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Coordinated Care 101: A Primer

APG Colloquium

C.R. Burke, Mariella Cummings, Sasha Dhall, Keith Wilson, M.D.

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Panel

C.R. Burke
APG Consultant
Former CEO, St. Joseph Heritage Healthcare

Mariella Cummings
APG Consultant
Former CEO, Physicians of Southwest Washington

Sasha Dhall, MPH
Vice President, Risk Performance & Growth
AppleCare Medical Group

Keith Wilson, MD
Senior Vice President, Medical Management and CMO
AltaMed Health Network

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What's on the Agenda

- Intro to Coordinated Care: Why, Where, What, How
- Care Coordination Principles and Operating Framework
- Break
- Leadership, Culture Change, and Reinforcing Incentives
- General Q&A

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What You Can Expect From Today's Session

- ✓ What does coordinated care mean, anyway?
- ✓ The range of risk arrangements and the approaches required to succeed
- ✓ What others have learned in their journey within population health management
- ✓ Take-away tools, approaches, and strategies to succeed within population health management
- ✓ Role of leadership and cultural change within clinical transformation
- ✓ An interactive session – sharing questions, answers, and observations

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Section 1

Intro to Coordinated Care:
Why, What, Where, How

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Why?

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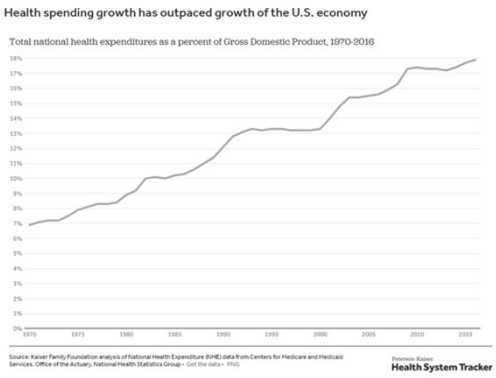
Follow the Money…

"The ballooning costs of healthcare act as a hungry tapeworm on the American economy."

- Warren Buffet 2018



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A Tale of Two Cities:

Traditional Attempts at Lowering Costs only Exacerbate the Situation

Payers Use the Levers Available to Them

- Fee schedule reductions or modest increases
- Push services out of the hospital into outpatient settings (imaging, infusion)
- Site of service equality for clinic, ASC, other outpatient services
- Utilization management: Pre-authorization/Denials/Formularies
- Higher deductibles
- Tiered or narrow networks

Resulting in Provider and Consumer Frustration

- Pressures to increase productivity
- Rising administrative costs
- Higher bad debt
- Impact on patient access (maxed out provider schedules)
- Provider burn-out
- Service and care fragmentation
- Higher out of pocket costs for consumers

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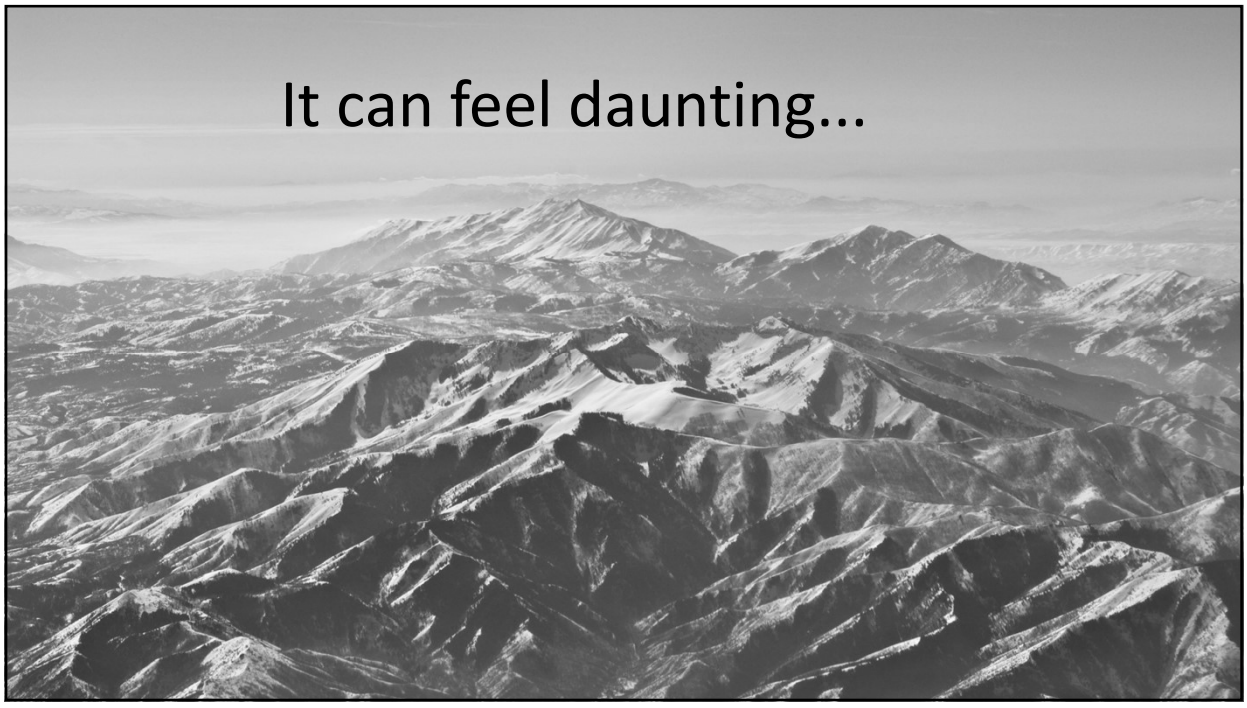

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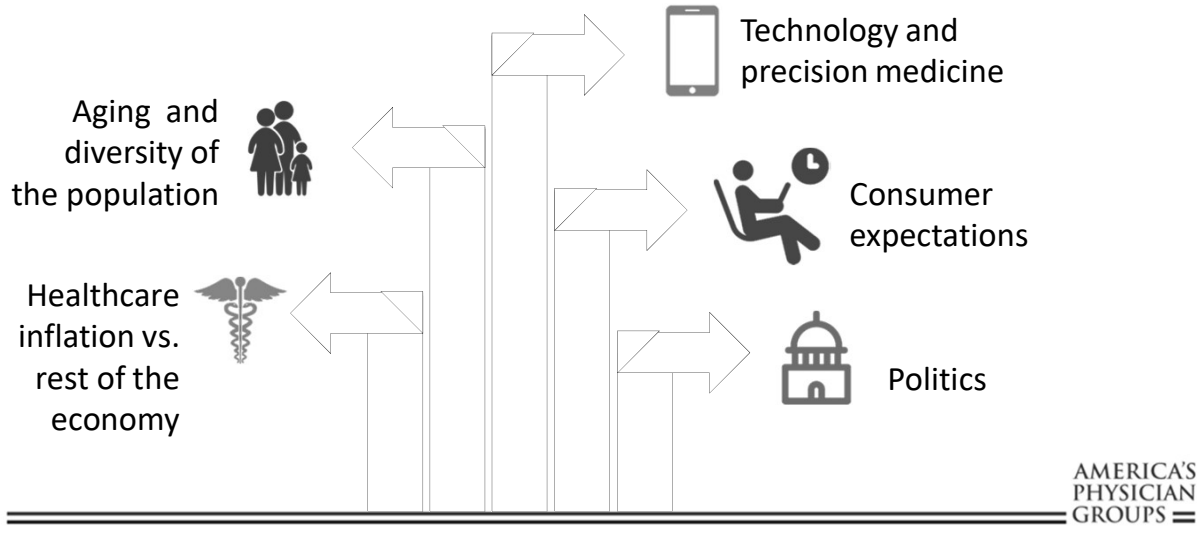
Macro Drivers of Change



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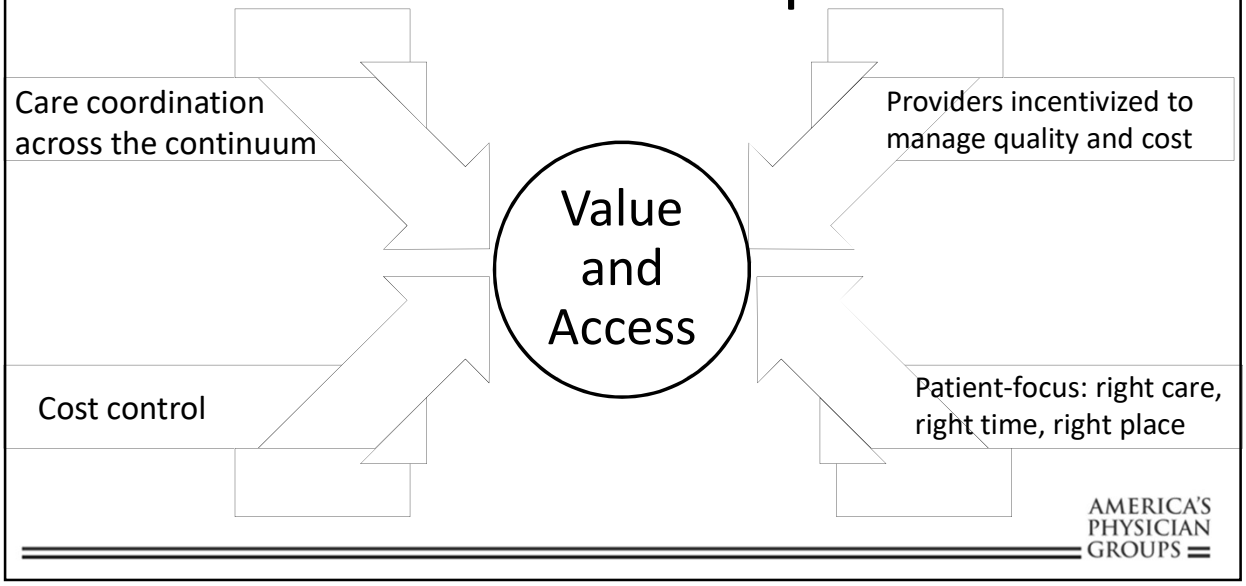
What Does the Marketplace Want?



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Consider the Facts…

34% of Medicare enrollees in Medicare Advantage ("MA") plans

- 22.0 million MA enrollees; increase of 40% 2014 - 2019

995 active Accountable Care Organizations ("ACOs")

- 44 M lives – 10% of US population; 8% annual growth
- 518 Medicare ACOs in 2019; 10.9M beneficiaries (25% of all Traditional Medicare)
- Commercial contracts ~60% of all ACO covered lives

More planning to participate in **full risk**

- 48% of ACOs planning for shared savings/shared risk
- 38% planning for capitation
- MACRA incentivizes move to APMs
- CMS move to require two-sided risk

Source: CMS, Kaiser Family Foundation; Avalere; Leavitt Partners and the National Association of ACOs, Health Affairs 8/14/2018 & 10/21/19

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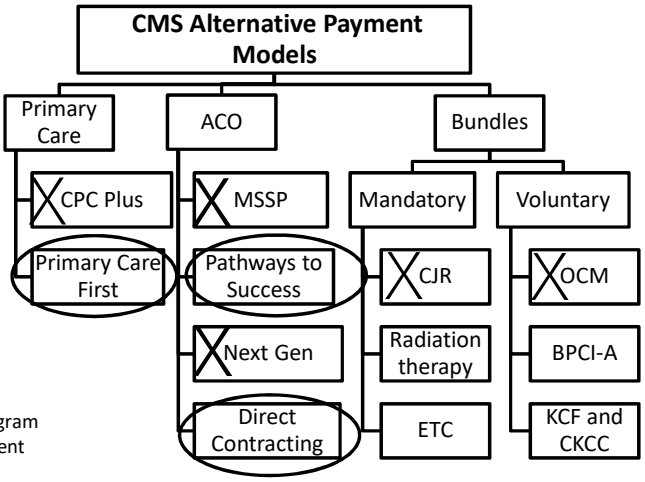
Medicare Models Continue to Focus on Greater Risk



X = Sunsetting ⬭ = New
CPC- Comprehensive Primary Care
MSSP- Medicare Shared Savings Program
CJR- Comprehensive Joint Replacement
OCM- Oncology Care Model
BPCI-A- Bundled Payment for Care Improvement- Advanced

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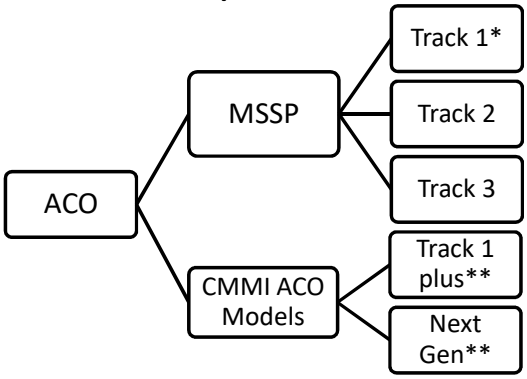
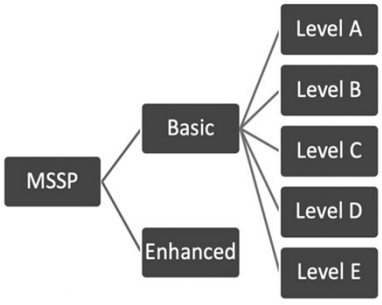
Former ACO Options



MSSP Contract terms are 3 years
- No downside risk , can renew for total of 6 years

** Sunsets in 2020

"Pathways to Success" Options



Contract terms are 5 years except for the July 1, 2019 start dates

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Overview Of Primary Care First

5 year regionally based multipayer voluntary model to begin in 2020

Builds on CPC+ Model; adds predictable payments and performance bonus. Goal is to spend less time on claims processing

Three Options:

- "Base" Model

- Seriously Ill Populations (SIP) Focus

^ Both

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Primary Care First Payment Model

Population Based Payment (PBP)

Intended to provide more flexibility in how primary care is provided

$24- $175 per beneficiary per month

Based upon risk group of practice

Payment will be same for all patients in practice.

Flat Fee for Primary Care Visits

(~$50 per visit (co-pay is required)

Performance-Based Adjustment

Max upside: 50% of revenue
Max downside: 10% of revenue
Based on Acute Hospital Utilization (AHU) performance
Must surpass quality gateway to be eligible for upward adjustment
Assessed and paid quarterly

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Direct Contracting Overview

- Designed for more advanced providers and organizations that have not typically participated in other models
- 5 year voluntary model
- Similar to Medicare advantage
- Capitated Payments available
- Beneficiaries must have freedom of choice
- Prospective beneficiary alignment (must have at least 5,000)
- Higher level Quality Measures

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Direct Contracting Payment Model

Type	Professional	Global	Geographic (Proposed)
Risk Sharing	50%	100%	100%
Cash Flow	7% of Total Cost of Care for "enhanced" primary care services	Partial (Primary Care) or Total Capitation Payments	Total Cap
Structure	7% of Total Cost of Care for "enhanced" primary care services	Partial (Primary Care) or Total Capitation Payments	Total Cap
Claims Processing	Participating Participants	Participating Participants (optionally Preferred Providers if Total Cap)	CMS or Total Cap

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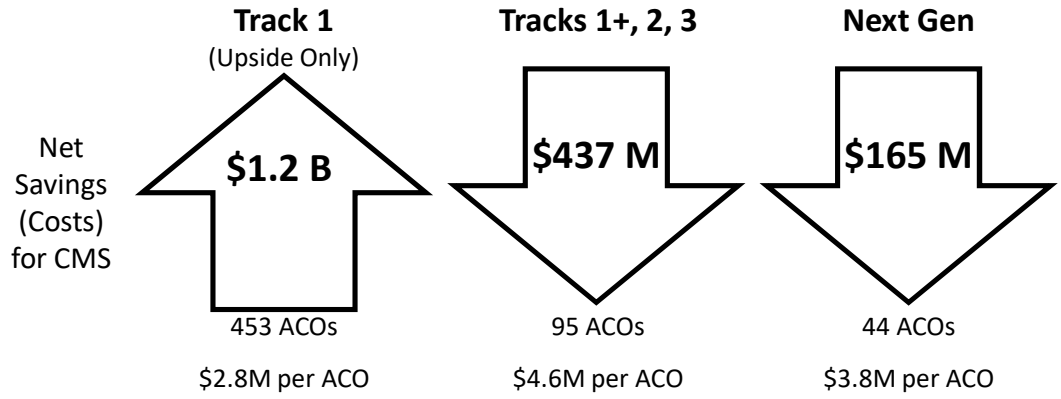
Medicare ACO 2018 Performance

548 ACOs saved Medicare $1.7B ($739M after settlements)



Source: CMS Analysis, Avalere, Health Affairs Blog 8/9/18, 9/11/19, 9/30/19; NORC, University of Chicago, "Next Generation Accountable Care Organization Evaluation" 8/27/18

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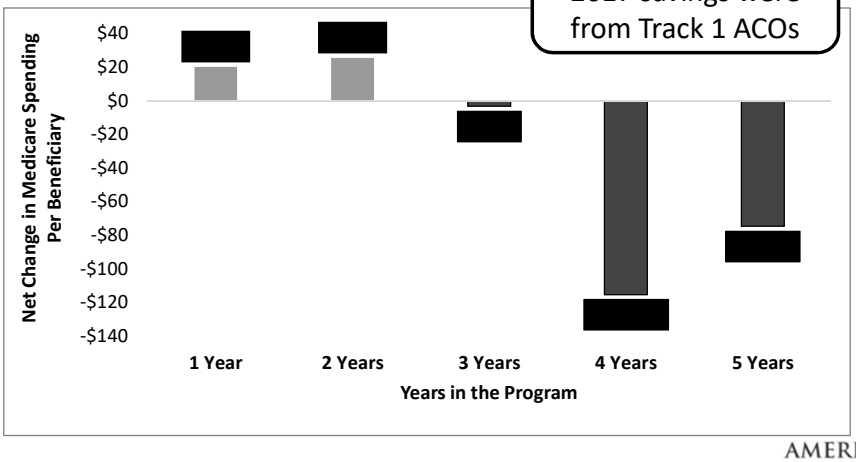
ACOs of All Types Perform Better Over Time*

$291/$314M 2017 savings were from Track 1 ACOs

Net Reduction in Medicare Spending per Beneficiary by ACO's Number of Years in the program based on analysis of 2017 CMS data



*Source: Avalere, 9/18/2018

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Disruptors: Accelerating the Change

UnitedHealthcare

amazon

Google

Berkshire Hathaway Inc.
J.P.Morgan

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Employers Are Increasingly Taking Action...

GE

Walmart
Save money. Live better.

intel

GM

Qualcomm

LOWE'S

BOEING

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Why Take Risk?

Don't leave money on the table
Participate in shared savings or share of premium, rather than leaving it with payers

Help with ways to improve patient care
Staff and IT support for better care coordination and information to keep patients happy and healthier

Give voice to physicians and other clinicians
Models all require physician leadership and leading roles for nurses, pharmacists, and others

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But they call it "risk" for a reason...

Major health systems announce losses in provider-owned health plans

- Sutter Health Plan lost $12.2M during the first half of 2017 on an enrollment of 48,284.
- Northwell announced closure of its health plan, CareConnect, after losing $157.8M in 2016.
- Memorial Hermann Health Insurance lost $15M in 2016.

Yet...

- Kaiser Permanente generated $2.2B in operating income in 2017.

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What?

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Value-based Critical Success Factors

- Vision and Leadership Commitment
- Strong Care Management Capabilities
- Effective and Engaged Care Teams
- Larger Patient Population
- Efficient Clinical Operations
- Contracting Models Support Population Health
- Compensation Models that Align Incentives
- Proactive Patient Engagement
- Enabling Information Technology

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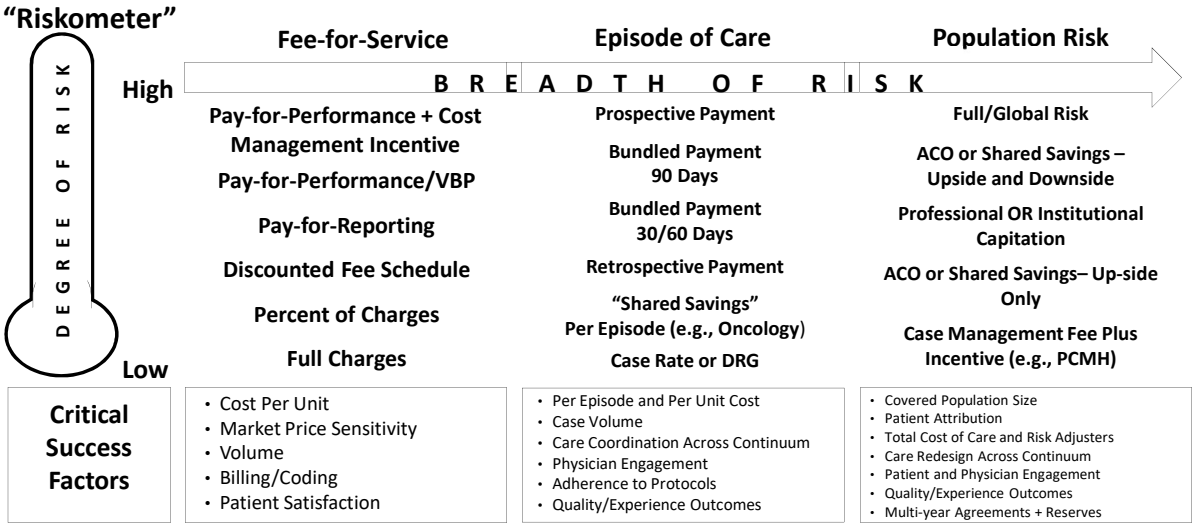
"Risk" Models Come in Many Flavors



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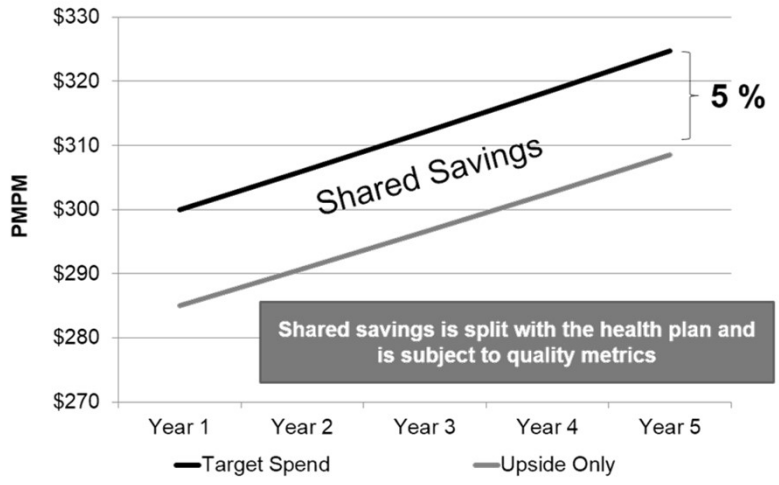
Shared Savings: Upside Only



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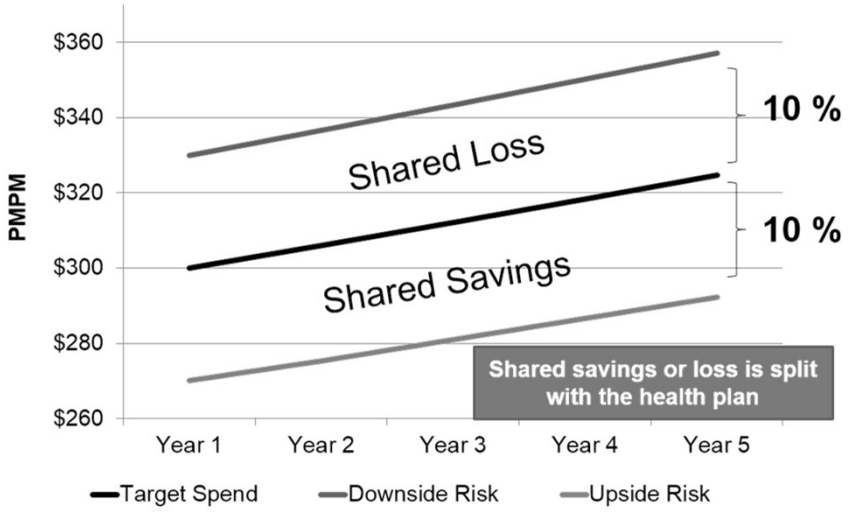
Shared Savings: Upside and Downside



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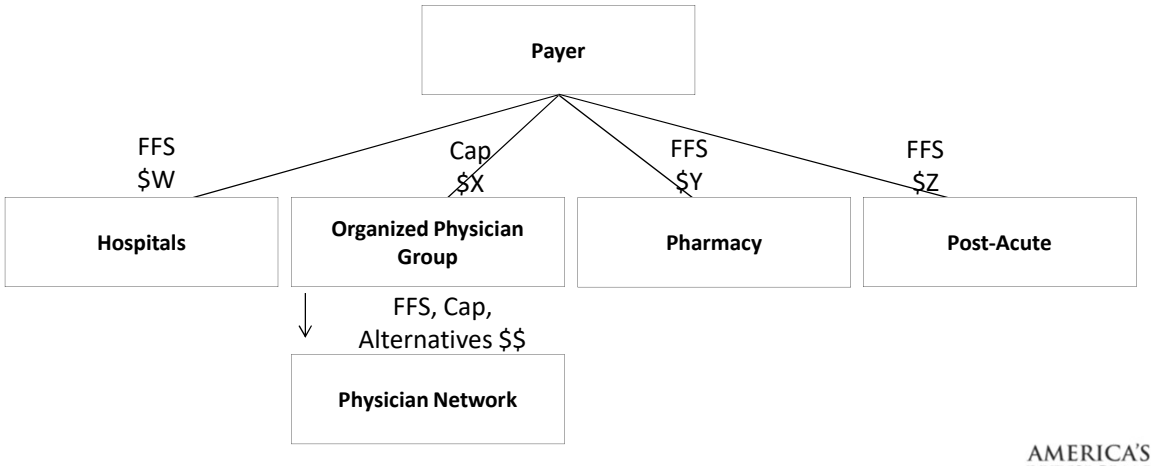
Professional Risk



Note: Only top 4 categories of health spending displayed.

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Full and Global Risk Contracts

Full Risk

- Capitation for institutional and professional services.
- Medical group and hospital often share surplus and deficit in risk pool.

Global Risk

- Single entity receives all funding and pays all claims.

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Regulatory Issues

States Regulate Risk Bearing Entities

- Know your state requirements - they vary widely.
  - Knox-Keene Health Care Service Plan Act of 1975 (California).
  - New York required the Department of Health to establish a program governing the approval of ACOs.
  - Massachusetts requires all Risk Bearing Provider Organizations ("RBPO") to register with state agencies.
    - Provider organizations that take on significant risk must fall under the DOI oversight even under alternative payment models

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Implementing Capitation-based Contracts

- Tracking and gathering encounter data and sharing with providers to change behavior.
- Termination clause to deal with: continuing care obligations, communication to members, medical record transfer, not to compete.
- Bonus pools for quality of care, patient satisfaction, and administrative compliance.
- Policies for use of other specialists and ancillary providers.
- Do you have a seat at the table for benefit design?

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Risk Adjustment

Hierarchical Condition Category ("HCC") Coding Becomes Increasingly Important With Increasing Degrees of Risk

Hypothetical example of individual patient risk score (numbers are examples).

Risk Adjustment Coefficients	$
Male Age 77	5,100
CHF	3,900
Diabetes w/complications	3,300
COPD	3,700
Beneficiary's predicted exp	16,000
Average exp for all beneficiaries	10,000
Risk Score	1.60

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Risk Adjustment

As degree of risk increases, risk adjustment becomes increasingly important. In Medicare Shared Savings, it impacts the provider's benchmark; and in advanced risk (capitation) for MA, it impacts the payment to the Plan and subsequent capitation to the provider organization.

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Commercial Risk

Full or Partial Risk

- **Provider's Own Self-Funded Employees**
- **Direct to Employer Contracting**
- **ACO**
- **Professional Capitation**
- **Full Risk or Global Risk**

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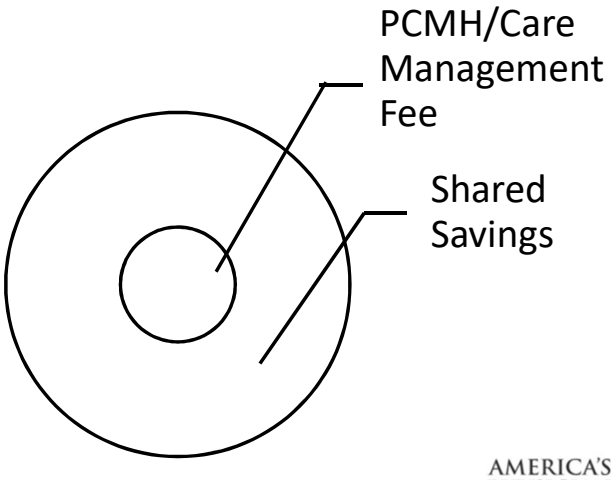
Commercial Carrier Programs

Often a Combination of Methodologies

- Some level of formal PCMH accreditation may be required.
- Care management fees paid on a PMPM basis are negotiable and often deducted from any savings.
- Number of attributed lives requirement may be lower (e.g., 1,500)
- Quality metric performance and STAR rating (MA) are important components.



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Commercial/Private Contracting

Additional Considerations

- Which products are included? Individual, exchange, employer group risk, self-funded, etc.
- Is this a private plan with a MA or Managed Medicaid product?
- 3 R's

Risk adjustment • **R**e-insurance • **R**isk corridors

- If pursuing partial capitation, what are carveouts (e.g., pharmacy, mental health, transplants, etc.)
- If shared savings, how are benchmarks established?
  - What is the attribution process?

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Attribution

Non-HMO attribution can be handled in several ways:

Prospective	Organizations are provided with a list of attributed members at the beginning of a performance year; attribution is based on data from the patients' use of services in the previous year.
Performance Year	Patients are attributed to organizations at the end of the year based on patients' use of care during the actual performance year.
Hybrid	Preliminary prospective assignment methodology with final retrospective reconciliation where there is prospective attribution initially; followed by retrospective reconciliation.

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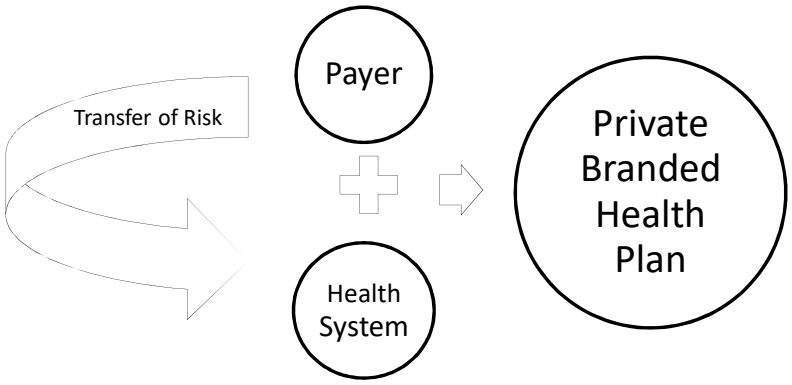
Medicare Advantage

- Enrollment growth, attractive option for health systems to:
  - Partner with payers - private branded plan



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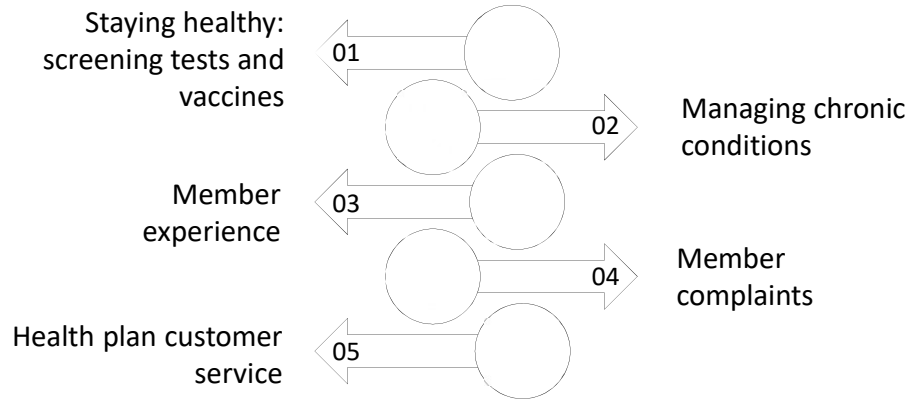
Medicare STAR Ratings

Five domains impact payment and enrollment growth potential.



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Managed Medicaid

- Managed Medicaid plans often willing to share risk and/or capitate providers.
- Shared savings/ACO, partial and full capitation alternatives.
- Need to understand the differences in populations and sub-populations, e.g., pediatric population, low-income adults, disabled individuals, dual eligibles, etc.
- Many organizations taking risk for Medicaid often have a high volume of Medicaid enrollees and experience caring for this population.

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Where?

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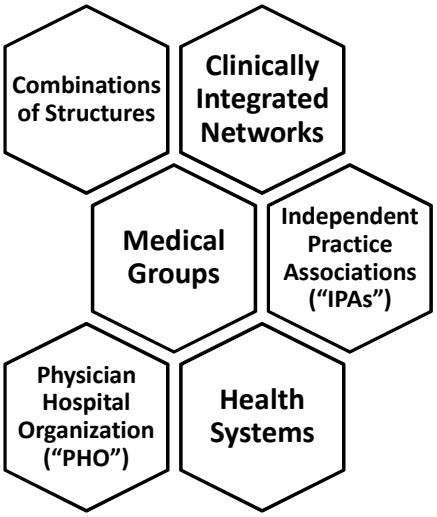
Types of Organizations Taking Risk



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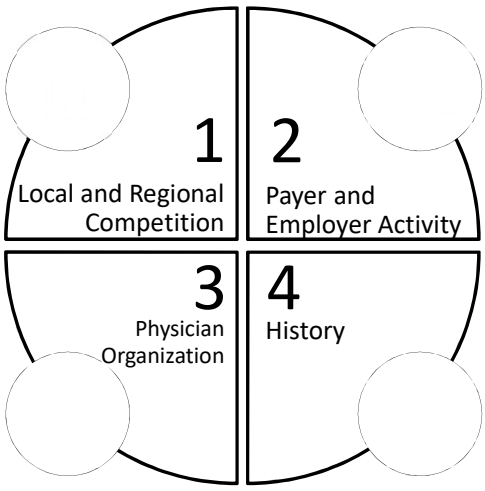
Market Factors to Consider



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Trigger Events that Accelerate Activation of Market Change

Employer direct contracting (e.g., Boeing, Intel)

Change in CMS rules

Competition moves first – white-label product with health plan

Kaiser or other out of state system enters the market

New outpatient models accelerate spread (e.g., Oak Street, Iora, One Medical)

Retail companies broaden scope of service (e.g., CVS, Walmart, Amazon)

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What Strategy Makes Sense for You?

- Creating the "glue" for clinical integration – sharing risk without merging
  - Separate healthcare systems
  - Separate medical groups
  - Other joint ventures
- Plan-to-plan private label products
  - Self-insured employers (including provider employees!)
  - Evolution of ACOs into capitation
- Provider-owned health plan
  - Commercial products
  - Medicare Advantage, Medicaid managed care
  - Regional product for Exchange

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How?

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Where Do You Start?

- ✓ **Establish the vision**
  - Is this a strategy or a new way of life?
  - Where is the opportunity?
- ✓ **Identify the leadership**
  - Clinical and administrative leadership must be aligned
- ✓ **What is the strategy**
  - Objective assessment of capabilities
  - Clear view of risk tolerance
  - Experience and potential for culture, behavior, and clinical change
- ✓ **Determine the population focus**
- ✓ **Establish the plan**

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Strategies for Adapting to Risk

Must Be Responsive to Market Conditions

Stage of Development	Entry	Proficient	"All-in"
	• Upside only • "No regret" populations	• Defined risk corridors • Aligned payers	• Organizational commitment
Products/ Populations	MSSP MSSP - Basic Self-insured employees P4P/PPO ACO – Upside only	Medicare Advantage capitation/risk Commercial capitation/risk MSSP/Next Gen risk Direct to employer	Medicaid/Dual Global Risk "Private Label" health plan Health plan joint ventures Provider-owned health plan
Critical Capabilities	• Network development • Integrated care management • Analytics • Governance – physician engagement	• Hospitalist/Care management team across the continuum • New care models • Predictive analytics • Aligned provider compensation	• Reserves • Full scope population health management services • Re-shape provider network/portfolio

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Consider the Population Characteristics

Medicare	Medicaid	Duals	Commercial
Chronic disease(s)	Moms, babies	Behavioral health	Prevention
End of life care	Behavioral health	Socio-economic challenges	Chronic disease
Physician loyalty	Patient dis-engagement	Patient dis-engagement	Physician "disloyalty"

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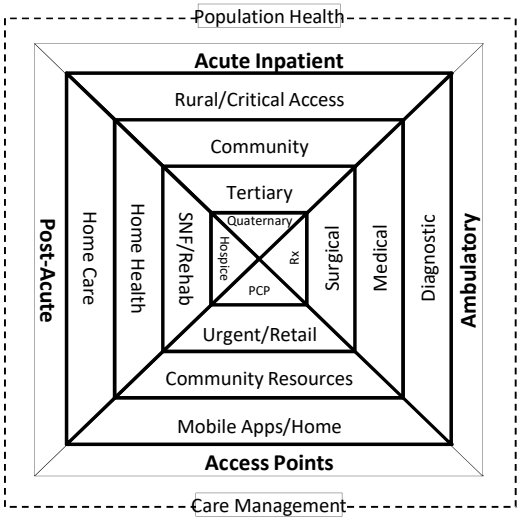
What is Your Network Strategy?



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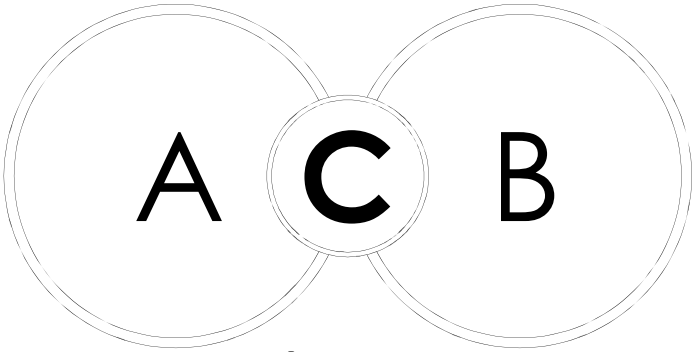
Dual Transformation



TRANSFORMATION **A**
Reposition Today

TRANSFORMATION **B**
Create Tomorrow

CAPABILITIES LINK
Catalyze Core Assets

Source: Anthony, Gilbert, Johnson, Dual Transformation: How to Reposition Today's Business While Creating the Future

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Surviving in World A While Shifting to World B

Activate Key Elements that Support Success in Both Worlds

- ☑ Actively manage "no regret" populations: employees, Medicare
- ☑ Develop bundled payment vehicles for certain procedures – expand market reach
- ☑ Create a more unified approach to care management: reduce redundancies, inefficiencies
- ☑ Relentless focus on patient access: anywhere, everywhere
- ☑ Optimize existing facilities through creative capacity management strategies
- ☑ Strengthen analytics to provide transparency on true costs and outliers
- ☑ Use payer $$ to evolve care models

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Implications of Transitioning to the "New" World

Confronting Our Sacred Cows

- Shifting capital away from bricks and mortar
- Making difficult decisions to reduce traditional "towers of power" (acute care beds)
- Aligning clinical resources with true population health needs: clinical network; physician mix
- Management resources and talent management

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Critical Success Factors – Population Risk

Financial

- Cash reserves
- Stable history
- Pricing
- Tolerance for risk
- Population risk profile
- Contract language

Functional

- Experience
- Population size
- Geographic coverage
- Analytics and data capture
- Actionable reports
- Care management and patient activation

Cultural

- Population focus (vs. provider-centric)
- Constructive collaboration among providers
- Accountability
- Stamina to respond to competitive forces (internal and external)

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Section 2

Care Coordination Principles and Operating Framework

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Where Do You Start?

- ✓ Establish the vision
  - Is this a strategy or a new way of life?
  - Where is the opportunity?
- ✓ Identify the leadership
  - Clinical and administrative leadership must be aligned
- ✓ What is the strategy
  - Objective assessment of capabilities
  - Clear view of risk tolerance
  - Experience and potential for culture, behavior, and clinical change
- ✓ Determine the population focus
- ✓ Establish the plan

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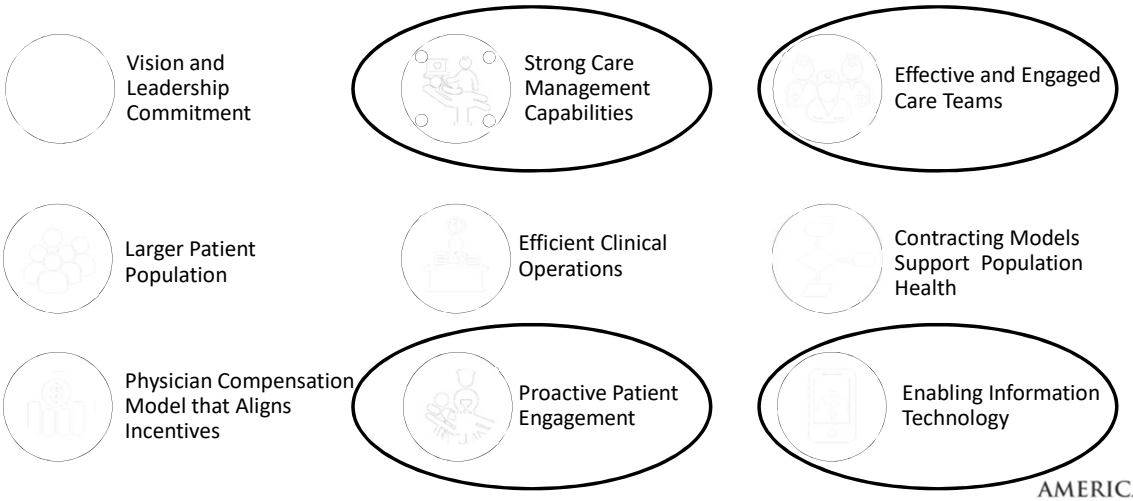
Value-based Critical Success Factors



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Strong Care Management Capabilities

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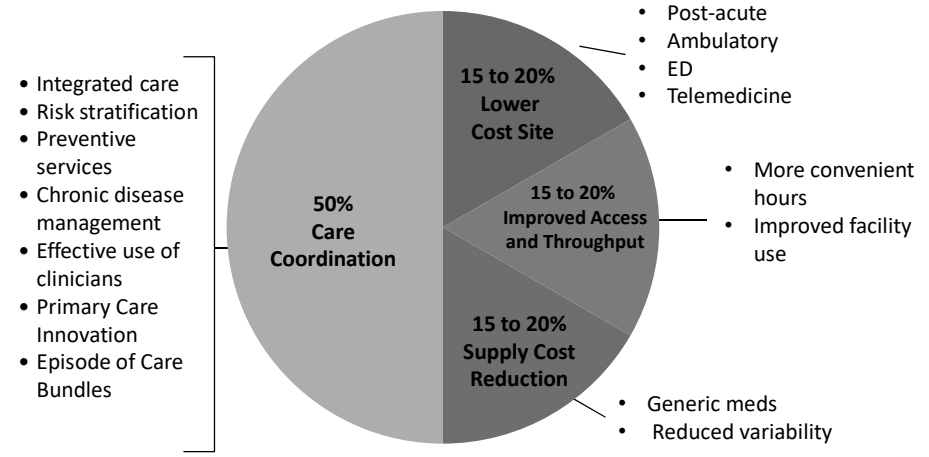
Care Coordination is the "GPS" for Patients and the Most Effective Cost Intervention in Achieving Benefits from Care Model Redesign



Source: Bending The Spending Curve By Altering Care Delivery Patterns: Health Affairs 2017: 36(5)

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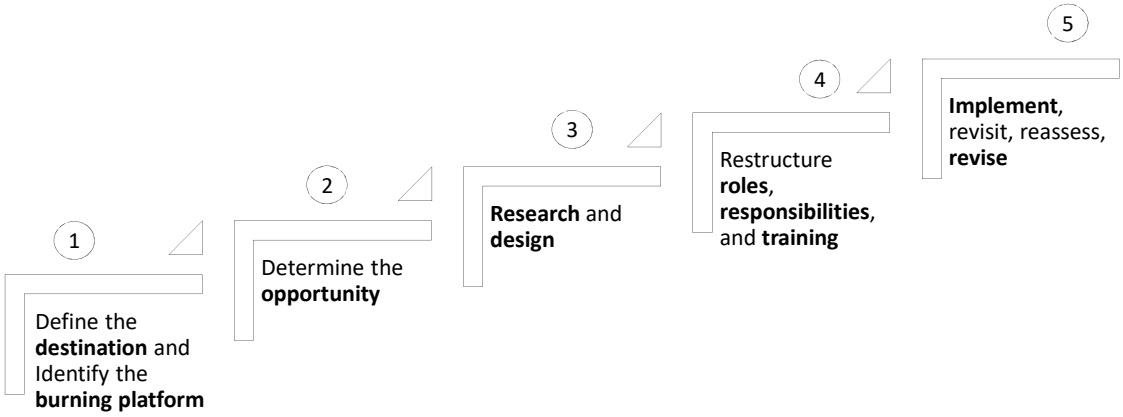
Care Coordination Starter Kit: Where to Begin?



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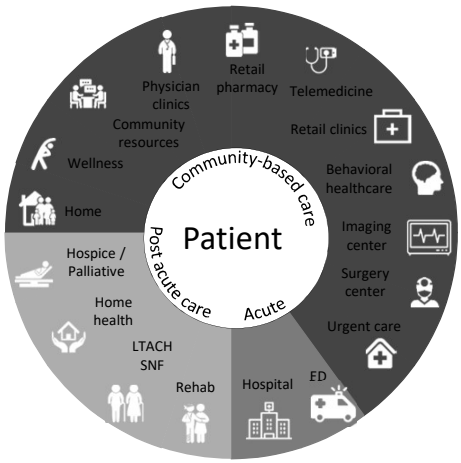
Leverage and Repurpose Existing Resources While Creating and Maintaining New Partnerships: Organized System of Care



Desired Attributes

- High-performing integrated model
- High quality, efficient care across the continuum and community
- Standardized process for care coordination
- Evidence-based practice and programs
- Engagement and empowerment of patients and providers
- Information technology infrastructure to support data driven interventions

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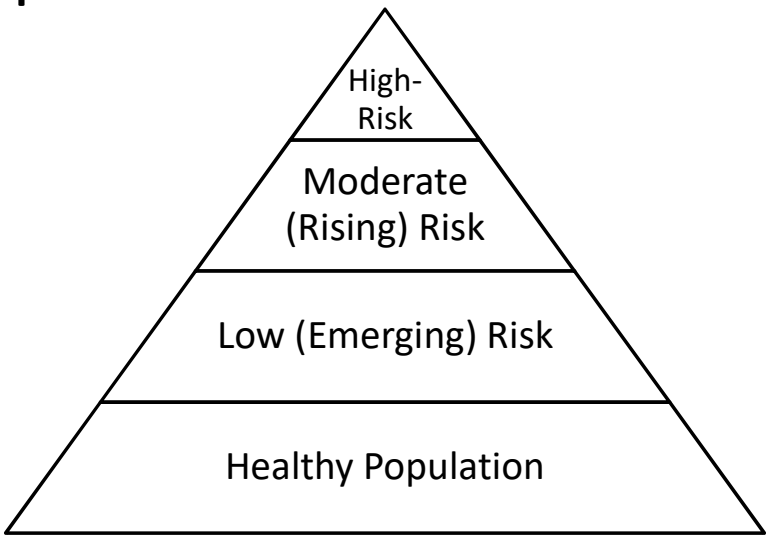
Population Risk Stratification



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Why Is It Important?

- Organizations assuming risk for populations based on overall performance
- Focus high intensity services on high risk populations
- Majority of healthcare dollars are spent by a small percentage of population
- Increasing need for providers to risk stratify
- Risk stratification helps care managers organize their workflow and task activities

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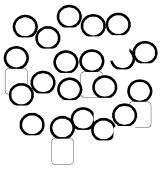
Apply Risk Stratification to the Care Model



Risk Stratification Tool

- Consolidate data from Claims, EMR,
- Analyze claims and clinical data
- Stratify patients by risk levels
- Refer to appropriate level of care

High Risk CM | Complex CM | Disease Management | Preventive Health

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Typical Risk Stratification Criteria and Triggers

Inpatient Triggers

- Patients with extended LOS (> 5 days)
- Patients with more than 1 unplanned admission within the past 90 days
- Patients with high intensity of service: ventilators, dialysis
- Age > 75 years
- Admission to a long-term care facility
- Certain high-risk diagnoses (both primary and secondary) including: heart failure, COPD, renal failure, stroke, complex cancers, dementia, or severe mental health issues
- High risk units (ICU, step down, transplant)
- Any admission or ED visit for a patient on CM

Outpatient Triggers

- Chronic diseases with potential down the road complications: diabetes, asthma, hypertension, coronary heart disease
- Triggers to indicate poor self-maintenance such as HbA1c > 10
- Patients with more than 3 chronic conditions
- Patients with more than 7 medications
- Patients with history of frequent ED visits and admissions
- Mild to moderate mental health issues

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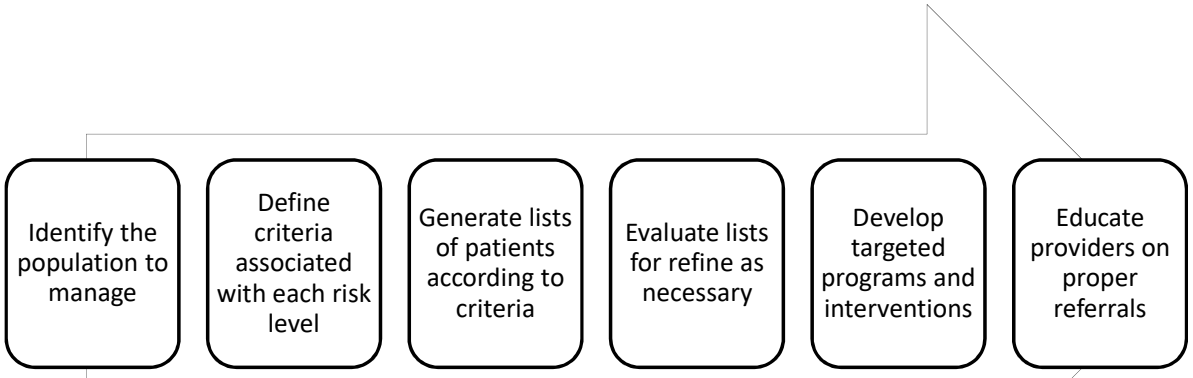
Redesigned Risk-based Care Model



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Typical Interventions for Different Risk Levels

High Risk CM	• Care Manager calls 3 times per week • In-person, in-clinic visit with patient • Work in partnership with practices and providers • Early intervention for urgent symptoms – refer to urgent care or hospitalists
Complex CM	• Care Manager calls 2 times per week • Early identification of patients requiring medical intervention • Symptom and disease education
Disease Management	• Interactive Voice Response ("IVR") outreach • Care Manager calls when triggered by IVR • Care Coordinator calls 1 time a month, can refer to Care Manager
Preventive Health	• Automated clinical workflow and patient reminders • Patient education materials

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Typical Care Manager Workflows

Push/Pull Referrals	Assess Needs	Care Plan	Follow-Up
• Educate referral sources which may include data, providers, and case managers • Establish a process via telephone, fax, technology	• Assess patients' needs (ADLs, IADLs, PHQ-9) • Consider scoring and tracking progress • Identify frequency of assessments • Develop protocols for interventions based on assessment results	• Set goals with the patient and caregivers • Develop action items and interventions • Identify barriers • Track progress	• Track progress • Adjust care plan as needed • Continually assess patient for right level of care and clinical program

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Effective and Engaged Care Teams

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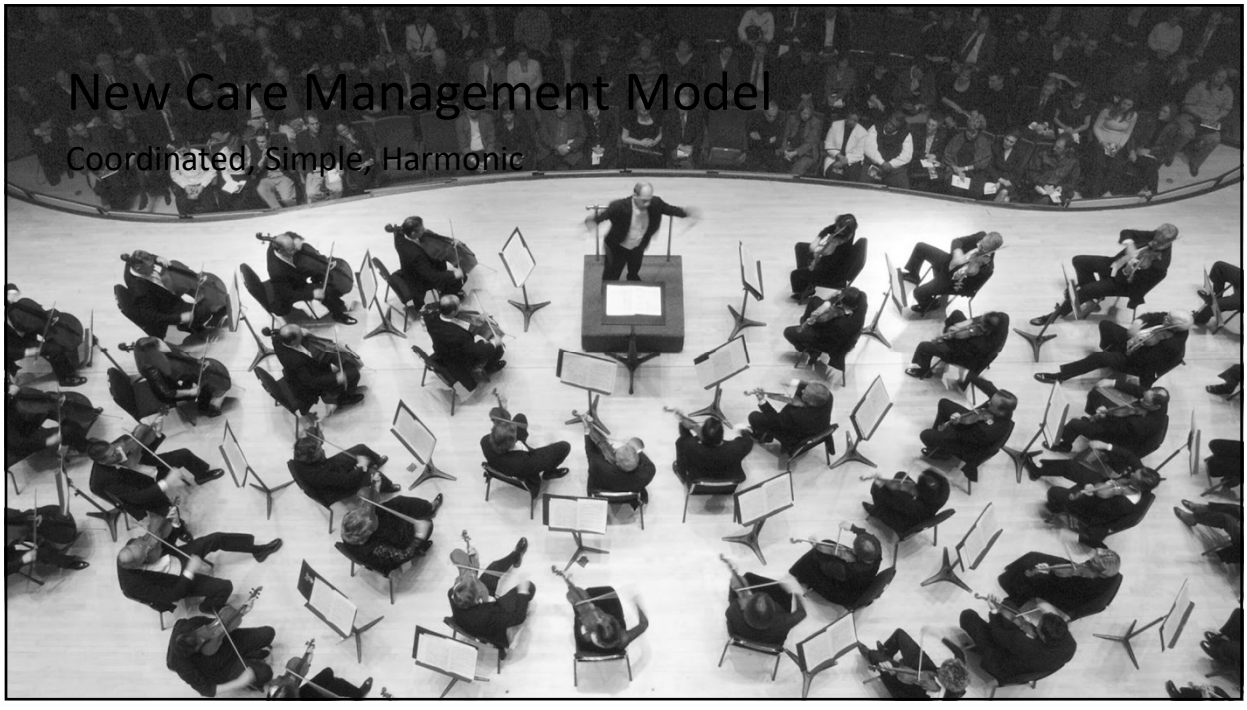

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Redesigned Care Team

Desired Attributes

- Accessible-"Always on"
- Longitudinal Care Plan
- Adjusts for Care Intensity
- Many Staff Roles Upshifted
- Use Shared Decision-Making with Patients
- Responsible in-sourcing
- Good Partnerships
- Meet Quality Guidelines
- Invest in upgrading people skills

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Care Management: What Is It and What Are Its Guiding Principles

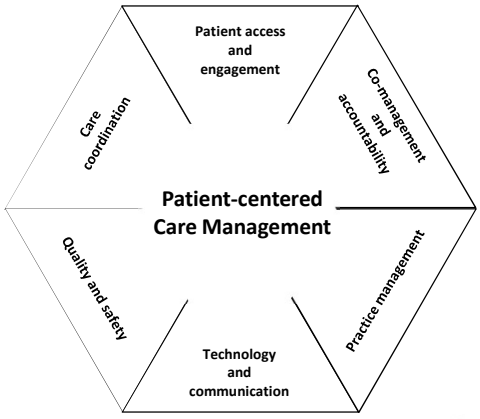
> *A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.*
>
> The Case Management Society of America

Care management infrastructure:

- Care management organization
- Hospital-based clinicians
- Inpatient care management
- Ambulatory case management
- Post-acute care settings
- High-risk clinics
- Disease management
- Pharmacy management
- Transitions management
- Referral and centers
- Utilization management
- Health education/promotion
- IT

Care management functions:

- Care plan development and management
- Education/Self-management
- Care coordination across networks
- Support to patient and caregivers
- Referral to community-based resources
- End-of-life support (advanced directives, palliative care and hospice referrals)



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Integrated Care Management

Foundational Principles	Care Management							
Care Settings	Hospital		Post-Acute Care				Ambulatory and Community	
Practice Areas	ED	Inpatient	SNF	Long-term care	Home Health	End of Life Care	Remote Care Managers	MD Office Care Managers
Roles and Responsibilities	• Readmission reduction • Appropriateness of admission/ gatekeeping • Connection to social services • Follow-up care • ED diversion	• Care progression • ALOS reduction • Post-discharge planning • UM (continued stay status) • Psychosocial services • Patient Class/ Observations	• ALOS reduction • Connection to the ambulatory care manager • Managing transitions of care • BP and other disease-specific programs	• End-of-life ("EOL") discussions • Connection to the ambulatory care manager if newly admitted	• Assist patients with self-management • Home assessment (falls, safety, etc.)	• EOL discussions • Palliative care • Hospice	• Telephonic assessment and counseling • ED visit prevention • Risk stratification • BP and other disease-specific programs	• Co-visits • PCMH integration • Management of complex chronic patients • Quality metrics and UM review • Managing transitions of care

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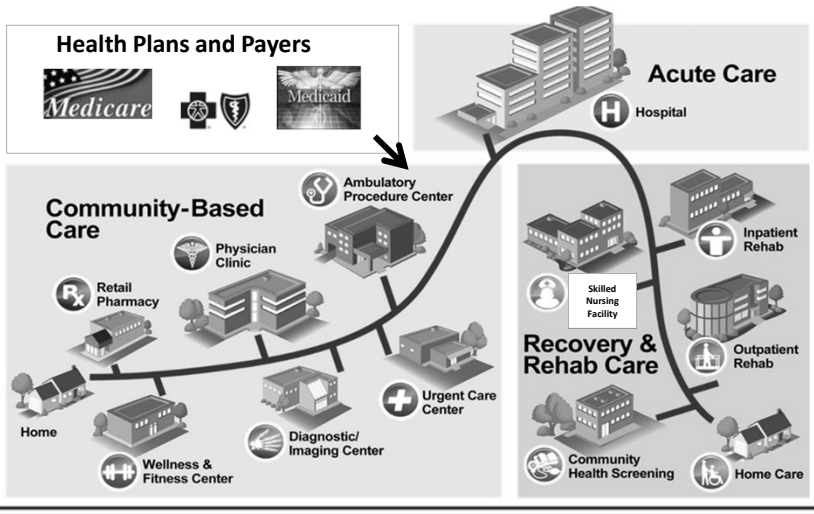
Care Management is the Common Thread: Linking the Patient Through Every Setting



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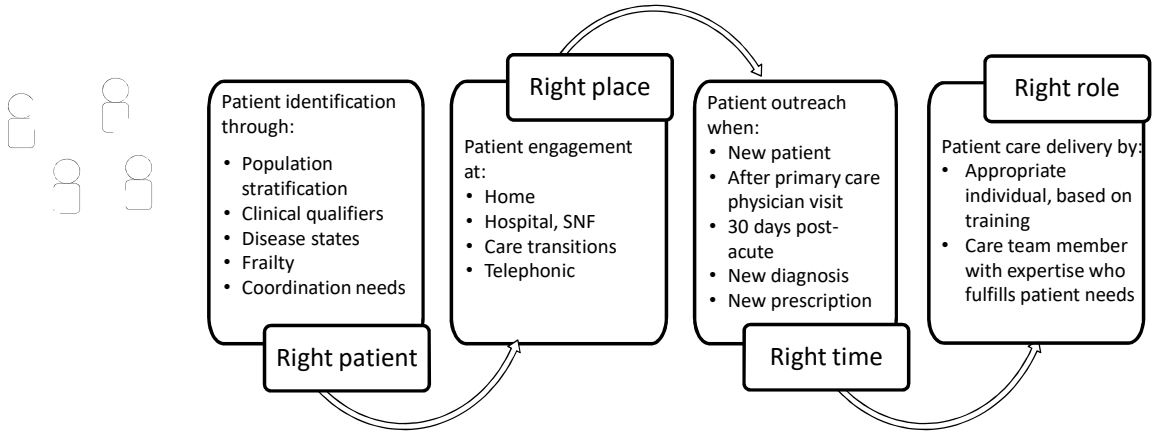
Care Management Program Design



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Basic Elements of a Patient Care Plan

Patient Goals
- Align essential health goals with patient and family/caregiver preferences and personal goals
- Goals need to be measurable – tie them with an outcome

Problems/Issues
- These do not need to be (and often are not) ICD diagnosis codes
- May include chronic conditions like diabetes or COPD, but also issues like nutrition or falls

Interventions/Achievable Action Items
- To-dos" or next steps that need to be taken in order to meet the goal(s)

Delegation/Timeline
- Interventions and action items can be assigned to any member of the care team and/or the patient/family along with a target completion date; progress should be tracked

Barriers
- Any actual or potential obstacles or challenges that arise that could impede the completion of an intervention or fulfillment of a goal; all barriers need to be overcome with an action

Living Document

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Types of Care Plans

Episodic	Routine	Complex	Advanced
Condition-based	Focused on annual wellness exam	Patients with Poly-Chronic Conditions	End-of-Life Issues
Prior to an anticipated episode of care	Discussion of patients goals for the year and options available	Includes patient and family/caregiver and multi-disciplinary team	Clarify patient perception of their health and treatment options
Surgical procedure with post-surgical needs	Planned	Patient Defined Goals	Medical and non-medical interventions
Anticipated		Unified Care Plan	

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Sample Care Plan

Goal	• "I want to be able to get back to my gardening." • General strengthening, improve and stabilize quad strength and ambulation.
Problems	• Currently walker-dependent s/p right knee replacement. • Pain management: Currently on PCA pump.
Actions	• Exercises to progress knee strength and range of motion to 80° flexion by D/C. Practice walker stability, stairs. • Progress from PCA to oral meds within next 24 hours with pain controlled at 3.
Delegation	• PT, OT • M.D., nursing
Barriers	• 3 steps to reach home front door: PT and OT working on walker safety on steps.

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Case Study and Group Discussion:

Intermountain Healthcare: Empowering Pharmacists to Manage At-Home Medications

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Intermountain Healthcare

- Idaho, Utah, Nevada
- Not-for-profit system of 24 hospitals, 215 clinics, 2,500 physicians and advanced practice clinicians in medical group, health insurance company (SelectHealth)

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Intermountain Healthcare

Intermountain at Home:

- Expansive home-based services incorporating more complex medical treatments and technologies
- Providing more complete care beyond brick-and-mortar facilities
  - Primary Care visits and checkups
  - MDs, advanced practice providers, nurses, pharmacists, care managers and others
  - Goal to keep patients comfortable and cared for at home
- One elemental piece of the program in safe, high-quality medication management

Challenge:

- Empower pharmacists to fulfill more active clinical roles through Collaborative Practice Agreements (CPAs) with prescribing providers

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Intermountain Healthcare

Collaborative Practice Agreements (CPAs)

- Authorized pharmacists have the appropriate training to provide clinical care in the related practice
- Agreements give pharmacists permission to:
  - Write and order laboratory tests
  - Write, order, and change the dosage or frequency of medications
- The first CPA allowed pharmacists to manage dosage levels for infused vancomycin
- Physicians recruited who would allow pharmacists to manage vancomycin for them
  - At first hesitance, but has evolved into a trusted relationship

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Intermountain Healthcare

Intervention

- Established committee led by Infectious Disease team
  - Created pharmacist protocol based on Infectious Diseases Society of America (IDSA) clinical practice guidelines for managing vancomycin
- Pharmacists given extensive training on Vancomycin management led by head of Infectious Diseases
- Protocol and training rolled out via in-person and online advanced education modules
- Each pharmacist had to pass practical case-based test to demonstrate skill level, and must re-certify annually

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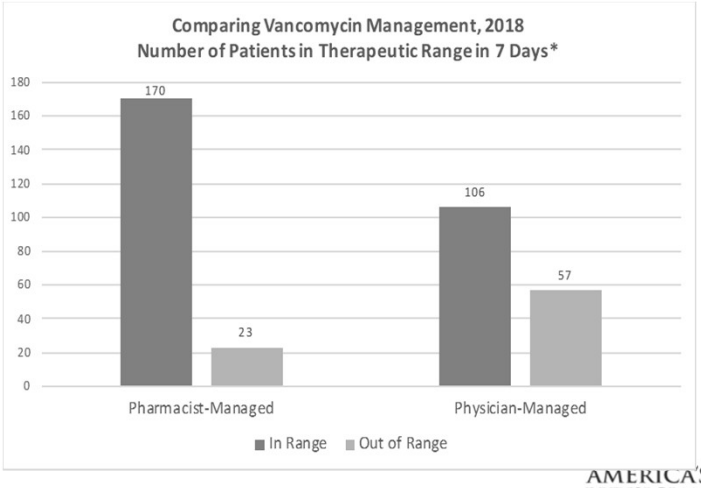
Intermountain Healthcare

Results

- Significant improvement in effective management of home-based patients on vancomycin
- Measurement is onset of therapeutic level (# of patients in therapeutic range in 7 days)
- In 2018, pharmacists able to obtain therapeutic levels within 7 days 88% of the time – compared with 65% of the time when managed by provider



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Intermountain Healthcare

What's next?

- CPA for home-based parenteral nutrition for adults
  - Finishing education and competency evaluations for pharmacists and dieticians
  - Next expansion will be to pediatrics/newborns

Summary

- CPAs empower pharmacists and providers to perform the roles they're meant to – getting patients rapid access to the care they need at home
- Program supports safety, quality and patient experience; prevents unnecessary hospitalizations; improves operational efficiencies; and minimizes cost

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Proactive Patient Engagement

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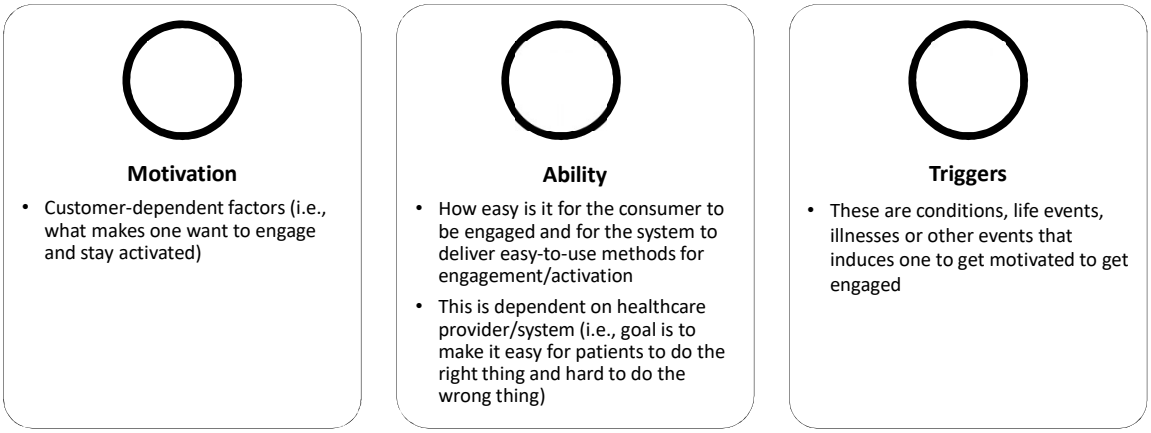
Framework for Successful Patient Activation



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Patient Engagement

"Actions individuals must take to obtain the greatest benefit from health care services available to them."

The Center for Advancing Health

- Focus on behaviors of individuals that are critical to health outcomes
- Individualize information and professional advice according to needs, preferences, and abilities

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How is Patient Engagement Different from Patient Activation?

Definitions

- Patient Engagement – acquisition of knowledge, skills and confidence to manage one's health that leads to self-reinforcing repeated interactions across multitude of healthcare channels
  - Education oriented
- Patient Activation – the activities and interventions that are used to support increased participation and personal accountability in their own health by patients and consumers
  - Action oriented

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Patient Engagement Paradigm Shift

From	To
• Telling patients what to do • Transfer of information • Compliance	• Listen, problem solve, and collaborate • Instill confidence • Build capabilities

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Validated Patient Activation Measures

Survey items assess the following:

Self Management

- Ability to self-manage problems
- Ability to engage in activities to maintain health
- Ability to be involved in treatment choices
- Ability to collaborate with providers
- Ability to select providers based on performance
- Ability to navigate the health care system

Levels of Activation

- Belief that the patient role in activation is important
- Having the confidence and knowledge to take action
- Proactively taking action to improve health status
- Staying the course even under stress

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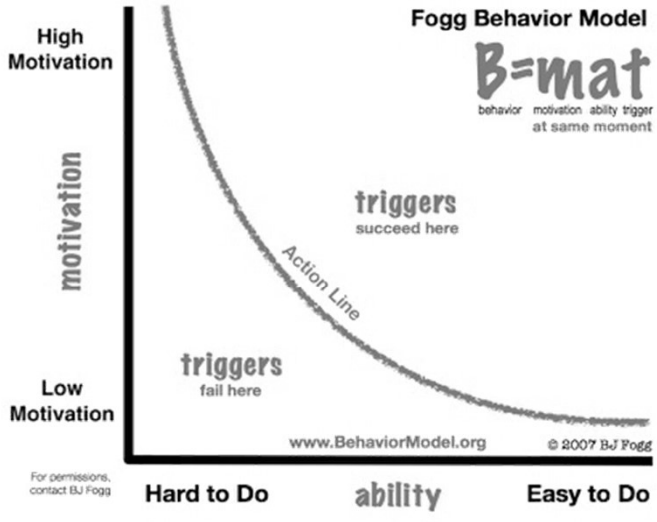
Solution Design and Development

Fogg method of Behavior Design (Motivation, Ability, Triggers)



Source: http://www.foggmethod.com/.

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Improving Activation Scores Improves Outcomes

↑ satisfaction
Patient activation scores = ↑ Clinical outcomes and patient
↓ Cost of care

Growing body of research indicates that validated patient activation scores can be a significant predictor of outcomes including improved service utilization of emergency department use and hospitalizations.

Increases in patient activation scores over 4 years were correlated with improvement in medication adherence, self-management knowledge functional health and reduced number of emergency department visits. When activation levels change, many health-related outcomes change in the same direction.

Hibbard, JH and Greene, J; What the Evidence Shows About Patient Activation. Health Affairs: 32 (2): 2012

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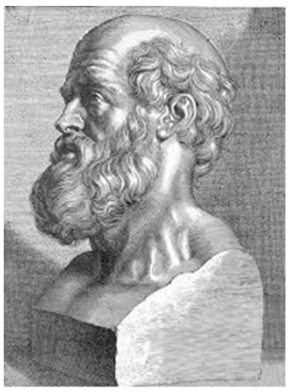

"It is more important to know what sort of person has a disease than it is to know what sort of disease a person has."

- Hippocrates

(460-370BC); Physician, Father of Western Medicine)

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Case Study and Group Discussion:

IntegraNet Health:

BINGO! Improving Quality Through Patient Engagement

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IntegraNet Health

IPA and MSO in Houston, Texas – est. 1997

- Offering shared-risk and population health management to 1,600 primary care and specialty physicians
- Close attention to preventive care and disease care initiatives to help physicians meet required quality standards and achieve healthier patient populations

Belief: The best way to improve quality metrics and clinical outcomes is to keep patients focused and engaged in their care

- Goal to use Patient Engagement Techniques (PETs) to empower patients to take charge of their health and have fun at the same time!

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IntegraNet Health

Challenge: Primary Care Physicians are accountable for quality measures, but face issues including:

- Occasionally assigned patients they have never seen
- Patients seeking care in the ER or Urgent Care when they do not have an established relationship with a medical home
- Patients may not follow up with PCP for preventive health screening
- Health literacy among patients may be low and patients may not understand the importance of preventive care
- Patients may only see their physician for illness treatment – not wellness related screenings

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IntegraNet Health

Interventions:

1. **"BINGO" (Being Old Never Gets Old) card** for MA patients for needed annual preventive screenings
   - Quality metrics listed in BINGO squares; providers record when screening occurred in each square
   - When patient completes all squares they receive a $15 gift card
     - Meets guidelines of the Centers for Medicare & Medicaid Services (CMS)

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IntegraNet Health

2. Community health worker (CHW) visits

- CHWs used in patient's home as the "boots on the ground"
- Primary focus:
  - Foster patient engagement
  - Promote access to available community resources
  - Provide educational resources to prevent or decrease exacerbations of chronic disease

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IntegraNet Health

2. HEDIS Health Fairs

- Help physicians achieve optimum quality metrics
- Members invited and receive preventive screening tests, including mammograms, blood draws, and blood pressure checks
- Qualified staff assess many of the HEDIS measures, with results submitted to PCP for review

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IntegraNet Health

Results:

- 2018 - CHW outreach helped PCPs close 810 quality measure gaps
  - Closed 822 gaps 1st half of 2019 - projected increase 100% year to year
- Key gap closed - diabetic retinal exams (DRE) up by 50% 2018 - 2019
  - Purchased camera for CHWs to take retinal photographs in patient homes
  - Photos sent to ophthalmologist with results sent to PCP
- Projection for 2019:
  - 135% increase in number of functional assessment gaps closed
  - 200% increase in pain assessment gaps closed
  - CHW education resulted in additional gaps in care closed
- 2019 - BINGO card program expanded to all MA members
  - Seeking CMS approval to extend BINGO card to ACO beneficiaries

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Information Technology and Data Analytics

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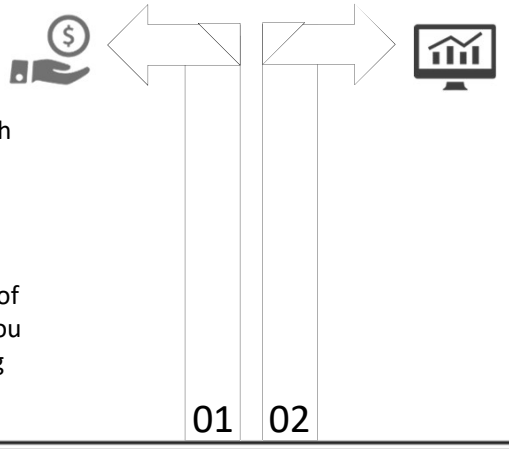
IT Support for Care Coordination Depended on Two Core Sources



Paid Claims Data

- Tells you who your patients are and much of what happened to them
- Cannot tell you how they are doing
- Not a good indicator of whether the things you are doing are working

01

EHR Data

- Provides more detailed information on clinical quality and care pathway compliance
- Data models are complex and often customized
- Few specific data standards across EHR software platforms

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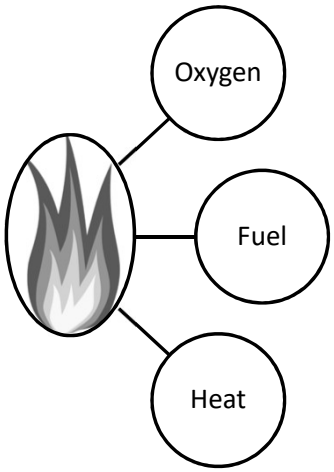
Giant Leap Forward for Humans



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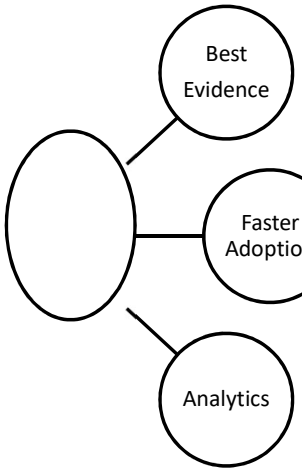
Giant Leap Forward for Care Coordination



What should be done?

How do we transform?

How are we doing?

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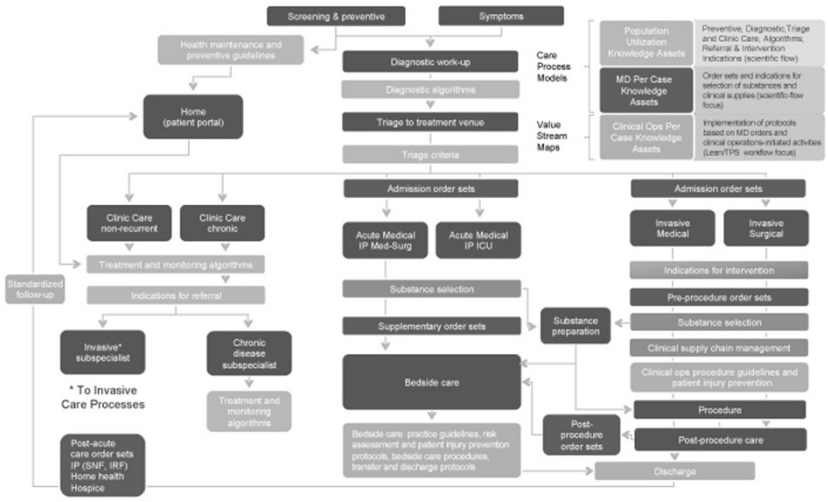
Other Key Enablers Were Electronic Data Warehouses Patient Registries and Care Improvement Maps



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But What About Patient Generated Data ?

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Potential Roadmap for Patient Generated Health Data ("PGHD")

2018-2023
Growth
- Provider and Patient Interest increases
- Apple opens Health Kit to App Developers
- Open Application Standards for data (FIHR)
- Liability Concerns Addressed

2024-2028
Maturity
- PGHD flows seamlessly as part of routine care and research
- Machine-learning assisted
- Fewer face-to-face provider visits needed for optimal care
- Remote access available for many health services

2016-2017
Early Adoption
- Cutting edge organizations see value and begin incorporating PGHD into EDW
- Interest in Precision Health begins

2012-2015
Exploration
- Explosion in consumer devices
- Federal government explores PGHD opportunities
- Patient collection of PGDH begins

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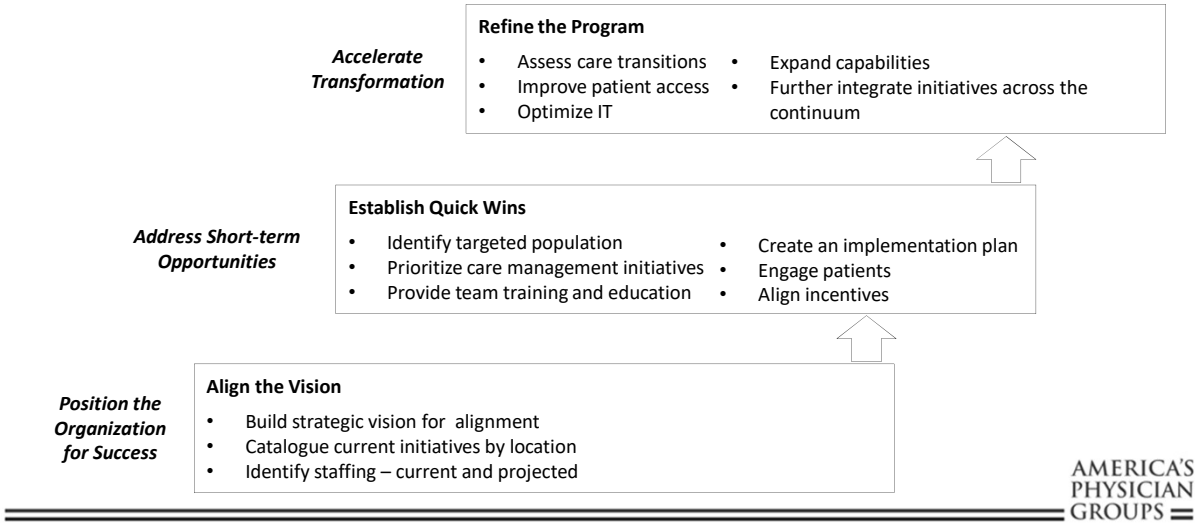
Putting It All Together….. Incrementally



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Section 3

Physician Leadership, Culture Change & Reinforcing Incentives

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How do we get Docs on board?

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It will **NOT** be easy…

Over 70% of change efforts **FAIL**

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Based on books and articles by John P. Kotter. Harvard Business Review

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Key Ingredients for Success

- Strong leadership
- Effective, value-based infrastructure
- Incentives to hit goals

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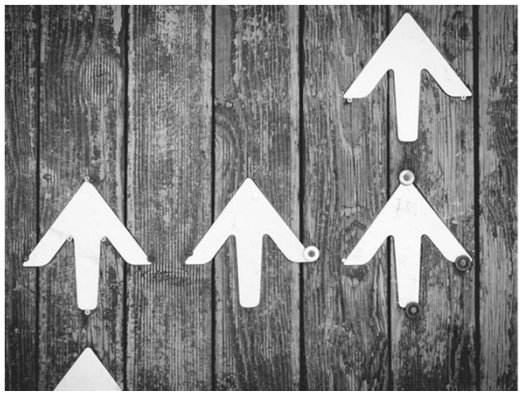
Strong Leadership



- Shapes culture of the group
- Drives engagement
- Promotes value-based strategies

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Characteristics of Strong Physician Leaders

Emotional Intelligence	Vision	Personal Commitment
Professional Credibility	Quality Improvement	Organizational Altruism

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The right leaders will guide the **changes** you need to make

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Kotter's 8 Steps for Change

Create a climate for change
- Establish a sense of urgency
- Create the guiding coalition
- Develop a change vision

Engage and enable the whole organization
- Communicate the vision for buy-in
- Empower broad-based action
- Generate short-term wins

Implement and sustain change
- Never let up
- Incorporate change into the culture

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Based on books and articles by John P. Kotter. Harvard Business Review

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Step 1: Establish our sense of urgency

- Most important step
- Complacency kills change
- Don't just focus on building a "rational" business case with lengthy, expensive analysis

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Step 1 (continued)

Tactics for building *true* urgency:

- Bring outside reality in
- Behave with urgency every day
- Find opportunity in crisis
- **Communicate**

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Step 2: Create our guiding coalition

- Must contain:
  - A shared objective
  - Trust
  - The right people-power, expertise, credibility

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Based on books and articles by John P. Kotter. Harvard Business Review

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Step 3: Develop our change vision

- Bold but achievable
- Paints a vivid picture of the future
- Appeals to hearts (and minds)
- Is easy to communicate quickly—in 60 seconds

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Step 4: Communicate our vision for buy-in

Must be:

- Constant
- Heartfelt
- Consistent

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Step 5 Empower broad-based action

- Common barriers that prevent change
  - Mindset
  - Systems
  - Bosses

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Step 6: Generate short-term wins

Wins must be:

- Visible
- Unambiguous
- Relevant
- Celebrated

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Step 7: Never let up

- Eliminate unnecessary, demoralizing work
- Continue learning from experience
- Keep urgency up

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Step 8: Incorporate change into our culture

To embed change into our culture:

- It's OK if resisters leave
- It's imperative that we promote the right people

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What **infrastructure** should you consider in a value-based world?

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Components of High-Performing Medical Groups

Effective Governance & Management Structure	Strong Physician-Administration Leadership	Aligned Incentives/ Physician Compensation	Patient Oriented Efficient Operating Systems	Financial Processes and Systems to Maximize Revenue	Quality Management & Controls
Governance	Leadership	Physician Management and Compensation	Patient Access and Throughput	Revenue & Expenses	Risk Management
Org Structure	Communication	Physician Performance	Non-provider Staffing	Physician Performance	Quality Improvement
	Strategy/New Business Development		Facilities	Contracting	Clinical Operations
			Use of Technologies	A/R Management	Medical Records
			Patient Satisfaction	Coding & Documentation	
			Operating Policies & Procedures	Central Business Office	
			Human Resources		

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From Survive to Thrive: Leading the Transition to Value. Marc Mertz and Dr. Peter Valenzuela. Group Practice Journal. April 2015

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Value-Based Implications

Effective Governance & Management Structure	Strong Physician-Administration Leadership	Aligned Incentives/ Physician Compensation	Patient Oriented Efficient Operating Systems	Financial Processes and Systems to Maximize Revenue	Quality Management & Controls
The group is better positioned to respond to opportunities and market changes	Dyads combine skills of physicians and administrators; Increases buy-in for group strategy	Medical groups take financial risk for care of population in many markets	Ready access to care results in higher quality and more efficient, coordinated care	Medicare Advantage reimbursement is impacted by diagnosis coding (HCC)	Quality scores impact reimbursement and contribute to continuous improvement
	Decision-making considers clinical, financial and operational factors	Group reimbursement increasingly ties to quality, patient satisfaction and cost of care	Patient satisfaction scores impact reimbursement and are publicly reported	Payer contracts include new reimbursement methodologies, including risk arrangements	Standardized use of clinical best practices produces better outcomes and efficient care

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Once you have your leadership and infrastructure, how do you reinforce **incentives**?

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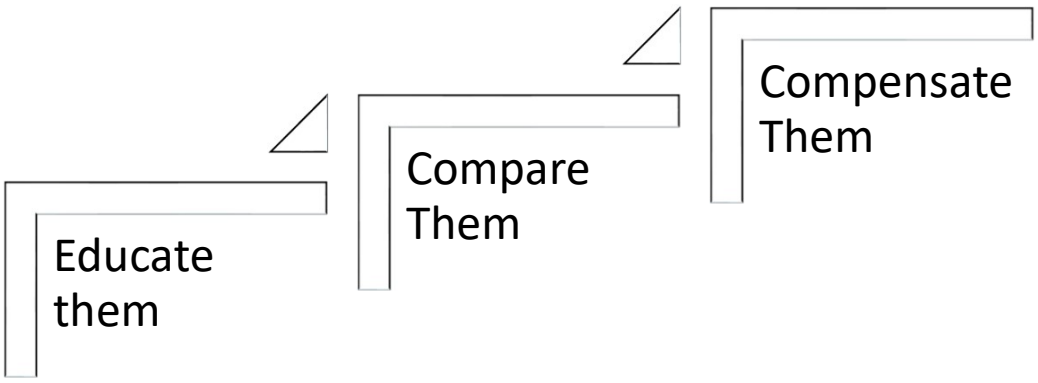
Ways to affect physician behavior



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Educate Them:
How does moving to value help Primary Care?

- **Rewards and Recognition** for prevention and management
- **Better Quality** outcomes for their patients
- **Connectedness** in an otherwise isolated world
- **Influence and Access** with payers to better contracts
- **Care management** services for which they are not paid
- **Efficient Data** transfer between themselves and specialists and facilities
- **Feedback** on performance and supports to improve

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Educate Them:
How does moving to value help Specialists?

- The network promotes awareness of specialists by primary care providers
- Reporting back to referring physician is enhanced
- The system can make it easier to refer to an in-network specialist than an outside one
- Can demonstrate superior quality in the market
- The specialist will have better access to the referring physician's clinical data

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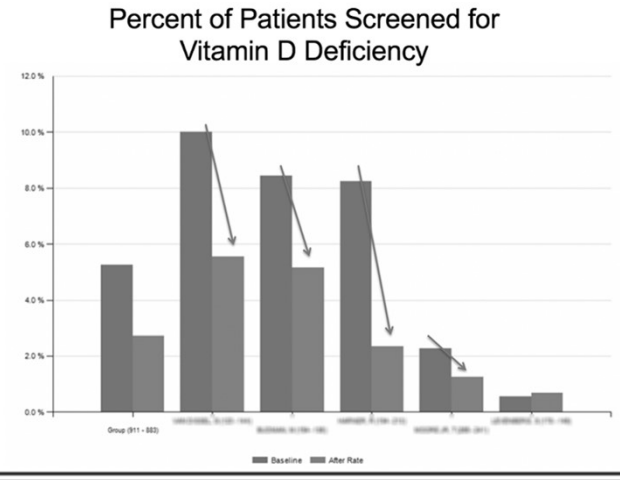
Compare Them:
What are your partners doing?



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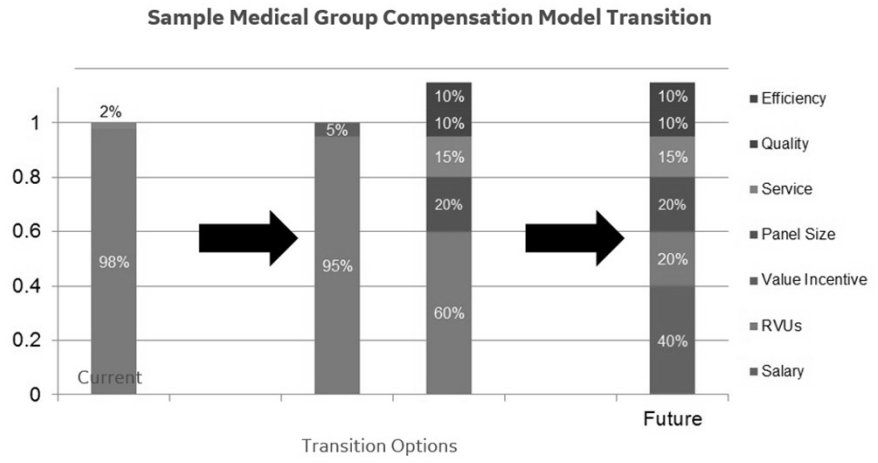
Compensate Them: What are you prioritizing?



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Case Study

Sharp Community Medical Group:
A Team-Based Approach to
Practice Transformation

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Sharp Community Medical Group

IPA of 800 primary and specialty care physicians

- Strong commitment from Board to become a group synonymous with outstanding quality—despite the fierce independence of varied and unique practices
  - The Vision 2020 goal—to raise overall quality and performance. This meant that <u>every</u> physician would be required to achieve a minimum performance standard

Celebrated 30th anniversary September 2019!

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Sharp Community Medical Group

CHALLENGE

- Diverse physician practices in unique communities
- Physicians want to be proud of quality/patient experience scores but demands of practice management can prevent this focus
- Many practices:
  - Lack systems supportive of care management and tracking for optimal process and outcomes
  - Operate on narrow financial margins, with little resource flexibility
  - Not equipped to manage practice changes needed to improve care

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Sharp Community Medical Group

INTERVENTION: Primary Care Performance Initiative

- Voluntary participation focused on improving select quality/patient experience measures -- unblinded performance scores provided to all physicians
- Participation requirements:
  - Performance improvement plan - to focus improvement efforts on priority measure
  - Medical Director 1:1s - to ensure clear goals and track progress
  - CME meetings - ensure awareness of evidence-based guidelines and discuss quality/patient experience measures
  - Learning collaborative participation - share best practices helping others improve on patient care delivery and outcomes

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Sharp Community Medical Group

INTERVENTION (cont.):

- Identified need for practice-level organizational change to accelerate improvement -- creation of more effective clinical teams, better coordination of care, improved information management, and office systems enhancing patient experience
- Leveraged **SCMG Practice Transformation Department --** program manager, 3 performance improvement specialists, and program coordinator to assist practices in incorporating patient-centered medical home and Lean Six Sigma concepts

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Sharp Community Medical Group

RESULTS – 96% physician participation in initiatives -- Positives:

- **Hypertension blood pressure control** -- performance improved by **13.5%** from 2017 by providing blood pressure training and competency to practice staff
- **Breast and colorectal cancer screening** -- most practices receiving support achieved the **75th percentile** in this measure by implementing team-based care and converting data into actionable reports
- **Overall quality performance** -- overall quality scores showed **significant improvement** among most physicians using support for practice transformation
- **Based on this success** – SCMG expanding Practice Transformation team to enable provision of greater assistance to our practices

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Summary

- Strong leadership drives change and establishes culture
- A value-based infrastructure promotes coordinated care
- Incentives motivate the behavior you need

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Questions?

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