AMERICA’S PHYSICIAN GROUPS

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When medically complex patients require hospital care, they tend to experience longer recovery times than other patients do and are more likely to readmit to the ICU. Contributors to total cost of care such as these can be mitigated by enhanced care coordination.

**Internal coordination can reduce setbacks**

One strategy for combatting patient setbacks is to break down clinical silos within a care setting and increase coordination across various hospital departments.

Medically complex patients with multiple comorbidities often require care from a team of specialists. As more caregivers become involved in the patient’s treatment, there is an increased risk of miscommunication and adverse events.

However, when physicians and other medical professionals collaborate as an interdisciplinary care team, they are able to more effectively treat their patients.

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**External coordination can improve access to appropriate level of care**

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1. **Overcoming barriers to discharge:** In some cases, patients may clinically be ready to discharge to a lower level of care, but are unable to do so as a result of constraints at the subsequent care setting. Providers and payers can work together to remove these barriers.

2. **Aligning medical necessity and the care setting:** Medically complex patients may benefit from remaining in a more specialized care setting. Clear communication between all entities leads to a better understanding of the patients’ clinical needs and ensures that patients have access to the care they require, thereby reducing readmissions in the long run.

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**References**

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7392362/
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From the President

Keeping APG’s Members Up to Date on Value-Based Healthcare

BY SUSAN DENTZER, PRESIDENT AND CEO, AMERICA’S PHYSICIAN GROUPS

The publication of this issue of the APG Journal coincides with our organization’s latest strategic “refresh,” in which we’ve examined how we can best serve our membership in advancing the cause of value-based healthcare. To that end, we’ve applied the famous “dead sleep test” in our deliberations: Namely, if all of us within the organization were awakened out of a dead sleep, could we instantly and succinctly state our strategic goals?

Human cognition being what it is, the dead sleep test inevitably drives the framing of strategy in simple and memorable terms. We thus devised two strategic pillars for APG: First, that we will drive, shape, influence, and lead the national transformation to coordinated, accountable, value-based healthcare; and second, that we will be physician groups’ single best source on the details of value-based care—the equivalent, in our very different domain, of Wolters Kluwer’s widely used clinical decision-support service, UpToDate.

We hardly know any practicing physician who doesn’t consult UpToDate multiple times daily to stay abreast of the latest clinical guidance on just about every condition imaginable. We know that we at APG will truly provide value for our members and partners if we can be a similar up-to-date, go-to source on value-based care.

Although our field may be less complex than management of the entire human body, it, too, is constantly evolving. For example, the article in this issue of the Journal by APG’s own Garrett Eberhardt on the newly proposed Medicare physician fee schedule discusses dozens of prospective changes in value-based care models, including many designed to boost the fortunes of the Medicare Shared Savings Program, the original accountable care organization structure embedded in the Affordable Care Act.

Unlike the real UpToDate, we at APG may not be able to create and house a single vast database on all aspects of value-based care. But we can supply our members with the knowledge that they need about these evolving care models, and draw on our close connections with those in government and industry who are shaping these approaches to get timely answers to our members’ most pressing questions and concerns.

This issue of the Journal also strikes similar themes about the importance of staying up to date in other aspects of healthcare. Richard E. Hawkins’s editorial about the new certification standards adopted by the 24 member boards of the American Board of Medical Specialties (ABMS) is a case in point. (Full disclosure: I formerly served as a public member of the board of ABMS, an organization whose work I continue to support and admire.)

As Dr. Hawkins, ABMS’s President and Chief Executive Officer, notes, “Patients expect their physicians to stay up to date with advances in their specialty and to participate in ongoing assessment and learning.” The new ABMS certification standards are also up to date, as they reflect the specialty boards’ collective transition away from the dreaded high-stakes 10-year exams that physicians traditionally have had to take to maintain board certification.
Increasingly taking the place of these exams are so-called longitudinal assessments—periodic educational sessions, quizzes, and other means of promoting ongoing learning and retention that have a strong evidence base behind them. A prime example is the American Board of Anesthesiology’s MOCA (Maintenance of Certification in Anesthesiology) Minute—a series of 120 multiple-choice, “single best answer” questions that diplomates must take one minute each to answer over the course of the year. They learn immediately if their responses are correct, followed by an explanation of the rationale behind the question, along with associated references.

It takes multiple approaches such as these to keep the House of Medicine up to date and enhance knowledge across the expanding healthcare enterprise. In another article in this edition, Susan E. Hahn of Quest Diagnostics, an APG associate partner, describes the relatively recent explosion of genetic testing, which has produced anywhere from roughly 75,000 to more than 165,000 different types of genetic tests. Meanwhile, as many as 3.5% to 5.9% of all individuals have a genetic variant associated with “significant health implications.”

The bottom line appears to be that clinicians of all sorts will encounter patients who fit this description and can benefit from tests used for multiple purposes, ranging from pharmacogenomic management to cancer care. But because many tests haven’t been validated—and some lab-developed tests are downright fraudulent—Ms. Hahn helpfully lists a range of reputable sources that can help non-geneticists ensure that they are “appropriately and efficiently using genetic testing.”

The extended APG family of members, partners, and sponsors offers extensive navigational support like this to assist in the journey to value-based care. We are all committed to sharing our knowledge and expertise to drive the transformation of healthcare. But as former Israeli Prime Minister David Ben-Gurion once said, “It’s not enough to be up to date; you have to be up to tomorrow.” May it be a future in which all have a fair and just opportunity to be healthy—and have broad access to the value-based care provided by the best of APG.

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FEDERAL POLICY COMMITTEE
October 31, 2022
HEALTH EQUITY AND SOCIAL JUSTICE FORUM
November 2, 2022

CONTRACTS FORUM
November 10, 2022
RISK EVOLUTION TASK FORCE
December 8, 2022

For the 2023 Meetings & Events schedule, visit APG.org.
Increasing Mobility in Older Adults
Reduce Falls while Improving STAR Measures

AN INTERVIEW WITH STEVEN CASTLE, MD, PROFESSOR GERIATRIC MEDICINE, UCLA, CLINICAL DIRECTOR OF GERIATRICS, VA GREATER LOS ANGELES

Mobility and fall prevention are important topics for older adults. Physical changes, health conditions, and sometimes medications used to treat those conditions, make falls more likely as we age. In fact, falls are a leading cause of injury among older adults.

Professor Steven Castle, MD, answered questions on this important topic as enhancing member experience and chronically low fall prevention measure scores are pressing needs.

HOW COMMON ARE FALLS IN OLDER ADULTS?

More than 1 in 4 older adults (over the age of 65) fall each year resulting in considerable morbidity in older adults.

Falling 1 time doubles the chances of falling again. 1 in 5 falls cause serious injury such as broken bones or head trauma.

The good news is falls can be reduced by increasing strength, balance, and mobility.

WHAT CAN BE DONE TO PREVENT FALLS IN OLDER ADULTS?

Multifactorial prevention strategies, targeted at known risk factors, have been shown to reduce the rate of falling by 30% in several randomized-controlled trials.

Risk screening and physical activity have been proven to reduce fall injuries. Regardless of age group, more older adults who reported no physical activity or difficulty with stairs, dressing or bathing had falls and related injuries.

Despite existing evidence and recommendations, the identification and management of elderly patients at high risk for falls remains largely neglected in clinical practice.

HOW DO YOU SEE PHYSICIANS’ ROLE IN PREVENTING FALLS?

Most older adults, as well as providers in primary care, view falls as ‘an accident,’ implying nothing needs to be or can be done. ‘Be more careful’ is often the response if falls are even discussed.

Instead, a more structured history and physical exam that looks at the components of balance and mobility enables engagement of the older adult to gain awareness of how their balance is not like when they were in their 40’s and allows the discussion of addressing modifiable factors. Framing the discussion about what matters to them with regards to their mobility should be the focus to support engagement.

HOW CAN A PROACTIVE APPROACH BENEFIT PHYSICIAN GROUPS?

With value-based healthcare cost, quality and satisfaction are all important. As an example, member experience is about 30% weighting for STAR measures.

Many physician groups have limited resources but starting with the basics is a good first step. The CDC has free resources. In addition, customizable programs such as Altura’s UpRight™ Fall Prevention program, can provide integrated solutions for physician groups.


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Federal Policy Update

Key Changes in the 2023 Physician Fee Schedule

BY GARRETT EBERHARDT, EXECUTIVE DIRECTOR OF MEDICAID POLICY, AMERICA'S PHYSICIAN GROUPS

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) released its 2023 Physician Fee Schedule proposed rule. The rule covers physician services paid under the Medicare program and furnished in a variety of settings, including physicians’ offices, hospitals, ambulatory surgical centers (ASCs), skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries’ homes.

According to CMS, the proposed fee schedule is designed to reflect the Biden administration’s broader strategy to create a more equitable healthcare system that results in better accessibility, quality, affordability, and innovation. If the final rule is adopted as is, it will also make important changes to various programs that affect APG members. Below is a look at the key changes.

MEDICARE SHARED SAVINGS PROGRAM

Advance Investment Payments

To encourage more new entrants into the ACO program, CMS has proposed a new system of advance investment payments (AIPs) for eligible ACOs that are new to the Medicare Shared Savings Program (MSSP) and identified as being “low revenue” (defined as an ACO whose total Medicare Parts A and B fee-for-service revenue of its ACO participants, for both beneficiaries assigned to the ACO as well as participants’ unassigned Medicare beneficiaries, is less than 35% of the total Medicare Parts A and B fee-for-service expenditures for the ACO’s assigned beneficiaries) and inexperienced with performance-based risk Medicare ACO initiatives.

These new ACOs may receive both a one-time fixed payment of $250,000, as well as quarterly payments for the first two years of the five-year agreement period. (According to the proposed rule, the quarterly payments would be "based on a risk factors-based score set to 100 if the beneficiary is dually eligible for Medicare and Medicaid or set to the Area Deprivation Index national percentile rank [an integer between 1 and 100] of the census block group in which the beneficiary resides if the beneficiary is not dually eligible, with higher payment amounts for assigned beneficiaries with a higher risk factors-based score.") ACOs must use the advance investment payments to improve healthcare provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries, including addressing social needs.

Payments would be capped at 10,000 assigned beneficiaries and would be recouped once the ACO begins to achieve shared savings in its current and next agreement period. If the ACO doesn’t achieve shared savings, CMS would not recoup the funding, except if the ACO terminates during the agreement period in which it received these payments.

ACOs would also publicly report on their websites the amount of any advance investment payments and the actual amount spent in each of the spend plan categories. The initial application cycle to apply for advance investment payments will occur during calendar year 2023, for a Jan. 1, 2024, start date.
**Smoothing the Transition to Risk**

CMS also proposed changes to allow ACOs to transition more gradually to accepting risk for shared losses. The changes would allow ACOs inexperience with performance-based risk to participate in one five-year agreement under a one-sided model, in which ACOs only share any Medicare savings with the government and do not bear any losses.

Specifically, ACOs could enter the BASIC track's glide path and remain in Level A, the first level, for all five years. These ACOs may be eligible for a second agreement period in the BASIC track's glide path—with two additional years under a one-sided model—for a total of seven years before transitioning to two-sided risk.

For performance years beginning Jan. 1, 2023, and in subsequent years, the proposal would allow ACOs currently participating in Level A or B the option to continue in their current level of the BASIC track glide path for the remainder of their agreement.

**Updating ACO Benchmarks**

Currently, CMS measures the performance of ACOs by evaluating expenditures against a benchmark of their historical costs. In the proposed rule, according to the agency’s website, CMS proposes modifications to its benchmarking methodology “to strengthen financial incentives for long-term participation by reducing the impact of ACOs’ performance on their benchmarks, to address the impact of ACO market penetration on regional expenditures used to adjust and update benchmarks, and to support the business case for ACOs serving high-risk and high dually eligible populations to participate, which will help sustain participation and grow the program.” The goal is to embrace “more long-term benchmarking concepts that would move toward the use of administratively set benchmarks in order to grow and sustain long term program participation.”

Thus, CMS proposes to incorporate a prospectively projected administrative growth factor into its process for calculating the historical benchmark for ACOs. This growth factor is called the Accountable Care Prospective Trend, or ACPT, and is a variant of the United States Per Capita Cost (USPCC). The ACPT would be projected by the CMS Office of the Actuary and would be a modification of the existing fee-for-service (FFS) USPCC growth trend projections already used for establishing Medicare Advantage rates. The ACPT would be set for the ACO’s entire five-year agreement period.

A “guardrail” would protect ACOs from larger shared losses, or potentially from the negative implications of financial monitoring, in which CMS assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers. The guardrail would be based on an updated benchmark computed using a proposed blend of the ACPT weighted average and existing national and regional expenditure growth rates, and would not apply to any shared savings calculation. CMS would also have the flexibility to reduce the impact of the ACPT portion of the three-way blend if unforeseen circumstances occurred during an ACO’s agreement period, such as a natural disaster, epidemiological event, legislative change, and/or other similarly unforeseen circumstances during the performance year that produce drastic differences between actual and projected expenditure trends.

**Negative Regional Adjustments**

As an analysis by the law firm Baker Donelson notes, ACOs “have expressed concerns about the dynamic under which an ACO that reduces costs for its own assigned beneficiaries also reduces its average regional costs, resulting in a relatively lower benchmark for the ACO under the blended national-regional growth rates used to track trends and update the ACO’s historical benchmark.”

As a result, CMS aims to reduce the impact of potentially negative regional adjustments. In Benchmark Year Three, CMS would lower the cap on negative regional adjustments from negative 5% of national per capita expenditures for Parts A and B services under the original Medicare FFS program to negative 1.5%.

After the cap is applied, CMS would gradually decrease the negative regional adjustment amount as an ACO’s proportion of dual-eligible Medicare and Medicaid beneficiaries increases or its weighted-average prospective Hierarchical Condition Coding (HCC) risk score increases. CMS would use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared with their regional service area.

**Helping Smaller ACOs Share in Savings**

CMS would expand the eligibility criteria for shared savings for agreement periods beginning Jan. 1, 2024. In subsequent years, it would allow certain low-revenue ACOs in the BASIC track to share in savings—even if the ACO does not meet the minimum savings rate (MSR) requirement.

Eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate would receive half of that rate for their level of participation (20% instead of 40% under Levels A and B, and 25% instead of 50% under Levels C, D, and E).

For eligible ACOs that do not meet that quality performance standard—but meet the proposed alternative quality performance standard—the sharing rate would be further adjusted according to a sliding scale.

*continued on next page*
Health Equity Adjustment

The proposed rule would implement a health equity adjustment of up to 10 bonus points to an ACO’s Merit-based Incentive Payment System (MIPS) quality performance category score when reporting all-payer electronic clinical quality measures and MIPS clinical quality measures. This adjustment would be based on high performance on quality measures, as well as provision of care for a higher proportion of underserved or dual-eligible beneficiaries.

To assess underserved populations, the adjustment would use the Area Deprivation Index score and Medicare and Medicaid dual-eligible status. Doing so would capture broader neighborhood level and individual beneficiary characteristics.

The bonus points would be added to the ACO’s MIPS quality performance category score if the ACO scores in the top third or middle third of performance for each measure.

QUALITY PAYMENT PROGRAM

CMS plans to continue streamlining and strengthening quality measure and improvement activities inventories by removing duplicative and topped out measures, as well as those with limited adoption.

It would permanently establish the 8% minimum Generally Applicable Nominal Risk standard for advanced alternative payment models (APMs), which is currently set to expire in 2024. It would also apply the 50 eligible clinician limit to APM entities participating in the Medical Home Model.

In addition, the agency included several requests for information in the following areas:

• How stakeholders would like CMS to respond to the transition from the 5% lump sum APM incentive payment awarded to qualifying APM participants in payment years 2019-2024 to the 0.75% conversion factor update in payment years 2026 onward
• Developing and implementing health equity measures for the quality performance category
• CMS’ proposed change in how qualifying APM participant determinations are made—which would move to the individual level rather than the current APM entity level—as well as how CMS can best encourage specialists in advanced APMs to participate in performance measurement

SPLIT (OR SHARED) E/M VISITS

For split (or shared) evaluation and management (E/M) visits, in which a physician and a qualified non-physician practitioner each perform a substantive portion of an E/M visit with the same patient, CMS proposed a one-year delay of its plan to define “substantive portion” as more than half of the total time spent by the billing practitioner.

TELEHEALTH SERVICES

CMS proposed extending the time that services are temporarily included on the telehealth services list during the public health emergency (PHE)—but are not included on a Category I, II, or III basis for 151 days following the end of the PHE.

By implementing the telehealth provisions in the 2022 Consolidated Appropriations Act, the agency will extend certain flexibilities for 151 days after the PHE ends. These measures would include the following:

• Allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary’s home
• Allowing certain services to be provided via audio only
• Allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide telehealth services

The proposed rule also delays the in-person visit requirements for mental health services provided via telehealth until 152 days after the PHE ends.

APG’S COMMENTS

The 60-day comment period for the proposed rule closed on Sept. 6, 2022. In its comment letter, APG shared its support for several CMS proposed policy changes to the MSSP Program, including adjusting ACO benchmarks to account for prior savings; expanding opportunities for low-revenue ACOs to share in savings; establishing a sliding scale for determining shared savings and losses; and reducing the impact of the negative regional adjustment.

APG recommended that CMS continue to test alternatives for how it gauges an area’s overall socioeconomic status in place of the Area Deprivation Index. APG encouraged CMS to expand the types of ACOs that are eligible for advance investment payments so that they include those in the enhanced tracks or those with specific health equity initiatives underway. In addition, APG recommended that CMS update the historical benchmarks by incorporating a prospective, external growth rate factor with policies designed to protect against unintended negative consequences. APG also recommended that CMS extend telehealth flexibilities past the COVID-19 public health emergency.

Reference:

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In June 2022, California enacted an omnibus budget law (AB 184) that included authorization for a new Office of Health Care Affordability (OHCA). Similar to efforts by other states, OHCA creates a strategic oversight body to collect healthcare payments data and analyze and direct the cost trend—relative to state domestic product and the worker wage index—through the setting of cost growth targets.

**WHAT ARE COST GROWTH TARGETS?**

A cost growth target is a per-annum rate-of-growth target for healthcare costs for a given state. This per-annum rate of growth considers the overall costs of the entire healthcare system expenditures within the state, relative to its total state domestic product. It can also be set relative to the rate of growth in national healthcare spending or the national gross domestic product (GDP).

Massachusetts, for example, compares its statewide cost growth target against a national GDP benchmark and per capita GDP growth, as well as average hourly wage growth.

Proponents assert that a cost growth target is an anchor. The anchor creates an expectation from which to create transparency within the market. Proponents argue that to be effective, the target must be complemented by other supporting strategies.

But statewide targets are just the start. California’s legislature has also left room for OHCA to establish regional, sectoral, and even entity-specific growth targets. OHCA’s oversight model depends on a statewide Health Care Payments Database run by the same department that houses OHCA. The database will provide information on healthcare spend by payers and providers across most of the market, except for physicians organized with 24 or less doctors.

**WHAT’S DRIVING THIS?**

As of late 2021, Connecticut, Delaware, Maryland, Massachusetts, Oregon, Rhode Island, and Washington had established growth targets. After passage of AB 184, California has now joined this group. Nevada and New Jersey have also adopted plans to develop growth targets.

The urgency to pass mandated cost oversight programs has been driven by significant problems within each of these states. In Massachusetts, healthcare costs rose 40% over 12 years, while spending on other services decreased by 17%. Oregon health insurance premiums equal 20% of a family’s total income. And Delaware’s per capita total health spending was the third highest nationwide.

**HOW ARE TARGETS IMPLEMENTED?**

Most state cost growth targets have ranged from 3% to 3.5%, typically in line with projected state domestic product growth. Most states have followed a common approach to developing and adopting these targets, as follows:

- Engage stakeholders in an advisory role
- Develop a cost growth target methodology
- Build capacity to analyze cost growth drivers and spending growth
- Use data to drive action

California followed this pattern over the past three years through a voluntary stakeholder collaborative effort to discuss and agree on a viable approach, using an independent convener called Convergence. This process yielded a report submitted to the legislature and Governor Gavin Newsom. APG participated in this effort.

The state also convened a formal panel to analyze and recommend a pathway toward a universal health coverage system, known as the Healthy California for All Commission. During this effort, APG’s risk-bearing members supplied...
data and experience on value-based provider payment models to the University of California Berkeley School of Public Health.

Early in this process, APG advocated for a broad, level playing field for applying cost growth targets to the entire market—similar to what Massachusetts did. Our efforts resulted in two broad outcomes:

1. First, OHCA prioritizes and requires a transition away from fee-for-service provider payment and toward value-based models.
2. Second, a broad swath of the physician market—in practices consisting of 25 doctors or more—will be included in the cost growth target oversight process. This approach ensures a more level playing field of shared responsibility among all provider types than would have been the case if proposals to exempt many medical groups had become part of the law.

Oregon, Massachusetts, and California have now passed legislation establishing a progressive enforcement strategy to achieve cost growth targets. Outlier payers and providers are identified and subject to performance improvement directives. Increasingly, states are adopting tougher measures, including financial penalties for noncompliance.

**THE MASSACHUSETTS EXPERIENCE**

The earliest adopter of state cost growth targets was the Commonwealth of Massachusetts, which in 2012 established an independent state agency, the Health Policy Commission, to lead the effort. Over the past decade, the state has managed to keep healthcare cost growth 0.6% lower than the comparable national average. Employing transparency as a key tool, Massachusetts used comparative data to highlight variations in the total cost of care among different providers. This process resulted in negotiations between health plan payers and providers that limited contract rate growth within the overall set targets.

The state’s approach featured four key elements:

1. **Common goal.** Payers and providers have aligned on a common target for reducing healthcare cost growth.

   **NEXT STEPS FOR CALIFORNIA**

   California will begin implementing its OHCA program in 2024 through a benchmarking of costs and increasing the accumulation of relevant data and information to set targets across its market. It will establish a formal Board to recommend policy to the Director of OHCA and will create an advisory committee of stakeholders that includes providers and payers subject to the oversight.

   As guardrails are set at increasingly more specific levels—from statewide to regional, to sectoral and even provider-specific—outliers will be addressed. It is widely expected that additional legislation will be enacted in the 2023 legislative session to clarify and detail further steps on the development of measurement standards.

   Since APG advocates that providers assume responsibility for the total cost of care, our work will continue and expand in Sacramento over the next few years as the law creating OHCA is implemented.

   **IT’S ALL RELATIVE**

   Some stakeholders have complained that growth targets are merely intended to function as revenue caps on specific providers, such as those with high costs and considerable market power. But it’s important to recall that, from the standpoint of California’s APG member groups, things could have been worse. A rival legislative attempt this year to create a single-payer system in the state would have outlawed risk-bearing provider groups in the delegated model as it exists today in California. Physicians continuing in independent practice would have had little choice but to be paid under a state-mandated fee-for-service schedule.

   Thus, from a “least worst” alternative standpoint, OHCA may turn out to have much to commend it—but there will be much work ahead during the implementation phase.

   **Credits:** This article is based on an Oct. 5, 2021, presentation by Bailit Health to the California Health Care Coalition.
ON THE COVER

Member Spotlight

Partnering With Home-Based Primary Care to Succeed in Global Risk

BY FRANKE P. ELLIOTT

Bloom Healthcare is an industry-leading provider of comprehensive home-based primary care and hospice services, based in Denver, Colorado. Bloom deploys a model of care specifically designed to serve medically complex patients who are homebound or home-limited. In so doing, Bloom Healthcare enhances the quality of life and well-being of our patients and their caregivers by providing high-quality healthcare in the home or in senior housing, such as an assisted living facility.

This article offers more information about the Bloom Healthcare model, and how it is specifically designed to support value-based healthcare—particularly the types of delegated arrangements under Medicare Advantage in which many APG member groups operate.

CHARACTERISTICS OF THE HOMEBOUND ELDERLY

Accessing routine primary care in a traditional doctor’s office is problematic for a large and increasing number of seniors with multiple chronic conditions, cognitive impairment, and functional decline, who live in the community but are homebound, defined as rarely or never leaving home. Nearly half of community-dwelling older adults are homebound in the year before death.1

According to a study published in JAMA Internal Medicine, among 35 million previously non-homebound community-dwelling Medicare beneficiaries, 4.5 million (12.7%) became homebound over a seven-year period, while another 1.2 million (3.4%) moved to a nursing home.2

Many of these individuals are among the highest-spending enrollees in the Medicare program. They are often older than the average Medicare beneficiary and in worse health; what’s more, a significant portion of their healthcare expenditures are persistent. However, the vast majority of persons in this category are not within their last year of life. These individuals are not actively dying, but they are at a point in their healthcare journey where they want to increase the quality—not quantity—of the healthcare services they receive to optimize the quality of their remaining life.

In addition, people who are homebound have many social needs on top of their medical needs. As a result of factors such as financial and social vulnerability, functional impairment, dementia, and multiple chronic conditions, they have complex care needs that are hard to meet in an office setting. This reality can be particularly problematic for medical groups and IPAs in shared risk or fully capitated global risk contracts. It is difficult to see or engage homebound individuals in a clinic-based setting frequently enough to effectively manage their multiple conditions and associated care needs.

BUILT FOR VALUE-BASED CARE

Unlike doctors of yesteryear who made house calls, today’s home-based primary care service providers catering to these populations must be more than independent practitioners providing episodic care, equipped with the proverbial black bag filled with bandages and a stethoscope. Rather, serving medically complex homebound patients requires a high-functioning, collaborative, team-based approach, in which patient-facing primary care practitioners are supported by a robust interdisciplinary care team that works in an organized and coordinated manner.

Members of that team include administrative coordinators, nurse clinical coordinators, social workers, pharmacists, behavioral health specialists, and complex case managers, who provide care in accordance with a comprehensive and personalized care plan developed with patients and their families. In turn, team members are supported by technology, data, and analytics that provide actionable information—allowing them to move from a reactive approach to proactive insights and interventions.

To optimize success, financially and operationally, these home-based primary care teams are best deployed in full risk, value-based payment models, in which financial incentives continued on page 37
**Patient Activation That Drives Performance**

**Partner with an Expert:**

Altura coordinates with physician groups to provide a flexible, patient-driven engagement team that drive results. We are multilingual and cultural competence certified for diverse populations.

Whether serving as a strike force for special projects or continuously supporting on-going initiatives, Altura alleviates the staffing concerns related to availability or skill level that most physician groups encounter.

**Patient Engagement Areas Include:**

- **Star/Quality Initiatives**
  - Colorectal cancer screening
  - Breast cancer screening
  - Diabetes screening
  - Others as needed

- **Prevention and cost-containment programs**
  - Preventing avoidable ED visits for high-risk, high-need patients (e.g. COPD, CHF)
  - Fall prevention (UpRight program)

- **Custom Programs**
  - New member welcome and assessments
  - Wellness and home care utilization
  - Research participation and other custom projects

**KEY OUTCOMES:**

- Increase Quality Score - Decrease Costs
- Enhance Revenue – Increase Patient Satisfaction

**“I stumbled often and worried about falling, but now I have the knowledge and support to improve my strength and balance to avoid a fall.”**

- Fall Prevention Patient

**“Staff levels and/or skill are always an issue and partnering with Altura helps address our patient engagement needs.”**

- VP Quality Management

**“Altura’s integration with our clinical team enables us to effectively engage our patients across many initiatives.”**

- Marc Hoffing MD
  Medical Director
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“Patient-driven technology that drives timely interventions”

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New Continuing Certification Standards Reflect Fundamental Changes

BY RICHARD E. HAWKINS, MD

Board certification by one of the 24 member boards that comprise the American Board of Medical Specialties (ABMS) represents a physician’s or medical specialist’s advanced knowledge, training, and skills in a particular area of medicine. It is a program of rigorous, continuous professional assessment and development that begins with initial certification after completing residency training and is sustained through continuing certification—an ongoing process in which board-certified physicians (diplomates) demonstrate their lifelong commitment to professional growth and excellence.

Numerous research studies demonstrate that diplomates of ABMS member boards practice safer, higher-quality medicine and have fewer disciplinary actions by state medical licensing boards than physicians who are not board certified. Physician participation in continuing certification is linked to improved care for patients with asthma, diabetes, and hypertension—all chronic conditions that have a significant impact on health and well-being in this country. It is also associated with improved care for children and the elderly.

In October 2021, the ABMS Board of Directors approved the new Standards for Continuing Certification (Standards) to be effective Jan. 1, 2024. The board’s approval followed three years of consultation with physicians, professional and state medical societies, consumers, and other public stakeholders from across the healthcare spectrum to reconceive the way specialty physician recertification is conducted.

The new Standards also reflect the recommendations from the Continuing Board Certification: Vision for the Future Commission, an independent commission that met throughout 2018 to provide strategic guidance to the ABMS Board of Directors and member boards.

This approval serves as a pivotal moment for ABMS, our member boards, and the greater healthcare community because it enables ABMS to deliver on its mission in two fundamental ways that closely align with the tagline of America’s Physicians Groups: “Taking responsibility for America’s health.”

**INNOVATIVE ASSESSMENT MODELS**

The first way relates to the recognition that ABMS and our member boards can bring value to board-certified physicians. The innovative assessment models endorsed by the Standards support and direct learning and complement the continuing education all physicians undertake to improve their knowledge and skills.

The transition to longitudinal assessments—away from high-stakes 10-year exams—will enable the boards to better balance formative and summative approaches. Moreover, the longitudinal assessment model is founded on strong evidence to promote learning and retention.
IMPROVING HEALTH AND HEALTHCARE

The second way is equally important: Board certification continues to provide the public with a credential that it can rely and depend on. Patients expect their physicians to stay up to date with advances in their specialty and to participate in ongoing assessment and learning. The Standards support physicians in demonstrating their commitment to doing so and to engaging in activities that improve the quality of care they deliver.

The Standards also support greater opportunities for physicians to participate in relevant activities that improve health and healthcare, including recognizing quality and safety improvement activities in which they are already engaged. In doing so, the Standards stress the importance of focusing on such issues as improving health and healthcare in the communities that diplomates serve, addressing healthcare disparities, and increasing health equity.

COLLABORATING WITH STAKEHOLDERS

In support of implementing the new Standards, the boards will collaborate with their professional societies and other stakeholders to enhance the practice improvement infrastructure and reduce impediments to engaging in meaningful improvement work. These innovative assessment models—combined with the "wide door" approach to approving improvement activities and a focus on improving health and healthcare—enhance the relevance of board certification to practicing physicians.

In addition, the new Standards acknowledge that effective professional self-regulation requires the involvement of our partners. Among them are specialty and state medical societies, hospitals and health systems (including academic medical centers), physician groups, continuing medical education organizations, and our Associate Members.

Each of these stakeholders offers continuing professional development opportunities, and therefore has an important role in supporting its members' engagement in meaningful learning and improvement work. ABMS remains committed to seeking opportunities to work with stakeholders, such as APG, to promote physician accountability.

Many member boards have already begun to make substantial changes to their continuing certification programs to align with the Standards and address the Commission's recommendations. Examples of these programmatic changes are highlighted in the Winter 2021 issue of ABMS Insights and represent our commitment to improve and evolve the continuing certification process.

A FRAMEWORK FOR CONTINUING CERTIFICATION

The Standards reinforce the core value of board certification for all stakeholders, most notably diplomates and their patients. They also speak clearly to our intention to continue engaging with others to modify and adjust our programs as needed to maintain the integrity of the credential for those who carry it and those who use it.

Like APG, which has built a framework that enables their physicians to provide the highest quality of care for patients, ABMS believes that the new Standards provide a framework for member boards to design certification programs that maintain the social contract between the medical profession and the public to improve the quality, safety, and value of healthcare.

ABMS board certification tells a story about a diplomate's knowledge, judgment, skills, and commitment to professionalism. The new Standards will help support diplomates and the ABMS community in meeting our promise of providing better care through higher standards.

Richard E. Hawkins, MD, is President and Chief Executive Officer of the American Board of Medical Specialties (ABMS). You can learn more about ABMS at ABMS.org, or follow the organization on Twitter at @ABMSCert.

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Employed and affiliated practices in your health system may not look the same, but that doesn’t mean they should perform differently.

By aligning incentive structures and offering user-friendly technology and support that fits into any existing workflow, you can empower your affiliate network to drive value-based care performance.
Technologies to Reduce Avoidable Readmissions and Lower Costs

BY PHYLLIS WOJTUSIK, RN

Hospital discharges to post-acute care (PAC) facilities have rapidly increased, resulting in more hospital readmissions and increased costs of care. One in four patients discharged from an acute care hospital to a skilled nursing facility (SNF) is readmitted within 30 days.

Readmissions’ financial costs are substantial; what’s more, readmissions are often preventable and may put patients at unnecessary risk of poor outcomes. To improve care and curb costs, it’s crucial to enhance care coordination efforts by sharing actionable data across differing systems—including between hospitals and PAC providers. With this information in hand, it’s possible to create a far better experience for patients across the continuum of care.

Technology and information are essential to this process. For example, admission-transfer-discharge (ADT) systems can track patients from their arrival at a hospital until they depart it, whether by transfer to another facility, discharge, or death. But tracking patients’ progress through the system isn’t enough; it’s also critical to know patients’ conditions at any time, to afford opportunities to intervene effectively in care. Risk-bearing providers need the connectivity, tools, and resources to help them analyze what’s happening with their patients in other care settings as it’s happening—literally tapping into patient-level information from other care providers, such as SNFs or home healthcare. Doing so enables systems to achieve the outcomes they seek—driving risk stratification of patients who are most at risk of readmissions, targeting interventions to them, and lowering the total cost of care.

However, one of the biggest challenges faced by physician groups, ACOs, and health systems is knowing what tools they actually need. Substantial investments can be made in digital health tools and platforms, such as electronic health records, care management systems, and data analytics. Once health systems determine which tools they need, they must deploy them and then track and monitor outcomes to evaluate what is really working.

Real Time Medical Systems can help through our Interventional Analytics solution, which delivers clinical line of sight into patients’ journeys through PAC. The system allows monitoring of length of stay in PAC facilities and helps to identify opportunities to intervene in care before adverse events arise. By bringing live data together into usable formats, Real Time helps risk-bearing acute-care providers be more efficient with less staff. The bottom line: reduced avoidable readmission rates, significant total cost of care savings, and healthier patients—all important hallmarks of value-based healthcare.

Phyllis Wojtusik, RN, is Executive Vice President of Health System Solutions for Real Time Medical Systems, an APG Associate Partner. She has more than 35 years of healthcare experience in acute care, ambulatory care, and post-acute care, and has led the development of post-acute networks and participated in the Medicare Shared Savings Program and other value-based contract programs. To learn more about Real Time Medical Systems, visit RealTimeMed.com, or follow the company on LinkedIn or Twitter at @myRealTimeMed.
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26% Reduction in mortality rates for engaged patients*

*Stat Source: Landmark Health Data Science and Analytics, 2022
Provider Compensation: Are You in Compliance?

BY JACKI JACOX, MPA, CPA

Provider compensation arrangements have long been a hot topic due to the complexity of governing laws and regulations and potential multimillion-dollar penalties for noncompliance.

In December 2020, the Centers for Medicare & Medicaid Services (CMS) finalized the federal register for modernizing and clarifying physician self-referral regulations (the Stark Law), which included clarifying fair market value and adding commercial reasonableness definitions for provider compensation.

CMS sought to better align the Stark Law with the Anti-Kickback Statute. It also declined to create a fair market value (FMV) or commercial reasonableness (CR) safe harbor, a statutory or regulatory provision that provides protection from legal liability or other penalty when certain conditions are met, such as creating a defined set of parameters for determining the FMV and CR of a provider compensation arrangement.

CMS clarified that it declined to create such a safe harbor because the FMV of a transaction may not always be sufficiently supported with published salary surveys. In addition, due to the uniqueness of each arrangement, no set parameters can be defined to ensure all arrangements are within FMV and CR.

This further emphasizes the importance of reviewing your provider compensation arrangements, assessing the level of risk associated with them, and obtaining an independent valuation for moderate to higher-risk arrangements.

KEY PROVISIONS

There are four key regulatory provisions:

- Stark Law
- Anti-Kickback Statute
- The False Claims Act
- IRS regulations

In fiscal year 2021, the U.S. Department of Justice (DOJ) recovered more than $5.6 billion from False Claims Act (FCA) cases, marking the second-largest annual total in FCA history. More than $5 billion of these losses involved healthcare industry cases, many of which included Anti-Kickback Statute and Stark Law violations. This monetary benchmark is for federal losses only; the DOJ also helped state Medicaid programs receive additional remuneration.

EXAMPLES OF RECENT SETTLEMENTS

April 12, 2022: Physician Partners of America LLC agreed to pay $24.5 million to resolve alleged False Claims Act violations for paying unlawful remuneration to its physician employees. Other infractions concerned reporting of its COVID-19 Relief Funds and performing unnecessary medical testing and services.

Aug. 6, 2021: National Spine and Pain Center LLC agreed to pay $5.1 million in restitution to Medicare to resolve a criminal settlement for entering into an arrangement that unlawfully
compensated physicians—a violation of the Anti-Kickback Statute.

**July 19, 2021:** Prime Healthcare Services and two of its doctors agreed to pay the DOJ and the California Department of Justice a total of $37.5 million to resolve False Claims Act violations for offering illegal financial incentives to physicians.

**Dec. 18, 2020:** Texas Heart Hospital, a wholly-owned subsidiary of THHBP Management Company LLC, agreed to pay $48 million to settle False Claims Act allegations related to alleged kickbacks.

**July 8, 2020:** Oklahoma City Hospital, Management Company, and Physician Group was ordered to pay $72.3 million to settle alleged federal and state False Claims Act violations arising from improper payments to referring physicians.

**HOW TO ASSESS YOUR RISK**

Performing a risk assessment of your existing or new provider compensation arrangements is a great way to keep track of those arrangements while also monitoring, managing, and mitigating the risks associated with them.

Use a heat map to assign each provider contract a risk assessment category of low (green), moderate (yellow), or high (red) risk. This provides decision-makers with a visual, comprehensive view to share while making strategic decisions.

There are many ways to complete a risk assessment. I recommend breaking it into three phases:

- **Phase I:** Develop assessment criteria by mapping out several provider compensation components and scenarios common to your organization.
- **Phase II:** Assess the risks associated with each provider compensation arrangement by mapping each arrangement according to the criteria developed and a color-coded system.
- **Phase III:** Respond to the risks of arrangements mapped in the moderate-to-higher risk range.

Below is an example of a heat map in which I mapped out all of an organization’s physician compensation contracts based on the risk score I assigned and identified using these three phases. This map was accompanied by a full report of each compensation component considered when assigning the risk score and a key code for each arrangement (e.g., C1, C2, C3, etc.).

- **Likelihood** represents the possibility (rare to almost certain) that a provider compensation arrangement is not in compliance with laws and regulations.
- **Impact** refers to the extent (insignificant to catastrophic) to which a risk event might affect the organization.

**CONCLUSION**

Aligning provider compensation with regulatory compliance and organizational goals can be a daunting task. Performing a visual provider compensation risk assessment can help you track and mitigate these risks.

In addition, hiring a third-party compensation subject matter expert will provide your organization with an independent, unbiased opinion of provider compensation fair market value and commercial reasonableness. And it will help mitigate the inherent organizational risks associated with complying with provider compensation laws and regulations.

**Jacki Jacox, MPA, CPA, is Director, Healthcare Consulting and Financial Advisory, at Mazars USA LLP. She can be reached at Jacki.Jacox@mazarsusa.com. To learn more about Mazars, visit mazars.us or follow the company on Twitter at @MazarsinUS.**
Addressing Burnout to Fulfill the Quadruple Aim

BY TIM KELLY

Although the public health emergency remains in effect, it is possible that the worst of the COVID-19 pandemic is behind us. Travel has resumed; businesses are returning to more in-office work; friends and families are gathering again. While these may be positive indicators, the pandemic and the general work environment for the physician community are still taking their toll on caregivers.

The emotional and physical load placed on clinicians’ shoulders persists as healthcare organizations continue to reel from the pandemic and the “great resignation.” Even as organizations compete to hire physicians and bid up salaries, burnout is rampant within physician populations, with disturbing implications for clinicians, medical groups, and the health of communities.

**BURNOUT: HOW DOES IT HAPPEN?**

According to the World Health Organization, occupational burnout is a syndrome resulting from chronic work-related stress, with symptoms characterized by “feelings of energy depletion or exhaustion; increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and reduced professional efficacy.”

The understanding of physician burnout continues to evolve, but the data connects the condition to the various demands of modern practice, such as workloads and administrative burden, among many other personal factors. In addition, sleep-related impairment is well studied within the physician community and is associated with burnout and self-reported clinically significant medical errors. These stressors decrease feelings of agency and autonomy and interfere with patient relationships, thereby eroding physician engagement and the sense of meaning in their work.

**THE GRAVE IMPLICATIONS OF THE STATUS QUO FOR PRACTITIONERS**

The current prevalence of clinician burnout paints a grim picture for the health of caregivers, the care delivery system, and communities, as follows:

- A recent study of 11,000 physicians found that 52% of respondents identified as experiencing a great deal of stress, while 28% were dissatisfied or extremely dissatisfied with their jobs.
- A Medscape survey of 13,000 physicians found that 21% of respondents reported depression. Of those roughly 2,700 physicians, 24% noted clinical depression and another 64% noted “colloquial” depression, or feeling “down.”
- A team of researchers at Penn State College of Medicine recently reported that, prior to the pandemic, screenings for depression in multiple hospital systems typically returned rates near 10%. These rates have risen to 30% to 33% at present.
- Tragically, studies also suggest that both passive and active suicidal ideations are approximately 80% higher in the physician community than those observed in the general population.
THE IMPACT ON OUR HEALTHCARE DELIVERY SYSTEM AND PATIENTS

Burnout is also wreaking havoc on medical groups and healthcare delivery organizations all over the country. One appreciable byproduct of the levels of stress and adverse working conditions for clinician populations is attrition. August 2021 marked the highest recorded number of healthcare and social assistance workers who quit their jobs in a single month: a staggering 534,000.6

The downstream implications for care continuity, patient relationships, and clinician workloads are devastating. When the indirect costs associated with these implications are coupled with the astronomical replacement costs for physician talent—now estimated to be $500,000 to $1 million for a single physician, according to multiple studies—the situation becomes even more dire for medical groups and healthcare delivery organizations.7

In addition, physician sleep impairments, largely correlated with burnout, have been associated with a 53% higher probability of self-reported clinically significant medical errors.2 A 2016 study by Martin Makary and Michael Daniel of the Johns Hopkins School of Medicine calculated that preventable medical errors in inpatient hospitals were the third-leading cause of death in the United States, accounting for more than 250,000 fatalities per year.8

The scope of this problem is vast. Improving the clinician experience is critical, and the implications of inactivation around this topic are weighty for clinicians and patients throughout the country.

WHAT CAN BE DONE?

The gravity of the current state has been recognized by the medical community and by researchers. Even as more studies of the meta-data are conducted, effective interventions are still proving elusive. Bright spots are emerging in the data, however, and there are steps that clinicians and healthcare organizations can take that can result in clinically meaningful reductions in physician burnout.9

For Clinicians

At the clinician level, one such intervention is the use of mindfulness-based interventions (MBIs) or mindfulness-based stress reduction (MBSR). Both of these use mindfulness meditation and other approaches to promote awareness and attentiveness.

The various data support that as clinicians use these interventions and grow in mindfulness, they become more aware of stress, proactively set priorities and limits, and develop a healthier relationship to work in a stressful practice environment. The data also correlate the use of these tools to lower levels of burnout in residents and specialists.3

Studies show that MBIs are most effective when embedded within organizations that both promote a culture of wellness to physicians in various educational phases, from postgraduate and into continuing medical education, and address system-related demands such as workloads and workflows.5

For Medical Groups and Other Healthcare Organizations

According to the data, organizational interventions that improve workloads and workflows or that promote specific cultural adjustments have the greatest impact.

Studies on improvements made to policies and processes governing clinicians’ time, care transitions, and interaction with technology indicate three ways in which healthcare organizations can reduce burnout: (1) adjusting policies to limit working hours; (2) creating modified work schedules; and (3) allowing for time banking (as in a Stanford emergency department program that allows doctors to log time spent doing under-valued activities, such as covering colleagues' shifts, to earn credits to purchase work- and home-related services, such as grocery delivery).10

Similarly, of the research analyzed that focused on workflow changes, eight out of nine studies found that workflow redesign, including targeted quality-improvement projects, had a substantial impact on physician burnout and job satisfaction.10

continued on next page
Changing how clinicians engage with technology can also reduce stress and burnout, and increase overall job satisfaction. Interventions targeting electronic health record (EHR) process improvements, for example, can be effective. 10

Implementing cultural adjustments has been shown to improve the clinician experience, too. One such adjustment is training clinical leaders to build psychologically safe environments. Conflict at work is a leading cause of disengagement and attrition and deteriorates well-being.

Providing formal training in leading with vulnerability, empathic listening skills, and meeting staff “where they are” helps create a safe place for clinicians to speak up about their battles with burnout. Clinician leaders and executives need this support as well. They can start small by modeling good habits, such as taking breaks and using paid time off.

Creating intention and focus on recognition and rewards is another example of cultural adjustment. Recognition for one’s work is a key factor in driving employee engagement and well-being—for example, receiving praise from a colleague or a superior. Instituting these practices and other reward mechanisms can have an immediate impact on clinicians.

Lastly, rewards programs should be evaluated to determine whether they support the clinician experience adequately. Compensation and benefit programs play an important role in attracting and retaining clinician talent. Incorporating programs that support clinicians’ physical, financial, social, community, and career well-being is critically important to reducing the effects of other life stressors that contribute to burnout.

A CALL TO ACTION

As noted above, burnout has severe negative personal consequences for the clinician community. Physicians suffering from burnout are more at risk of debilitating stress, interpersonal disengagement, depression, and suicide. Furthermore, burnout impacts the health of communities; affected clinicians make more clinically significant medical errors, adhere less to practice and safety standards, and are more likely to provide suboptimal patient care. 11

Is better supporting the clinician experience the underpinning of successfully executing our communal “Quadruple Aim” aspirations—reducing costs while improving population health, the patient care experience, and the well-being of healthcare teams? It could be an important catalyst. There are interventions that can reduce the prevalence of burnout now. The situation is urgent, and activation around these issues is critical to supporting physicians and communities in a journey toward well-being and great levels of human flourishing.

Tim Kelly is Managing Consultant of the Group Physician Advisory Services division at The Partners Group. He and his team work closely with total rewards leaders to help medical groups attract and retain physician talent and ensure their total rewards frameworks support the clinician experience. At The Partners Group, we believe impacting the health of our caregivers impacts the health of our communities. You can follow the company on Twitter at @tpgrp.

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BY SUSAN E. HAHN, MS, CGC

In the past, the ability to understand genetic influence on health was limited by technology. This situation changed with the completion of the human genome project in 2003 and the onset of next-generation sequencing (NGS), which enabled sequencing of DNA at unprecedented speeds and sharply lower costs.

Now, more than 500 laboratories offer tests for more than 20,000 conditions. The Genetic Test Registry reports that there are nearly 75,000 tests available, while a database compiled by the technology company Concert Genetics records more than 165,000 tests. Most are laboratory-developed tests that are not subject to FDA oversight, although they are subject to regulations under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) law. With only approximately 25,000 genes in the human genome, the substantial number of available tests can be attributed to differences in methods, sample type, variant assessment, and/or genes included in multigene assays.

Approximately 3.5% to 5.9% of individuals have a genetic variant associated with significant health implications. Beyond diagnosis and risk assessment, genetic and molecular testing are used to evaluate drug response (pharmacogenetics); inform prognosis and treatment of solid tumors that result from acquired, or somatic, mutations that occur in cells; direct organ transplant decisions and management; and test for infection.

Although genetic testing is costly, it is highly effective when used appropriately. For example, quickly diagnosing babies with spinal muscular atrophy is paramount to avoid irrevocable damage that begins at birth. Asymptomatic patients with hereditary cancer syndromes such as Lynch or hereditary breast and ovarian cancer syndrome should receive enhanced and earlier cancer surveillance, chemoprevention, and/or prophylactic surgery.

In some instances, a genetic diagnosis ends the diagnostic odyssey, thus reducing unnecessary, costly, and time-consuming evaluations and procedures. Knowledge of a specific gene or variant may also provide opportunities for families to connect to a support network, participate in research, enable family planning, and inform personal decisions.

This rapidly evolving and complex testing landscape can pose a challenge for non-genetics professionals looking to deliver value-based care. Many are not trained to assess genetic risk, order genetic tests, or interpret results. They also may be unfamiliar with referring patients to genetics professionals.

Consequently, genetic testing is both overused (20.6%) and underused (44.8%). While overutilization is an economic and quality concern, underutilization is concerning from a health outcomes perspective.

There are three ways that non-geneticists can ensure they are appropriately and efficiently using genetic testing:
1. UTILIZE REPUTABLE LABORATORIES PRACTICING RESPONSIBLE GENOMICS

Because genomic medicine is new and emerging, there is tremendous variation in what laboratories offer. Competition has driven some labs to differentiate themselves with complex genetic test offerings that may lack sufficient evidence. For example, some boutique laboratories offer large panels containing genes where the relationship to the disease has not yet been fully validated. In this instance, more is not necessarily better. Other laboratories practice outright fraud.6

The good news is that many reputable laboratories provide genetic counselors and other genetics professionals, who can provide training and consultations tailored to a practice’s clinical genetic testing needs; offer “just in time” consults with providers regarding orders and interpretation of results; flag potential duplicate or erroneous test orders; and receive clinician feedback on genetic testing offerings and services to better address their needs.

2. ACCESS PUBLICLY AVAILABLE RESOURCES

Many resources listed below provide accurate information about genetic disorders, including testing, treatment, and research opportunities:

- **MedGen (ncbi.nlm.nih.gov/medgen)**
  Search for genetic conditions by symptom or name. MedGen includes a link to professional practice guidelines, position statements, and recommendations.

- **GeneReviews (ncbi.nlm.nih.gov/books/NBK1116)**
  Provides clinically relevant information on inherited conditions, written by experts on the specific disorder.

- **Treatments for Genetic Disorders (rx-genes.com)**
  Provides information about current treatments, as well as clinical trials that affect the underlying pathogenesis and progression of the disease.

- **Orphanet (orpha.net)**
  Portal for rare diseases and orphan drugs.

- **Clinical Pharmacogenetics Implementation Consortium® (cpicpgx.org)**
  CPIC provides detailed gene/drug clinical practice guidelines free to the public. Guidelines focus on how to use available pharmacogenetic results.

- **PharmGKB (pharmgkb.org)**
  Resource regarding the impact of genetic variation on drug response.

- **National Human Genome Research Institute (NHGRI) Glossary of Genomic and Genetic Terms (genome.gov/genetics-glossary)**
  Includes nearly 250 terms, explained in an easy-to-understand way by NHGRI scientists and professionals.

3. FIND SUPPORT FROM CLINICAL GENETICS PROFESSIONALS

Medical geneticists and genetic counselors are important members of the diagnostic and therapeutic team; they help close knowledge gaps to assure effective test utilization. These resources are available at many medical centers. Also, numerous companies offer remote genetic counseling services. Useful databases and directories include these:

- **American College of Medical Genetics and Genomics: Genetics Clinics Database (https://clinics.acmg.net)**
- **National Society of Genetic Counselors Directory (https://findageneticcounselor.nsgc.org)**

In the end, the authority for ordering appropriate testing rests with the treating provider. APG members, America’s laboratories, and other professional organizations can work together to maximize the benefit of molecular and genetic testing while ensuring that non-value-added (and potentially detrimental) services are not ordered.

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How Delegating Coding Can Reduce Burnout and Improve Care

BY SUSAN RICHARDS

The U.S. is in the midst of a public health crisis. Simply put, healthcare demand has risen beyond our current capacity to meet it.

Today, 80% of rural Americans live in medically underserved areas, known as healthcare deserts, and the problem is worsening each year. Healthcare deserts also exist in urban environments, especially those populated by historically marginalized groups. Physicians and other types of healthcare providers are in short supply in many areas of the country. Compounding this issue, the number of Medicare enrollees is expected to grow by 26% over the next few years, and the population of people living with multiple chronic conditions is rapidly increasing as well.

Meanwhile, many physicians are suffering from burnout, a form of exhaustion caused by constantly feeling swamped. Adding even more patients on top of a system that is already overtaxed will only worsen the strains.

To address these issues, we must think about how we can extend the capabilities of providers and relieve them of nonclinical tasks to increase their capacity to care for patients—without adding to their already full plates. One of the first steps provider organizations can take to address provider burnout is to implement and operationalize Hierarchical Condition Coding (HCC) programs.

PROVIDERS’ ADMINISTRATIVE BURDEN: A GROWING PROBLEM

For many years, providers have been performing more than the lion’s share of administrative work. According to a 2016 study in the Annals of Internal Medicine, for every hour physicians spend seeing patients, they spend nearly two additional hours on paperwork. A more recent study found that physicians spend an average of just over 16 minutes on electronic health records (EHRs) for each visit—a length of time that frequently exceeds the actual visit with the patient.

Considering that most primary care providers (PCPs) see approximately 20 patients a day, the paperwork quickly adds up. In addition, providers who report six or more hours of after-hours charting per week are 50% more likely to report burnout—a leading cause of physician turnover. The need to reduce administrative workloads is clear.

COVID-19 has provided a startling glimpse into the future of healthcare if we do not address these systemic issues—and highlighted the need to reduce administrative workloads and optimize coding processes. The pandemic has also emphasized what healthcare workers have long known: the value of having accurate data to make real-time decisions, all of which are driven by medical coding.

While future pandemics or healthcare crises can’t be prevented, it is possible to increase the supply of providers who are ready and able to serve patients—and not bogged down in administrative work. Appropriate coding is part of the solution.

DELEGATING CODING TO THE EXPERTS

Medical coding translates diagnoses, procedures, medical services, and equipment into universal medical alphanumeric codes, typically for the purpose of payment. A shift is underway across U.S. healthcare from the use of so-called Current Procedural Terminology (CPT®) coding, which captures medical, surgical, and diagnostic procedures and services, to Hierarchical Condition Coding, which captures multiple conditions and drivers of a patient’s health status and prognosis over a long period of time. HCC, which links in turn to the International Classification of Diseases 10th Revision (ICD-10) diagnosis coding system, was adopted by the Centers for Medicare and Medicaid Services in 2004 as a risk-adjustment tool, and is now central to the operation of Medicare Advantage and other value-based care programs. HCC is used to assign patients a so-called risk adjustment...
factor (RAF) score, which is used in turn to predict the costs of providing healthcare to them over time.

With CPT coding, providers choose from a subset of approximately 10,000 codes for their specialty and practice capabilities. These codes have been created by the medical specialists who perform the procedures (the American Medical Association). In contrast, HCC coding includes more than 72,000 ICD-10-CM codes for providers to choose from. Diabetes alone has 300 codes.

This increased specificity is intended to provide more detailed information for measuring the quality, safety, and efficacy of care. However, the ability to transcribe clinical documentation into the complex ICD-10 classification system requires skills that are often outside of and counterintuitive to clinical expertise—making it harder for providers to find the codes they need for reimbursement.

Another problem with having providers undertake coding is that if mistakes are made, they often are not caught. Coding errors are primarily identified through retrospective reviews. While these reviews are necessary as part of quality assurance and compliance programs, value-based care is focused on preventing and managing disease. Retrospective reviews often occur long after the opportunity to benefit the patient or identify and address emerging population health trends in a timely manner.

Instead of forcing physicians to guess at correct code assignments from lists on electronic health records, what if they handed off the responsibility to expert risk-adjustment coders? As of 2015, only 18% of practices had full-time medical coders on staff. If more provider organizations delegated coding to experts, the industry could effectively address the root cause of process issues that lead to administrative burden.

**PROSPECTIVE OR CONCURRENT CODING?**

HCC can take place in three ways: prospectively, as in before a patient visit to help physicians identify suspected conditions; concurrently, which occurs after a visit but before the medical record is submitted for evaluation and payment; and retrospectively, which can occur a year or more after an encounter. Prospective coding (also known as pre-chart prep) and concurrent coding provide the advantage of offering an immediate opportunity to use coding data to improve clinical practice, whereas retrospective coding offers no opportunity for immediate clinical impact.

Although prospective and concurrent coding have slightly different goals (see Figure 1), they both aim to support complete and accurate documentation of encounter data and maximize the use of clinical resources. They are frequently accompanied by another process, clinical documentation improvement (CDI), which is the process of reviewing medical record documentation for completeness and accuracy.

**BENEFITS FOR PATIENTS AND PROVIDERS**

With these considerations in mind, having expert coders undertake HCC, rather than providers themselves, can produce important benefits, as follows:

1. **Supporting complete medical record data.** When providers focus on documenting correctly in the medical record, while coders focus on coding, better and more complete medical records result. With better data come better treatment and outcomes—and reduced costs of care.

2. **Reducing clinician malpractice risk.** Diagnostic-related issues are the biggest root cause of malpractice claims. Removing the responsibility of coding from providers, who may code a condition inaccurately, may mean less risk of diagnostic failures.

3. **Supporting compliant risk-adjustment practices.** Provider organizations that use expert coders will capture a more complete picture of a patient’s health, which can help ensure adequate funding for care in risk-adjustment payment models.

**HCC CODING AND THE FUTURE OF CARE**

While healthcare organizations may have lofty goals for patient outcomes and financial performance, these goals cannot be accomplished without excellent clinical care.
A Care Coordination Tool for Getting Medications Just Right

BY DIANNE DAVIS

Physicians and other clinicians have many tools for addressing patients’ medical needs, ranging from the basic stethoscope to sophisticated gene therapies. But they frequently lack the capacity to address the social determinants of health—the conditions in which people are born, live, work, and age—that are the primary driver of overall health status. And clinicians’ ability to affect these conditions is even more limited when patients are outside the clinic, where they spend most of their time leading their lives.

For most clinicians, uncovering these factors that impinge heavily on health relies on self-reporting by individuals. But how many patients with COPD tell their doctors about the leaky roof that led to mold in their kitchens, exacerbating their breathing problems? Or about the scatter rugs covering wood floors that result in periodic falls, or the complete list of every medicine they take—including herbal supplements and the pills that their other doctors have prescribed?

The Partners in Care Foundation, a nonprofit foundation based in San Fernando, California, supports the optimal health of low-income adults and children with complex medical needs. Each year, the organization helps nearly 25,000 individuals live with safety and dignity in the community home of their choice, minimizing hospitalizations and avoiding institutional settings such as specialized nursing facilities. Partners’ experience visiting homes and seeing patients’ social circumstances up close regularly demonstrates that what happens in the home can enhance or diminish the impact of healthcare treatments.

In the course of this work, Partners has developed a variety of innovative and powerful models and tools to align healthcare with the social care needed to improve health and wellbeing.

THE HOMEMEDS APPROACH

One of the most valuable tools in this toolbox is HomeMedsSM, which helps people get their medications “just right” and ensures patient medication-related safety. HomeMeds consists of a computer program combined with a home visit by specially trained community health workers (CHWs), social workers, or health coaches.

The visit begins with the CHW or health coach conducting an inventory of all medications that the person at home is taking. This inventory includes recently prescribed medicines, as well as older prescriptions for medicines that person may still be taking, plus over-the-counter products and supplements and even certain foods that may interact with medications.

The CHW or health coach also interviews the person to identify any adverse effects of medication, such as changes in blood pressure or pulse rate, dizziness, falls, and confusion; documents any adherence issues and how well the person understands his or her medication regimen; and undertakes a visual review of the person’s surroundings, such as making note of scatter rugs if there is a history of falls.

When this information is loaded into the software program, proprietary algorithms identify any unnecessary therapeutic duplication, any fall risks or confusion related to possible inappropriate psychotropic medications, and any cardiovascular issues related to medication use. The program then guides an in-home survey and flags any potential problems, which are reviewed within 72 hours by a pharmacist.

If there are recommendations to be made, the pharmacist issues two electronic reports, each of which is editable. A comprehensive report goes to the prescriber and includes details about the person and alerts and recommendations to the prescriber from the pharmacist. The second report is a patient report, which may not include all the information on the comprehensive report but always includes any suggested changes to the medication regimen.

A pharmacist’s concerns and recommendations from the report are also provided electronically to the patient’s primary care physician. Since the prescriber and pharmacy are linked to the patient and prescriptions, the pharmacist has access to that information regarding where to send the report.
IMPROVING HEALTH AND SAFETY

Partners’ HomeMeds is proven to reduce medicine-related injuries and cut emergency department and readmission costs for high-risk patients. (See Journal of Patient Safety, March 2022: “Linking Technology to Address the Social and Medical Determinants of Health for Safe Medicines Use,” and Journal of the American Geriatrics Society, January 2021: “A Collaboration Among Primary Care-Based Clinical Pharmacists and Community-Based Health Coaches.”)

Not only does HomeMeds improve a person’s health and safety, but it also supports HEDIS quality measures for physicians by reducing the use of high-risk medications, providing a fall prevention solution, and identifying drug interactions.

Since 2011, more than 53,712 older adults have had their medications screened for potential risks via the HomeMeds program. A staggering 60% of those screened had potential problems. The ability to identify these issues for patients and their clinicians—and illuminate the social conditions that contribute to health and illness—are what make the Partners in Care Foundation an essential collaborator in the provision of healthcare.

Dianne Davis is VP of Partners HomeMeds and Community Wellness. For more information about HomeMeds or the Care Coordination Toolbox, please contact Partners@picf.org. You can also follow Partners on Twitter at @partners_care.

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and shared clinical goals are fully aligned across providers and payers. Bloom Healthcare is thus purposely built for value-based payment models that reward improved quality and health outcomes and reduce avoidable medical expenditures for an elderly patient population with complex, chronic conditions and advanced stage illness.

In addition to serving as a global risk High Needs Direct Contracting Entity in the Direct Contracting model (now transitioning to ACO REACH), Bloom Healthcare partners with Medicare Advantage organizations and delegated entities in value-based care models and excels at driving superior outcomes and enabling patients to age in place and remain in the comfort of their home.

Last year, Bloom patients experienced 25% fewer emergency room visits and inpatient admissions, resulting in approximately 16,000 fewer days in the hospital and 31,000 fewer days in skilled nursing facilities.

Franke P. Elliott is the Co-Founder and Chief Strategy Officer of Bloom Healthcare. You can follow the company on Twitter at @BloomHealthcare.

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Provider organizations that seize the opportunity to change their infrastructure and administrative processes today will be better poised to navigate the future of healthcare—not just for tomorrow but for years to come.

Susan Richards is Director of Risk Adjustment Coding & Education at Episource and has more than 20 years of leadership experience in the healthcare industry. To learn more about Episource, visit Episource.com or follow the company on Twitter at @EpisourceLLC.

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3 Themes for Advancing Value-Based Care and Medicare ACOs

BY BRIAN STEELE, MD, AND MICHAEL BARRETT

As value-based arrangements have become increasingly common, our management services organization, Collaborative Health Systems (CHS), has partnered with more than 10,000 independent primary care physicians for the past decade as they move to value-based models like the Medicare Shared Savings Program (MSSP). In 2020, CHS helped Medicare healthcare providers earn an average quality score of 97%—and achieve $91 million in total savings through the Next Generation ACO and MSSP models.

As these models continue to evolve, the Centers for Medicare & Medicaid Services (CMS) recently accepted applications for participants in the new Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model. This new approach builds on lessons learned from previous models and focuses on promoting health equity and addressing healthcare disparities for underserved communities.

With this in mind, there are three themes that we believe CMS should have top of mind as it looks to the future of ACO REACH and other programs:

- **More tools.** MSSP and even REACH ACOs are still limited in their ability to drive toward the highest value care possible. CMS should explore new tools that ACOs and REACH ACOs can implement, such as stronger incentives to use preferred networks that demonstrate improved quality and reduced beneficiary costs. Tools that have proven successful in innovation models should be implemented in permanent programs like MSSP.

- **Data and program modeling.** Given the structure and methodology design of ACOs, there is much uncertainty about performance until well after the performance year ends. It would be helpful for CMS to release greater levels of data in a timely and near-real-time manner, particularly those that would enable entities to more precisely model program parameters. Doing so would lead to greater levels of participation among providers and give ACOs the ability to more precisely pinpoint areas that will lead them, and the program, to improve patient care more successfully.

- **Program stability and longevity.** Entering a new program or shifting requirements takes significant planning to effectively execute. Therefore, we encourage CMS to provide a more structured and timely process related to issuing information and engaging with industry stakeholders.

In providing these considerations for CMS, we also recognize that the value-based care journey is young, and there is much to learn for all parties involved. Looking ahead, it will be imperative to build on the past while innovating for the future to provide better care for individuals, improve population health management strategies, and reduce healthcare costs for current and future Medicare generations.

Brian Steele, MD, is Chief Medical Officer, and Michael Barrett is Vice President, Strategy and Business Development, for Collaborative Health Systems. You can keep up with the company on LinkedIn at LinkedIn.com/company/collaborative-health-systems/.

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“3 THEMES FOR CMS

This redesign is encouraging, and further improvements from CMS over time will continue to be critical components in fostering greater participation and enabling a model to succeed.
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