compliance and operational deficiencies that we see on a routine basis. To avoid unnecessary regulatory scrutiny and improve operational efficiency and effectiveness, we highly recommend that health plan CEOs, CFOs, and COOs use this list to gauge their organizational opportunities for improvement.

If any of the following seem to fit your organization, it is time to take a serious look at the adverse impact these factors can create.

1. The organizational culture supports the philosophy that 80 percent is good enough.
2. A disengaged board is not paying attention to what is or isn't being reported. Management is not being held accountable for results.
3. The administrative structure is heavily siloed—evidenced by interdepartmental finger-pointing, lack of personal accountability for results, and limited or nonexistent monitoring and follow-up.
4. High staff turnover is resulting in a loss of executive and senior managers with
significant historical knowledge and experience. In many cases, staff who are recruited to fill these key positions have insufficient knowledge or expertise and receive little or no additional training.

5. Provider contracts are not being fully vetted as to reasonable and operational implementation. These contracts are often one-sided, with too many variations of the same basic agreement in play (e.g. lots of special deals), with business rules that do not provide for a clear and consistent configuration to pay claims correctly. This can result in high auto-adjudication error rates, workarounds that lead to significant overpayments, and rework in the form of recovering lost funds and conducting ongoing follow-up.

6. Policies, procedures, and processes are poorly documented and communicated. Management is not frequently reviewing and updating these policies, and staff often are not following them—due to little or no accountability for mistakes made from neglect, ignorance, or intentional noncompliance.

7. Internal controls are insufficient to identify and mitigate significant weaknesses in core processes. This can result in a higher risk of loss due to fraud, waste, and abuse.

8. Compliance departments are underfunded (understaffed). These departments do not have the authority or responsibility to aggressively pursue routine monitoring and oversight of plan operations—or to conduct routine operational audits, assessments, and investigations.

9. Internal data integrity and reporting are weak. Executive dashboards do not identify significant changes or trends fast enough, leading to significant overspending and recovery efforts that may be too late.

10. Third-party recovery activities are not robust enough to recapture overpayments within a reasonable period of time. It becomes much harder to recover an overpayment if the error goes undetected for months or years. A well-staffed Recovery Unit typically has a very high return on investment.

1. ORGANIZATIONAL CULTURE: IS 80 PERCENT GOOD ENOUGH?

These days, it is not uncommon to find health plans and delegated provider organizations that are simply overwhelmed by all the federal and state requirements. These organizations have accepted that they cannot achieve full compliance.

Many health plans have reached a point where they now create a line item in their budgets for regulatory fines and expect to have ongoing deficiencies. But allowing this “80 percent” philosophy to become a business strategy brings with it many hidden costs, including costs associated with:

- Chasing corrective actions
- More frequent regulatory audits and other intrusions
- Lower production
- Loss of staff pride in their work, stemming from less-than-stellar expectations

Transitioning from an “acceptable” level of performance to “star”-level performance starts at the top. It begins with a philosophy grounded in quality improvement, doing it right the first time, and encouraging employees to find problems and solutions.

Our experience consistently shows that organizations that have a sound and well-communicated philosophy regarding ongoing quality improvement, high standards, and accountability tend to have more positive outcomes related to regulatory audits.

No organization is perfect, and all organizations experience problems on a daily basis. However, the key to striking a balance between cost and quality and to achieving operational and financial success is to identify early, correct early, and monitor on a continuous basis. Some call this “staying ahead of the curve,” “anticipatory leadership,” or “top down.”

We call it “common sense.” Based on our experience, we believe people rise to the level of expectations. Therefore, much

continued on next page
thought should be given before allowing an “80 percent is good enough” philosophy to become embedded in the organization.

2. DISENGAGED OR UNINFORMED BOARD

When we find an organization in crisis—regulatory, operational, and/or financial—we usually find a disengaged or uninformed board.

While for-profit boards tend to be much more engaged on a monthly basis, it is not uncommon to find for-profit and not-for-profit boards composed of people with little or no knowledge or understanding of health plan operations. This tends to create a total reliance on information from the executive management team. In other words, acceptance without question.

While it is important for boards to have trust in their executive management team, trust only goes so far.

Health plans need to carefully consider their board appointments. Board members have a fiduciary duty and responsibility to their organization and its owners, as well as to the entities the organization contracts with (e.g. CMS, private employers, and individual members). They must operate with the highest level of knowledge, understanding, and integrity. A disengaged or uninformed board member cannot be effective—and in a crisis, cannot help lead the organization.

Most board seats are occupied by highly educated people who are experts in their own fields. However, board members must have the knowledge, experience, and understanding of how health plans operate to fully understand what the executive leadership team is reporting each month.

This is the only way they can know whether to challenge the information being reported because it doesn't make sense or is suspect. It's also the only way they know when to demand action from the executive team because it's evident that immediate steps are needed to steady the ship.

Waiting months for answers that make sense, or being satisfied with whatever answer is given when the house is on fire, is not acceptable behavior from the executive team or the board.

3. HEAVILY SILOED ADMINISTRATIVE STRUCTURE

Unfortunately, we see more structures that are siloed than are not. It's so easy for an organization to fall into a silo mentality, and when that happens, efficiency is compromised.

No one is ready to assume responsibility because the other guy or another department is responsible—for not meeting a quality or production standard, for missing a regulatory filing deadline, for failing to pay a claim accurately and on time, or for resolving a member complaint.

A siloed organization cannot achieve a “one and done” production and quality standard because the departments are not working together to achieve that common goal. Rather, everyone is busy pointing the finger at each other.

Breaking down the walls of a siloed organization takes time, and with it will come some gnashing of teeth in the form of staff reassignment or even terminations as needed to remove the major offenders.

One of the ways out of silos is the adoption of companywide performance goals and rewards for superior (individual and departmental) performance. Policies and procedures must make it clear who is being held responsible for meeting these goals.

Further efforts to eliminate the silo mentality include internal education and focus on upstream and downstream customers and suppliers. Organizations that understand and implement a philosophy that promotes the belief that each department is both a customer and a supplier create a significant advantage in assisting staff to connect the dots and improve performance across the organization.

Siloed organizations have greater difficulty implementing needed interdepartmental changes and improvements, as it is common to see and fix the problem in one department, only to find the root cause resides within another department. This contributes to inefficiency and rework, both of which are costly to an organization.

Our experience demonstrates that siloed organizations are less prepared to evidence accurate data, monitoring, and reporting with a high level of confidence. This is frequently a result of myopic departmental views, rather than looking at the entire organization and all of the contributing points along the way.

In Parts 2 and 3, we will drill down into the rest of these 10 areas and discuss how to eliminate or mitigate these deficiencies, implement best practices, and restore efficiency, effectiveness, and profitability.

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Team-Based Care: Delivering Quality and Efficiency in a Risk-Based Model

Healthcare's twin goals of quality and efficiency are never more aligned than they are in value-based care. Here, leaner is not “meaner.” Rather, it leads to greater efficiency, which improves—not detracts from—quality and effectiveness.

Value-based healthcare continues to gain attention as a delivery model in which physicians, hospitals, and other providers are paid based on patient health outcomes. This differs from the traditional fee-for-service approach, in which providers are paid for the quantity of services provided. With value-based care, the value is determined by measuring clinical outcomes and the total cost of care to deliver these outcomes (NEJM Catalyst, 2017).

THE QUAD: BEST PRACTICES FOR VALUE-BASED CARE

Success in value-based care requires a laser focus—organizing the work to be done and continually measuring and adapting to results.

At VillageMD, we organize our work into four areas, called “the Quad,” with defined team members, responsibilities, and work targets. The Quad includes attribution, acuity, quality, and utilization. Each component contributes to value-based care, and together, the areas are key to achieving greater quality and efficiency.

The Quad components represent best practices for delivering value-based care across a broad patient population, composed of both Medicare and commercial

"Seeing patients who have relatively simple problems—before they lead to an ED visit or hospitalization—is key to reducing utilization.”
beneficiaries. By using team members to assist in care delivery, providers can manage a larger panel of patients without necessarily seeing more patients.

In a team-based model, the Quad empowers clinical and nonclinical team members to pursue higher quality and greater efficiency across a patient population. The model enables practices to drive toward achieving the triple aim of improving the experience of care, improving the health of populations, and reducing per-capita healthcare costs (Berwick et al, 2008)—as well as a fourth aim of improving physician satisfaction.

ATTRIBUTION: RIGHT PATIENTS, RIGHT DOCTOR

The first quadrant is attribution—making sure the right patients are seen by the right doctor, at the right time. Attribution is important because payers measure the cost and quality of a primary care practice against national and local results, based on their attributed patients.

In a value-based system, attribution occurs one of two ways:

1. Retrospectively. Here, patients are attributed (assigned) to physicians who have provided the majority of their primary care in the previous measurement period. If a doctor sees a patient more than any other primary care physician, that patient is likely to be attributed to that doctor.

2. Prospectively. This approach assigns a group of patients to a physician on the first day of the calendar year.

Payers use both forms of attribution. To successfully manage the patient population, providers must focus not only on activity at the beginning of the year, but also on the addition or deletion of patients throughout the year.

At VillageMD, we focus on high-risk patients who are highly likely to have avoidable utilization. They are risk-stratified based on disease burden, specialty and ancillary utilization, and social determinants of health. Social determinants of health include a patient’s socioeconomic status, education, housing, environment, and other factors related to where and how people live and work (CDC, 2017).

We also look for utilization patterns that indicate patients would benefit from early proactive interventions, such as education on the signs and symptoms of exacerbation of their disease. Our goal is to see all patients at least once a year to educate them on preventive guidelines, capture quality metrics, and build a long-term relationship. Our high-risk patients are seen on average more than five times a year.

The key to successful attribution management is having a team of outreach specialists who help identify patients who need to be seen—and ensure they are seen promptly and as often as required. Waiting until a patient is ill and needs an appointment is not a successful strategy!

ACUITY: UNDERSTANDING PATIENT RISKS

Acuity involves understanding a patient’s disease burden and coding it accurately; this is a critical element of risk stratification.

On average, physicians have a practice panel of 1,500 patients. About 20 percent of this panel (300 patients) typically consumes the majority of healthcare resources in the practice. Knowing acuity level helps providers prioritize patients, so that those with the most complex health issues are seen more frequently and have access to the right resources at the right time.

For Medicare beneficiaries, risk acuity is measured through ICD-10 diagnosis. Physician education on accurate ICD-10 diagnosis and documentation at least once a calendar year is critical to accurate risk capture. VillageMD combines electronic medical record (EMR) and claims data and presents the provider with any missing or suspected ICD-10 codes at the time of a patient visit.

Incorporating data directly into a provider’s workflow allows accurate and timely risk capture. When combined with utilization data and social determinants of health, providers can identify the patient population their team should focus on.

At my practice, Village Family Practice (VFP) in Houston, annual wellness visits give the provider more time to accurately capture risk and quality metrics. The visit is most successful if data are gathered beforehand and presented to providers at the time of the visit. The team behind the scenes can review claims and medical records, which allows providers to do what they do best: Take that information and act on it.

QUALITY: DRIVING CONSISTENT RESULTS

Quality involves every member of the team. Patients measure quality differently than payers. How quickly does the practice pick up the phone? Is the online scheduling portal easy to use? Is the office clean and the parking adequate? Did the provider dress, act, and educate in a professional manner?

These questions inform a patient’s measure of quality. Every team member needs to understand how they contribute to a high-quality patient experience.
To succeed in clinical quality metrics, the nursing staff is very important. At VillageMD, we explain quality metrics to the nursing staff and educate them on how their activities can help drive better clinical results. A nurse who doesn’t understand the latest colon cancer screening guidelines is unlikely to answer a patient’s questions correctly or place the right screening order.

We teach to a very defined set of rooming guidelines, educating nurses on what should be done before a provider enters the room. The guidelines are specific to age, sex, disease, and symptoms. This not only allows the provider to be more efficient, it also significantly increases the chances of accurate quality code capture.

For example, when a patient with diabetes comes in, the nurse who rooms the patient draws labs, dips a urine microalbumin test, orders an ophthalmological referral or retinal photograph, and ensures the patient’s shoes and socks are removed for the physician to complete a foot examination. Consistently completing these activities allows the physician to focus on a patient’s illness and concerns. This leads to higher quality and higher efficiency.

**UTILIZATION: RIGHT SERVICES AT THE RIGHT TIME**

Utilization is all about when, where, and why patients access the healthcare system. This includes primary care, specialty care, emergency department (ED) visits, and hospital admissions. Claims data provide a lookback, but often are too old to be useful. Combining EMR and claims data is a more accurate way to identify utilization both inside and outside the practice.

Consider the patient with an underlying diagnosis of anxiety who complains of tightness in the chest, or the elderly individual with frequent urinary tract infections. When these patients seek care in the ED, it is typically not the best utilization. Rather, these patients should be contacted frequently by the primary care practice and educated on when it is necessary to use the ED. Once again, it comes down to taking a team-based approach to deliver value-based care and drive efficiency for the patient, the practice, and the healthcare system.

Seeing patients who have relatively simple problems—before they lead to an ED visit or hospitalization—is key to reducing utilization. At VillageMD, we order routine urinalysis and urine cultures at the time of admission to a home health agency. We identify urinary infections before they progress to urosepsis. Identify the simple things, before they become bigger problems.

The common theme to driving quality and efficiency is the role of a provider, not always as the “doer,” but as the leader and teacher. It takes a team approach—proactive and data-driven—to engage the right patients and improve quality and efficiency across the “Quad” of value-based care.

**References:**

According to the Centers for Disease Control and Prevention, 5.7 million people in the U.S. have heart failure. The condition accounts for 1 in 9 deaths and costs the nation more than $30 billion annually in combined costs. Heart failure is also the No. 1 reason for hospitalization among Medicare patients—and the top reason for readmission within 30 days of treatment.

At Marshfield Clinic Health System (MCHS), we recognized that it is possible to bend the curve to achieve true triple aim success in heart failure—with improved outcomes, improved patient experience, and reduced costs. The key: proactive patient-centered care management and timely treatment of heart failure patients through the continuum of care—from hospital, to step-down, to home.

EMPHASIZING EDUCATION AND SUPPORT

MCHS has 5,541 heart failure patients, and approximately 1,800 of them are enrolled in our Heart Failure Improvement Clinic (HFIC). The HFIC care team initiates care through hospital discharge plans and/or physician referrals.

HFIC staff meet with patients at the initial point of care to develop a care plan. They then begin to thoroughly engage and educate patients to facilitate optimum management of their condition. The team works closely with hospital, nursing home, and county health department staff, as well as family and other caretakers. The goal: make sure all parties are coordinated and proactive in treatment and management.

The clinic emphasizes education and support—empowering patients to modify their lifestyles and adhere to treatment plans that ultimately lead to optimized quality of life, improved clinical outcomes, and reduced cost. Special focus is given to helping patients understand the following:

- Heart failure warning signs and symptoms
- The importance of diet (including reading and understanding food labels and restricted sodium intake)
- How to implement a regular exercise regimen tailored to their ability and needs
- How to manage medications

The team also provides patients with a heart failure education book, a magnet listing symptoms they should report, a support number to call, a daily weight log, and a scale, if needed.
INTERACTIVE VOICE RESPONSE SYSTEM

One of the unique aspects of the program is that patients have access to an interactive voice response (IVR) phone system. Developed by MCHS, the system prompts patients for input, and if it notes positive signs and symptoms, it automatically alerts an RN to call the patient.

The IVR is linked to the patient's electronic health record (EHR) and automatically updates key measures, such as weight. During off-hours, all alerts and support calls are managed by Marshfield Clinic's 24-hour Nurse Line. Patient-specific guidelines and protocols noted in the EHR are followed 24/7 to provide immediate response and eliminate unjustified variation.

If necessary, the RN can implement a diuretic and potassium protocol with prescription medications. Intravenous diuretics can be provided at most MCHS telehealth sites—a convenience for the patient that significantly decreases hospitalizations and emergency room (ER) visits.

Finally, the IVR system triggers the HFIC team to review the chart and follow up with the patient on the next business day. At this point, the team can assess the patient’s current signs and symptoms of heart failure and ensure care is managed accordingly.

Patients are also coached on how to monitor their heart failure signs and symptoms, and on when to seek medical consultation, including:

- Medication titration that is patient specific, utilizing the American Heart Association heart failure guidelines
- Diuretic and potassium protocol that can be used in the office or remotely by phone/telehealth
- Office IV diuretic infusions

The clinic follows a group practice, team-based model to support effective management of comorbidities (renal insufficiency, diabetes mellitus, chronic obstructive pulmonary disease, etc.)

THE ROLE OF PHARMACY

Pharmacy provides medication education to help patients become more knowledgeable about their medications and how/why they affect their heart failure signs and symptoms.

The pharmacist calls patients prior to their first visit to review and educate them on their medications. This allows the pharmacist to understand what medications the patient has at home, what is ordered per the patient's record, and then reconcile the differences. It also provides a basis for the provider to discuss medications with the patient if there are discrepancies in what is prescribed and what the patient is taking.

CARE COLLABORATION

The team collaborates with area nursing homes, assisted living, and community-based organizations to ensure coordination throughout the continuum of care.

This includes educating external staff caring for HFIC patients on standardized protocols (weighing patients every morning immediately after going to the restroom, providing healthier low-sodium food and beverage options through a color-coding system, fluid restriction documentation and rationale, coordinated discharge instructions, and when to call HFIC for additional patient support.)

Currently, we have extensive efforts to assist patients with advance care planning and document the results, so
all caregivers have access or knowledge of the plan of care. This empowers patients to make these important decisions when they are well, and it helps family members be the patient’s voice when the patient is no longer able to do so.

FOUR KEY INNOVATIONS
Our clinic features four key innovations and unique aspects that enable our team to effectively manage care for the geographically widespread—and predominately rural and medically underserved—population we serve:

1. We developed and implemented a distance-bridging IVR system.
2. 24/7 Nurse Line protocols, built upon the IVR, enable round-the-clock access to standardized care. This eliminates unjustified variations and positively impacts patient experience.
3. Intravenous diuretics are available at outpatient telehealth sites across our 55,000 square miles of care—ultimately reducing ER and hospital admissions and readmissions.
4. RN-based patient care management allows for more one-on-one time and personal relationships, and ultimately, better patient engagement in care. It also offers cost structure advantages.

STANDARDIZING COMMON PROTOCOLS
All HFIC staff follow the same model of care, utilizing common protocols, processes, and educational material. The clinic’s nurse practitioners and RN staff utilize standard document templates to ensure information provided in the medical record is consistent, clear, and concise.

Key documents that are vital to program reliability and success include Eligible Patients for Enrollment Policy, Telephonic Enrollment Criteria Policy and Procedure, and HFIC Staff Enrollment Procedure.

Procedures important to our team are:
- Administration of IV furosemide
- Provider enrollment
- Follow-up visit
- Heart failure patient education
- Heart failure hospital discharge follow-up
- Patient walk-in procedure

In addition, electronic triage resource guides ensure consistent patient triage for a range of symptoms, including chest pain, difficulty breathing, edema triage, weight gain, weight loss, and lightheadedness.

To facilitate continued patient engagement and care management adherence, MCHS uses telehealth to monitor
and manage heart failure signs and symptoms. This allows for additional patient convenience, improved outcomes, and reduced costs. HFIC support is available through 24/7 Nurse Line management and on-call expertise.

**IMPROVING PATIENT SATISFACTION**

HFIC is focused on the triple aim model of improved patient experience, improved patient outcomes, and reduced cost of care. Providing patients with a valued experience is an essential element to ensuring engagement, buy-in, and ultimately, adherence to their care plan—which leads to improved outcomes.

Our clinic utilizes monthly Press Ganey patient satisfaction scores to determine overall satisfaction and specific opportunities for improvement. The HFIC Press Ganey scores demonstrate that patients are very satisfied with their care and patient experience—the mean score consistently ranks above the 99th percentile. For overall satisfaction, the clinic has a mean score of 92.8 in the state of Wisconsin and a rank of 66.

**POTENTIAL SAVINGS: $10 MILLION**

On average, HFIC yields an annual, per-patient savings of $7,416. Furthermore, data suggest that HFIC has the potential to reduce total medical and pharmacy costs of our current clinic heart failure patients by nearly $10 million annually.

These savings come from superior care management that lowers total spend on cost of care but results in better clinical outcomes.

Heart failure is a chronic, progressive disease that is characterized by frequent ER visits, hospital admissions and readmission, and ultimately, high mortality rates. It is not curable, but it is possible to bend the curve and extend both the quality and quantity of life through effective disease management. That is the ultimate objective for our heart failure patients.

Narayana S. Murali, MD, FACP, CPE, is Executive Director and President of Marshfield Clinic, as well as the EVP of Care Delivery and Chief Clinical Strategy Officer of Marshfield Clinic Health System (MCHS), the largest rural multi-specialty group medical practice in Wisconsin. Kori Krueger, MD, MBA, is Chief Quality Officer for MCHS. Tammy Simon, RN, MSN, is Vice President for the Institute for Quality, Innovation and Patient Safety at MCHS.

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**Better outcomes with behavioral economics**

- 89% adherence to daily meds
- 0.96 improvement to A1c in elderly diabetics
- Up to 46% reduction to readmissions

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Physicians are passionate about the quality of care they provide to patients. After all, that is the reason they chose their profession. But many of today’s physicians also report being disappointed with the present state of medical practice. In fact, 7 out of 10 say they cannot recommend the profession to their children or other family members.

That’s the message from the 2018 Future of Healthcare survey, which features responses and comments from more than 3,400 physicians nationwide. Conducted by The Doctors Company, the nation’s largest physician-owned medical malpractice insurer, the survey reveals a complicated picture about physicians’ attitudes toward the state of healthcare.

The survey results indicate that in the future, healthcare will likely be much different than what providers and patients are accustomed to today. The number of physicians may continue to decrease, with fewer entering the profession and many practicing physicians retiring in the next five years. Patients may no longer see a physician for noncritical conditions, with advanced practice providers such as nurse practitioners and physician assistants likely filling the gap.

And while practice consolidation appears to have slowed, many doctors view evolving technologies and reimbursement models as encumbrances to the most important reason they practice medicine: caring for patients.

Here are some of the survey’s most relevant findings:

- 54 percent believe current electronic health record (EHR) technology is having a negative impact on the physician-patient relationship.
- 62 percent are not planning to change practice models within the next five years.
- 54 percent are contemplating retirement within five years, due to changes in healthcare.

Physicians were clear in their comments. “If I had to start today, I would choose another field of endeavor,” said one. Another opined, “We love what we do, but … we need to restore the dignity back to the physician-patient relationship.”

**SIGNs OF HOPE**

Although the survey results strike a cautionary note for the future, they also give some reasons for optimism.

Most importantly, while many doctors say they are disheartened with the state of medicine, their passion for patient care remains. As one California surgeon noted, “There is no other life I would choose, regardless of compensation or regulation.”

In addition, younger doctors shared a more positive perspective of EHRs. Moreover, after a period of relative flux in practice models, doctors now anticipate that their practice settings will stabilize over the next five years. The vast majority say they will not change practice models in the near future. This structural solidification may give patients more
reassurance and predictability when it comes to their healthcare experiences.

What can be done to reverse some of the disenchantment? Based on the responses to this survey, we need to think long-term. Physician disenchantment may ultimately change the face of healthcare as we know it.

As it stands today, by next year we will already reach a tipping point, with more primary care physicians retiring than graduating from primary care residencies across the U.S.\(^2\) From this alone, we can predict a reshaping of services, with physician assistants and nurse practitioners comprising more of the family practice workforce.

The medical profession is emerging from a period of uncertainty. The use of EHRs is finally becoming familiar, if not popular. And though new business structures and pricing methods may not be second nature, the challenges are at least better understood.

Surveys like the Future of Healthcare are instructive and vital in helping to advance the practice of good medicine. Doctors deserve a loud voice in the healthcare debate, so that quality care and the doctor-patient relationship are the cornerstone of every decision.

Bill Fleming is Chief Operating Officer of The Doctors Company. To see more survey results, go to www.thedoctors.com/future.

References:
\(^1\)https://www.thedoctors.com/future

SURVEY RESULTS: PHYSICIAN COMMENTS

- “Physicians need to get involved and create change and [not] just do as they are told.”
- “Clearly, changes are coming. I hope physicians can focus on helping patients while managing a balanced lifestyle to ensure that their personal needs are adequately attended to.”
- “The federal government should leave the practice of medicine to physicians. The increased regulatory demands of value-based medicine are overwhelming.”
- “Patient care should, and hopefully will be, a person-to-person interaction.”
- “I have moved to direct care [and] take no insurance or government funds. I work for the patient.”
- “We as a country need a sustainable, fair payment model that recognizes the value of all medical specialties and the limits that patients can realistically pay for healthcare. We need to change [the] amount of documentation burden—i.e. get rid of E/M coding, which does not apply to our next medical documentation requirements in primary care.”
- “There is a need for integrated EMR connecting hospitals and doctor offices. Documentation and compliance could be automatically obtained and not require redundant input and authorizations.”
America’s Healthcare System Could Be So Much Better

But it would take a change of culture and investment to make that happen

BY DONALD REBHUN, MD, MSPH

The ongoing conversation around health care in the United States presents a daunting question: How is it that this country—with all its wealth, education and innovation—has among the highest health care costs of any industrialized nation, yet its clinical outcomes still lag behind?

Illustrating the point, according to a Kaiser Family Foundation analysis, disease burden in the U.S. is greater than in other similar countries, with poorer management of preventable diseases resulting in increased use of emergency rooms, increased hospital admissions, worse outcomes, higher costs, and higher mortality rates.

There are numerous opinions coming from inside and outside of the medical community on how best to improve treatment quality and outcomes, boost patient experience and reduce the cost of care. We believe that medical organizations that embrace integrated coordinated care are uniquely positioned to help drive the changes needed. There are groups throughout the country that have decades of experience practicing coordinated care and many more that are embracing this care delivery model each year. It is worth taking a closer look at how these groups are financially structured and the foundations of their clinical cultures.

The vast majority of American health care providers are still operating in a model that the industry refers to as “fee-for-service,” in which the provider is paid based on the services and treatment rendered, not on the patient’s health outcome (quantity rather than quality). However, very different types of health care finance models have existed for decades. Most accept a variety of payments including shared savings, bundled payments, being part of an accountable care organization (ACO), shared risk and full risk.

In the full risk model, a provider organization is paid a flat per-patient, per-month rate. The group thus accepts the clinical and financial accountability of a defined population. In order for organizations to be successful under this and other risk-based contracting models, they must have: an engaged and committed clinical and business leadership; invested in building a unique infrastructure with focus on prevention and early detection; and an advanced care management department working closely with numerous healthcare professionals, applying innovative resources and programs and using data/analytics to improve the quality of care delivery. This model places financial incentives for providers to keep the patient in the best possible health in order to reduce downstream health problems and complications with their associated costs.

In the short term, a fee-for-service financial model may offer steady, predictable income; however, it is not a sustainable strategy for the long term. Making the shift from a volume-based fee-for-service model to a value-based risk-bearing care

“Medical organizations that embrace integrated coordinated care are uniquely positioned to help drive the changes needed.”
model can prove to be beneficial for patients and the medical organizations themselves. But how and what changes are needed by organizations, most of which recognize that these and other changes are inevitable?

While many medical groups claim that they are “patient centered,” the key is implementing day-to-day action that proves it. For example, HealthCare Partners, a DaVita Medical Group, has spent the last three decades caring for hundreds of thousands of patients in Southern California. Over that time, we built an intentional culture where patients are at the center of the clinical model. In this model, coordinated teams align with physicians who have the independence to develop a care plan in collaboration with their patients. This basic but fundamentally unique approach laid a cultural foundation for all of our clinical programs and naturally fostered an environment where a full-risk model has been highly successful.

Our group and other medical groups that prioritize value-based care use key performance indicators to determine how successful this approach has been, such as monitoring how often patients are going to the emergency room for non-emergent care and how often they are being admitted to the hospital. Typically, a group’s assumed financial risk, coupled with a patient-centered culture, heightens the organization’s focus on, and investment in, helping to safely promote avoidable hospital stays and deliver the right care, in the right place, at the right time.

For example, at HealthCare Partners, this includes investing in and prioritizing innovative new programs such as in-home care for frail and elderly patients and often those who have chronic illness and are homebound, and a specific program to provide care for patients with chronic obstructive pulmonary disease (COPD).

Here are some notable results from the program providing home care for high-risk patients: 27 percent reduction in emergency room visits; 26 percent reduction in avoidable hospital admissions; and 25 percent reduction in hospital bed days.

As for the COPD program, its results include: 30 percent reduction in avoidable hospital admits; 23 percent reduction in emergency room visits; 39 percent reduction in hospital bed days. This has led to 34 percent reduction in total costs.

These programs, which support the value-based model of care, may seem challenging to implement for many health care providers still operating in the old fee-for-service model; however, they don’t have to be. Small changes, starting with an intentional culture and a willingness to shift toward prevention and focused care for high-risk populations, can go a long way in helping transform America’s health care system. The potential benefits and the effect could bring much-needed change.

The views expressed are those of the author(s) and are not necessarily those of Scientific American.

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This article was originally published in Scientific American on Sept. 25, 2018, and can be found at the following: https://blogs.scientificamerican.com/observations/americas-health-care-system-could-be-so-much-better/
Behavioral Economics: The Missing Tool in Your Risk-Based Toolkit

BY MATTHEW LOPER

It’s now 2019. Why haven’t ACOs taken over the world? Why isn’t every IPA taking on global capitation? Why do we still have preventable readmissions?

As a member of America’s Physician Groups, your organization is clearly in the vanguard. You have carefully contracted with payers to ensure you get appropriate attribution for the risk and results of your population. You hired a small army of medical coders to analyze thousands of encounter data to ensure they are capturing every appropriate diagnosis to get a RAF score that reflects your patient population. You have worked tirelessly to streamline your team’s clinical workflows and hired more care managers to outreach patients constantly.

You have seemingly done everything you can to maximize the health outcomes in your population. But there is one huge problem. Even when you give the right treatments to the right patients at the right times, half of them will go home and still not do what they’re supposed to.

The health outcomes of any population are mostly determined by the daily behaviors that patients perform outside of your care settings. Whether they take their medications as directed, whether they follow-up appropriately, what they eat, how much they move, if they continue to smoke. And guess what? You just bet your financial future on these individual behaviors for which you have almost no control.

Our whole health system was designed on a flawed assumption: that if you give patients information and access to the right care, they will make the decisions that are rational and in their best interest. Over the past three decades, behavioral economics has proven that people make irrational decisions all the time, but do so based on a set of predictable cognitive biases and heuristics.

Behavioral economics is now one of the fastest growing fields of research, with hundreds of published studies, multiple Nobel laureates like Richard Thaler and Daniel Kahneman, and best-selling books like Nudge and The Undoing Project. If you understand how and why these irrational decisions are being made, you can change patient behaviors and outcomes for the better.

For any provider organization adopting risk, understanding and applying behavioral economics appropriately is absolutely crucial to your ability to succeed under risk-based care.

Here are some of the core principles from behavioral economics and how they can be applied to key healthcare problems.

INTENT-BEHAVIOR GAP

Patients often want to do the “right thing” but often fail to follow through with the action. Behavioral economists call this difference between plans and action the Intent-Behavior Gap. I personally intend to go for a run, eat salad, and meditate this weekend, but I will probably end up binging six hours of Netflix and eating a large pizza alone on the couch.

“Even when you give the right treatments to the right patients at the right times, half of them will go home and still not do what they’re supposed to.”
In medicine, we must realize that the Intent-Behavior Gap is only human and work with our patients to overcome it.

**PRESENT BIAS**

Human motivation is driven by instant and tangible gratification, not what we know is rationally in our own best interest. Even though the diabetic rationally knows that her metformin is good for her down the road, when she takes it, she feels no different right away. Even though she rationally knows that the Snickers bar is bad for her, it tastes really good right now.

To change behaviors for the better, we must provide the instant and tangible gratification to overcome present bias. In study after study, researchers have demonstrated how financial incentives can be used effectively to motivate and reward healthy behaviors.

These studies have ranged from improved smoking cessation\(^1\^2\) to better medication adherence\(^3\^4\) to more visits to the gym.\(^5\)

**LOSS AVERSION**

Vin Scully, the legendary Dodgers announcer whose career spanned 1950 to 2016, once said, “Losing feels worse than winning feels good.”

People are more motivated to change by the threat of loss than the promise of gain. In one study, overweight individuals were offered an incentive upfront and then lost $1.40 for any day that they didn’t demonstrate 7,000 steps through a fitness tracker. That group produced more than twice the improvement—versus a group that was simply paid $1.40 for every day they achieved 7,000 steps.\(^6\)

At Wellth, we have used similar loss-framed incentives to consistently generate 85 to 90 percent daily adherence to care plans—even when selecting for high-acuity Medicaid populations.

**CHOICE ARCHITECTURE**

The way information is presented and framed drastically impacts the choices that individuals make. Telling a patient, “You have a 95 percent chance of survival” produces very different feelings than saying, “There is a 5 percent chance you die”—even though they are mathematically equivalent.

Behavioral economics combined with user-friendly technology has been shown to produce significant improvements to patient behaviors, like taking medications as directed.
When given a choice, we often go with the default option. For example, in Austria, individuals donate their organs upon death by default, unless they choose to explicitly opt out of being an organ donor. In the U.S., individuals must make the active choice to opt into being an organ donor. In Austria, 90 percent of people donate their organs, while only 15 percent of Americans are so altruistic.

When given too many choices, we can get overwhelmed by the tyranny of choice. I have personally spent countless hours of my life trying to decide with my significant other which takeout place to order from. “We could get Thai.” “Yeah, Thai is good, but I could also really go for a burrito.” “Or, we could be healthier and get sushi.” “But it’s Friday night, let’s live a little and get burgers.” “I had burgers for lunch; let’s get chicken tikka masala and samosas.”

Thirty minutes later, passive-aggressive nondecisions have devolved into outright arguments, as low blood sugar has turned both of us into hangry monsters.

Whether presenting treatment options to patients, creating intake forms, or offering up educational information, always remember: The way in which the information is structured can have a big impact on the choice a patient makes.

The prevailing thought in healthcare is that if we provide access and education to patients, they will make the right choices. And then we are constantly surprised when they don’t show up for appointments, fail to schedule the right screenings, or become nonadherent to therapy.

This lack of patient follow-through isn’t due to laziness, or spite for practitioners who made them wait too long, or because they don’t understand your instructions. The answer is actually very simple: Patients are human, and humans are irrational. But they are irrational in predictable ways. Behavioral economics is the last missing tool in your risk-based toolkit that can help you better understand how to improve patient outcomes.

After all, the concept of risk-based care itself is that payers should create financial incentives to pay providers for better health outcomes. It is crazy that we aren’t extending the exact same incentives to the patients themselves.

Matthew Loper is Co-Founder and CEO of Wellth. The company uses behavioral economics and scalable technology to help patients with chronic conditions improve the daily behaviors that impact morbidity and mortality.

References:
3Kimmel et al. (2008) “A test of financial incentives to improve warfarin adherence.” BMC Health Serv Res. 8:272

Loss-framed incentives generated 89 percent daily adherence to care plans, even when selecting for high-acuity Medicaid populations.
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Making the Leap to Global Risk in Primary Care

BY STUART LEVINE, MD

The dawning of 2019 brought to Akron, Ohio, and Austin, Texas, what residents in Columbus, Ohio, had already experienced: a unique care model for Medicare Advantage patients. This model—enabled by global risk contracts with regional and national health plans—facilitates integrated care led by primary care physicians.

While global risk contracts have thrived for years in pockets of the U.S., including agilon health platform networks in Southern California and Hawaii, the Midwest region has been largely void of such arrangements. Now, forward-thinking physician leaders are beginning to change that.

Integrating payment with care delivery allows physicians to spend more time with patients and work in teams to offer the right care at the right time—enhancing quality and promoting cost-effectiveness. And over 300 Midwestern primary care physicians and 55,000 Medicare Advantage patients couldn’t be more satisfied.

Common to all integrated delivery systems are finely-tuned structural, cultural, clinical, and operational capabilities. When woven together, these capabilities position groups for success by:

- Assuming responsibility for the total cost and quality of care and patient experience for their senior population
- Using a business model that fully aligns the physician’s professional needs of mastery and sense of purpose with the resource requirements for optimal care

This unique model puts patients, families, communities, and primary care physicians at the center of the healthcare system. It emphasizes “hospitalization as failure,” as well as the importance of creating the type of healthcare that has been successful in many America’s Physician Groups members for decades.

In other words, treat everyone like they are your family member, and you are writing the check. Achieve the quadruple aim: higher quality, lower total cost of care, greater patient satisfaction, and a renewed joy of medicine for providers.

A TRANSFORMATIVE PARTNERSHIP

In 2019, Austin Regional Clinic and Premier Physicians, both of Austin, Texas, furthered their commitment to value-based care by entering into global-risk contracts with three Medicare Advantage health plans. Similarly, Pioneer Network Physicians in Akron, Ohio, and Central Ohio Primary Care of Columbus, Ohio, entered into global-risk contracts with four of the preeminent Medicare Advantage health plans in their respective markets.

These leading primary care groups had been operating under shared savings arrangements with varying success. To solidify the future of their practices, the groups’ physician leaders recognized the imperative to enter into a health plan contract that fully aligned payment with care delivery.

“The resources needed to leap into global risk arrangements require a unique set of capabilities.”
Following their lead, other independent physician practices in these markets have engaged in full-risk capitated health plan arrangements, either by joining the groups as employees or shareholders or through an affiliation that allows them to maintain their existing independent practice. As a result, the number of physicians with complete accountability and control over the care of their Medicare Advantage patients has expanded.

How did they transition to global risk? These medical groups all enjoyed market-leading positions, embraced physician leadership, and had organized governance systems and processes, as well as infrastructure designed to succeed in shared savings arrangements. Still, they recognized that the resources needed to leap into global-risk arrangements require a unique set of capabilities, which their organizations did not yet possess.

Specifically, they lacked the ability to invest in new infrastructure and to align physician incentives ahead of outcomes. They also needed sufficient access to capital, as well as the contracting and operational expertise and supporting technology to perform the necessary health plan functions.

By partnering with agilon health, the groups were able to access a platform proven to succeed under global-risk health plan arrangements.

In addition to the importance of structural and cultural alignment, success in global risk also requires a validated clinical model. At agilon health, each market-specific clinical model embraces a data-driven approach to risk stratification of both patients and physicians, as well as an honest assessment of current clinical capabilities and an appraisal of market norms.

The result is a tailor-made prioritization that supports the short- and long-term execution of the highest quality and most cost-effective care.

Following a standardized scoring process to evaluate the group's medical management infrastructure, each delivery system is building the necessary integrated systems of care, with a focus on treating the most chronically ill, frail, and complicated patients. At the center of their efforts is a goal to prevent unnecessary emergency room visits and hospital admissions, as well as improve the hospital discharge process to prevent rehospitalization.

**STORIES OF SUCCESS**

With each medical group, agilon health has brought enabling technology, standardized administrative and clinical operating processes, and human capital. And for each practice, the local market-based teams and physician group partners tailor the execution model to build upon current capabilities and enhance the existing integrated delivery system.

For example, in Austin, care transitions and post-acute management are coordinated through a large geriatric home visit, palliative care, and skilled nursing facility (SNF) practice that has partnered with Austin Regional Clinic and Premier Physicians.

In Columbus, the group's hospitalist department leads efforts to improve emergency department diversion, shorten hospital length of stay, and improve transition of care to back into the community. In addition, it has built an extensivist outpatient clinic to prevent unnecessary hospitalizations.

In Akron, care transition nurses are deployed to the group's primary hospitals, with a narrow network of

**In conjunction with optimized primary & specialty care**

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offer data, education, and support for physicians so that everyone understands the importance of proper documentation of acute and chronic conditions.

The teams focus on:

- Nuances of medicine that improve quality and outcomes
- Differential benefits available to patients enrolling in Medicare Advantage
- The growth of Medicare Advantage panels
- Effective use of preferred specialist providers and ancillary services

PCP scorecards across all metrics are available to ensure data-driven physician engagement. These metrics are also used by the group’s medical leadership to support the physicians who need it most.

The result is a highly engaged practice. Annual surveys of all primary care physicians in these Texas- and Ohio-based medical groups reflect NPS in the mid-60s to mid-80s, highlighting physicians who are extremely satisfied with their work.

Another bellwether for success is industry-leading growth. These engaged physicians are encouraging their patients to attend Medicare education events and to access experts knowledgeable in Medicare coverage. Such efforts are paying off, as patients are beginning to understand how unique supplemental benefits can facilitate more coordinated and efficient care.

ENGAGING PRIMARY CARE PHYSICIANS

Physician engagement across the more than 300 participating primary care physicians is a critical component. Dedicated provider relations teams offer data, education, and support for physicians so that everyone understands the importance of proper documentation of acute and chronic conditions.

The teams focus on:

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The number of Medicare Advantage members serviced by these medical groups in Austin, Columbus, and Akron has grown more than two times the market average.

The physician leaders at Austin Regional Clinic, Central Ohio Primary Care, Premier Physicians, and Pioneer Network Physicians agree that by moving to an operational model that fully integrates payment and care delivery, they are seeing significant improvements across their practices.

They are witnessing strong physician engagement, improved medical management, network management strategies, new sites of care, and robust patient engagement. Most importantly, physicians have found renewed joy in the practice of medicine. This allows them to more fully dedicate themselves to caring for patients, knowing that the new Medicare Advantage program—and their group—will grow and thrive.

At agilon health, our focus is high-quality, cost-effective care that physicians and their support teams can deliver to their communities in perpetuity. One of our guiding principles is to bring the joy back to practicing medicine for primary care physicians. When that occurs, great things follow. ○

Stuart Levine, MD, is Chief Medical & Innovation Officer at agilon health.

Retaining Providers...continued from page 23

to providing patient satisfaction. Organizations now know that high levels of patient satisfaction are critical to long-term success and are driven by a multitude of factors.

Physician interaction with patients is a component of a satisfying patient experience, but it’s not the whole story. In reviewing patient satisfaction scores with new physicians, we often need to provide remedial coaching in time management and patient communication. But the organization also needs to optimize a well-functioning practice environment.

Groups need to listen to both patient and clinician feedback about how office and business practices can be improved to enhance the patient experience. By owning our contribution to patient and physician satisfaction, we can avoid the cognitive dissonance and frustration that leads to deteriorating performance and clinician turnover.

TWO-WAY COMMUNICATION

Once your orientation and initial feedback sessions are complete, your work is still not done. It is critical to provide ongoing, two-way communication with new physicians for at least their first two years with your group.

Their insights into how the group can function better are often very helpful, and allowing them to voice these ideas will help build their relationship with the group. These conversations should include a discussion of physicians’ professional goals and how the group could help them to meet these goals.

Review of new physicians’ performance data should occur at least quarterly for the first two years. In addition, any patient complaints or compliments should be reviewed as soon as they are received with the individuals involved in the care of that patient. In general, face-to-face conversations are more effective than emails or phone calls. If we want our new physicians to care about our patients, we have to show that we care about them.

It may be a cliché, but retaining your new clinicians, building loyalty to your organization, and optimizing their careers, is not rocket science—it’s much harder. It’s about developing strong systems for orientation, evaluation, and coaching, with individualized paths for high-value human resources.

Successful organizations take these efforts seriously and devote considerable time and resources to them. Organizations that do not succeed in this work will chase their tails, inefficiently competing for a limited pool of new clinicians. ○

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Acknowledgment:
The author would like to thank Jack Silversin, principal of Amicus Consulting, for educating many of us about the development and value of physician compacts.
The U.S. healthcare system provides suboptimal outcomes at costs that are double the average of other wealthy nations. The four major drivers of these excess costs are administrative overhead, pharmaceutical pricing, pricing of medical and hospital procedures, and imaging costs.

The first two cost drivers may be beyond the control of physicians. However, we can have influence over the latter two by choosing the most efficient site of service and eliminating low-value care. These last two drivers account for 27 percent of the excess spend in our healthcare system. In fact, studies have suggested that low-value care represents about a third of all healthcare delivered.

The term “low-value care” actually diminishes the significance of the problem. In reality, this care is at best wasted, and at worst, is often harmful. A recent study of Medicare, Medicaid, and commercial claims in Washington state placed the magnitude of low-value care at 44 percent of all care delivered.

The current reimbursement model creates perverse incentives that foster the delivery of such care. To eliminate low-value care, providers and health systems must be willing to move to value-based care and quickly transition to risk-based arrangements—where providers and health systems are responsible for the total cost of care. A necessary element of this transition is an infrastructure that supports this new model.

One existing model is Choosing Wisely, a program from the ABIM Foundation. This is a well-intentioned program that attempts to reduce low-value care, but it only begins to address the magnitude of the problem. For example, this program fails to address many invasive, potentially harmful, and costly interventions that don’t have supporting data of improved health outcomes or quality of life.

These include, but are not limited to: carotid endarterectomy in asymptomatic carotid artery stenosis, the aggressive treatment of low-risk Gleason 6 prostate cancer, the overuse of lumbar spinal fusion, and the overuse of arthroscopy for osteoarthritis of the knee—to name just a few.

To eliminate low-value care, a more robust model is required. The Optimal Care model (Figure 1) has been designed to meet this need.

THE OPTIMAL CARE MODEL

OptumCare is the national, physician-led, ambulatory care delivery system of Optum. The Optimal Care model currently being scaled across OptumCare was conceived from the Bench to Bedside program of New West Physicians.

The fundamental tenet of this program is the rapid transition of high-quality, evidence-based medicine into daily practice. The Bench to Bedside program was previously detailed in the Journal of America’s Physician Groups. Optimal Care takes this program to the next level, incorporating the following enhancements:

Introduction to Optimal Care

Figure 1: The goal is the rigorous elimination of wasted care
1. Creating a cultural transformation at the provider, physician group, and national levels, driven by physician thought leaders across OptumCare.

2. Developing and promulgating an educational foundation for evidence-based medicine, focused on the elimination of low-value care. Here, CME-accredited lectures are created for each specialty area and supplemented by The OptumCare Forum for Evidence-Based Medicine:

   - The Forum takes recent, high-quality studies—whose results should inform daily practice—and distills these into easily deployed recommendations in a CME-accredited periodical.

   - Infographics embedded in electronic health records (EHRs) serve as point-of-care reminders on low-value care metrics.

   - Short clinical briefs and patient-facing handouts support evidence-based conversations with patients.

Historically, the delay from the publication of high-quality research to practice implementation is five to 10 years. The Optimal Care model is designed to reduce this to 12 weeks.

3. Embedding point-of-care technology in the EHR, so it is available to the patient and primary care provider at the time of the encounter. These tools include straightforward algorithms focused on the delivery of optimal care (Figure 2).

   The tools also stratify specialist physicians by clinical outcomes and quality metrics, total cost of care per procedure or diagnosis, and proximity to the patient. They further identify the most efficient site of service for any test or procedure. Used in concert, these tools minimize low-value care and reduce total cost of care.

4. Transparently reporting quality and utilization metrics for both primary care and specialty providers. The primary care metric compares performance at a provider and medical group level (Figure 3). It looks at utilization of low-value tests and procedures, stratified against the performance of the provider’s peers, other medical groups, and national OptumCare benchmarks.

   The specialty reports look at both individual specialist and practice-level metrics focused on quality, total cost of care, and optimal site of service—again, stratified against peer physicians and national benchmarks. The reports highlight specialists’ utilization of low-value care measures. Regular meetings are conducted to share and analyze the data, focused on highlighting best practices to support both primary care providers and specialists in their efforts to reduce unnecessary care and improve patient outcomes.

OVERCOMING BARRIERS AND EDUCATING PATIENTS

The implementation of Optimal Care comes with several challenges:

- Cultural transformation is a difficult process and requires a history of trust and success at prior initiatives. It will not succeed if it is the “initiative of the month.”

- Provider engagement around evidence-based medicine can face barriers. Evidence-based medicine will sometimes be in conflict with community standards and patient expectations, and will often be in conflict with revenue generation in a fee-for-service model. This is particularly true for
those providers who are still largely practicing in a fee-for-service model and are just beginning to venture into value-based care.

- Accurate comparative reporting requires sophisticated healthcare economic analytics, which need to be consistently applied across often-disparate practice models and markets.
- New tests and procedures need to be vetted with respect to improvements in health outcomes and cost effectiveness, using established benchmarks such as quality adjusted life years (QALY) and number needed to treat (NNT).

Despite these challenges, the above model has been demonstrated to improve healthcare outcomes while reducing total cost of care. To achieve even greater success around the elimination of low-value care, alignment needs to occur across multiple stakeholders—including, most importantly, our patients, so they are in lockstep with providers, health systems, and health plans.

Aligning patients around Optimal Care requires a patient-focused educational initiative supported by robust shared decision-making (SDM) tools, which can be deployed at the point of care. Although these tools exist, they are not yet fully developed to ideally serve this functionality. This important enhancement is in development.

In addition, most health plan benefit designs are not specifically oriented to align incentives around decreasing total cost of care. For example, lower patient coinsurance (or rebates) for optimal care decisions would serve to better align patients and providers around the choice of high-performing specialists and the most efficient sites of service.

Lastly, health systems need to be willing to shift tests and procedures to the least expensive site of service, with equivalent outcomes and patient safety. More innovative benefit designs are beginning to move to reference-based pricing and service line capitation—both of which will force providers and health systems to focus on lowering total cost of care. The Optimal Care model supports providers on this journey.

The reality is that our government does not have a track record of successfully controlling rising healthcare costs. Our patients and employers cannot afford our current healthcare system, and they deserve a system that delivers better outcomes.

The tipping point is upon us. The solution relies to a large extent on the willingness of providers and health systems to eliminate low-value care. As this occurs, the magnitude of reduction in total cost of care will be large enough to reverse the trend of continually rising healthcare costs.

Kenneth Cohen, MD, FACP, is a practicing internist who serves as Chief Medical Officer for New West Physicians and Senior Medical Director for OptumCare. He serves on the Board of Directors of America's Physician Groups.

PCP Optimal Care Performance Report

Figure 3: All Data Transparently Shared

Kenneth Cohen, MD, FACP, is a practicing internist who serves as Chief Medical Officer for New West Physicians and Senior Medical Director for OptumCare. He serves on the Board of Directors of America's Physician Groups.
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