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Jeffrey Le Benger, MD, FACS
Putting Patients First by Retaining Physician Control

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Members and friends,

Welcome to the Journal of America’s Physician Groups Colloquium edition … and to some interesting times in healthcare.

It’s been gratifying to see the value movement flourishing, even picking up momentum. Signs include the continued rise of commercial accountable care organizations (ACOs) and Medicare Shared Savings Program (MSSP) ACOs, a profusion of new value-based products, the ongoing growth of the Medicare Advantage program, and more.

Additionally, ever since Congress overwhelmingly passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, policymakers and legislators have been eager to keep up the transition to risk-based delivery. The Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma and Health and Human Services Secretary Alex Azar have repeatedly committed in word and action to accelerating the movement.

For doctors and physician groups still on the fence, one thing is certain: The value movement isn’t going away. If anything, the latest development shows we’re on the fast track.

In August, CMS released a proposed rule for the MSSP that would shorten the deadline for ACOs to begin taking downside risk. Currently, the majority of participants are in Track 1, an upside-only model allowing up to six years to move into two-sided risk. The new rule would reduce that time to just two years.

I believe this proposed rule is the biggest game changer since MACRA, and it reflects policymakers’ impatience with the progress in improving healthcare. Verma has said that upside-only risk (really “risk” in name only) doesn’t incentivize ACOs enough to reduce costs or improve outcomes.

By putting pressure on ACOs to accept risk sooner, CMS seems to be saying it’s time to fish or cut bait. The costs—and the stakes—are just too high to keep dabbling.

Granted, risk is a big, scary leap for many groups. It’s a huge commitment. But at America’s Physician Groups, we agree with CMS: The imperative to move to value is more urgent than ever before. It’s time for change, stat. And despite talk of groups quitting, we’re hearing even more about other organizations rising to the challenge and doing the hard work of truly managing care. For those groups, along with our members—who see the results in healthier patients and lower costs—APG is here for you. It’s why we exist.

On that note, we welcome you to our Colloquium 2018—The Essentials of Value-Based Care. The title says it all. Our sessions will offer vital information to help you succeed: how to manage downside risk, identify and deploy resources, overcome challenges, and much more. You’ll meet and learn from dozens of physician group leaders with decades of experience in value-based care.

I hope your time with us is inspiring and encouraging. And if you’re already taking risk or getting ready to, and are not yet an APG member, I hope you’ll consider joining. With some of the country’s most sophisticated value-based organizations in our ranks, along with educational resources like the Colloquium, our Annual Conference, this journal, and much more, you’ll gain the support and savvy you need to thrive in risk. With our help, you got this.

Come join us. ☝️
In recent studies, up to 79% of patients with NAFLD had normal aminotransferase levels\(^1\)

Are you missing NAFLD in your patients?

- NAFLD affects over 80% of obese adults and nearly 50% of patients with Type 2 Diabetes\(^3\)

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\(^2\)Epidemiology of non-alcoholic fatty liver disease: Bellentani et al. Digestive Diseases 2010;28(1):155-61.

The FibroScan\(^\circledR\) Family of Products (Models: 502 Touch, 530 Compact, and 430 Mini+) is intended to provide 50Hz shear wave speed measurements and estimates of tissue stiffness as well as 3.5 MHz ultrasound coefficient of attenuation (CAP: Controlled Attenuation Parameter) in internal structures of the body. The FibroScan\(^\circledR\) Family of Products (Models: 502 Touch, 530 Compact, and 430 Mini+) is indicated for noninvasive measurement in the liver of 50 Hz shear wave speed and estimates of stiffness as well as 3.5 MHz ultrasound coefficient of attenuation (CAP: Controlled Attenuation Parameter). The shear wave speed and stiffness, and CAP may be used as an aid to diagnosis and monitoring of adult patients with liver disease, as part of an overall assessment of the liver. Shear wave speed and stiffness may be used as an aid to clinical management of pediatric patients with liver disease.
News and Events

CLINICAL QUALITY LEADERSHIP COMMITTEE
APG Colloquium, Hyatt Regency Capitol Hill, Washington, DC

I AM APG ADVOCACY COMMITTEE
October 12
Hyatt Regency Capitol Hill, Washington, DC

NORTHEAST REGIONAL MEETING
November 1
Mount Sinai, NY

SOUTHEAST REGIONAL MEETING
November 6
Orlando, FL

CONTRACTS COMMITTEE
November 8
Los Angeles, CA/WebEx

SOUTHWEST REGIONAL MEETING
November 13
Phoenix, AZ

STATE GOVERNMENT PROGRAMS COMMITTEE
November 13
Los Angeles, CA/WebEx

PHARMACEUTICAL CARE COMMITTEE
November 14
Location TBD

WEBINAR WEDNESDAY
November 14

TEXAS REGIONAL MEETING
November 15
Dallas, TX

FEDERAL POLICY COMMITTEE
November 15
WebEx

CALIFORNIA POLICY COMMITTEE
November 29
WebEx

APG ANNUAL CONFERENCE 2019
April 11-13, 2019  San Diego, CA

WELCOME TO OUR NEW MEMBERS
America’s Physician Groups is pleased to welcome the following new members who have joined us in 2018:

- Catholic Health Services (CHS) Physician Partners IPA (NY)
- ChenMed (FL, GA, IL, KY, LA, PA, VA)
- Consejo de Salud de Puerto Rico, Inc. (PR)
- DuPage Medical Group (IL)
- Hawaii Permanente Medical Group (HI)
- IntegraNet Health (TX)
- Marshfield Clinic, Inc. (WI)
- SOMOS Community Care (NY)
- Premier Family Physicians (TX)
- Starling Physicians, PC (CT)
- Steward Health Care Network (AZ, AR, CO, LA, MA, PA, TX)
- Tandigm Health, LLC (PA)
- UniPhys ACO, LLC (FL)
- USMD Health System (TX)
- VillageMD (IL)

ADVANCED MEDICAL MANAGEMENT ACQUIRED BY SEOUL MEDICAL GROUP

Advanced Medical Management, Inc. (AMM), a management services organization headquartered in Long Beach, California, was recently acquired by Seoul Medical Group, Inc. AMM is a full-service healthcare operational management provider and business consulting company specializing in administrating and servicing IPAs, fiscal intermediaries, and government agency clients. The organization will retain its current leadership and staff, and will continue operating as a standalone business entity. With increased resources and capabilities, AMM looks forward to seamlessly and proactively supporting existing and future clients.

Seoul Medical Group, an independent physician association headquartered in Los Angeles, comprises hundreds of physicians and specialists serving patients in Los Angeles, Orange, and Santa Clara counties. For many years, the group has been a regional leader in enabling physicians to maintain their independence by eliminating common risks and expenses associated with individual private practices.
Mazars USA's Healthcare Consulting Group is proud to support APG’s vision of driving the evolution and transformation of healthcare delivery throughout the nation.

Find out how Mazars can optimize your organization’s performance in the following areas:

• Public Policy Interpretation and Strategy
• CMS and State Audit Readiness Assessment, Preparation, and Response
• Comprehensive Program, Policy, and Procedure Development
• Compliance – including CMS, State, and Accreditation
• Contract Analysis and Negotiation
• Enterprise Risk Management
• Finance and Revenue Cycle
• Fraud, Waste, and Abuse
• Quality and Utilization Management

...and much more.

Gil Enos, Principal
916.565.6130
www.mazarsusa.com/hc
With November 6 quickly approaching, all eyes in Washington are on the 2018 midterm elections. While the administration has been busy churning out updates from the Federal Register governing Medicare physician fee rates and changes to the Medicare ACO program and other alternative payment models, members of Congress are bracing themselves for the looming election.

The congressional agenda has been heavily influenced by the political uncertainty that comes with an election year. At press time, Congress was focused on passing the handful of appropriation packages before government funding expired at the end of September. The House and Senate were also expected to take up legislation to reauthorize a number of expiring programs and authorizations.

Meanwhile, the Senate was consumed by the contentious debate over Supreme Court nominee Brett Kavanaugh's confirmation. With the passing of Sen. John McCain (R-Ariz.), the chamber also welcomed its newest member: former Sen. Jon Kyl (R-Ariz.), who will fill McCain's former seat until a special election in 2020. This leaves the Republicans' slim majority in the Senate intact at 51-47—at least until November.

However, the scales are tipped in Republicans' favor in these midterms. Only one-third of Senate seats are up for reelection every two years (compared with all 435 House seats). This year, Democrats must defend 25 currently held seats, while Republicans are only defending seven. Moreover, 10 of those 25 Democratic seats are in states that went to President Trump in 2016. Democrats need to keep all 10 of those, plus pick up two more, if they want to take control of the chamber—an almost impossible feat.

As this article was going to print, the Senate passed its version of a comprehensive opioid package. Now, the Senate version will need to be reconciled with the House-passed H.R. 6, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which passed June 22 by a vote of 396-14. The hope is that House and Senate negotiators could reconcile their differences in October, but it's possible Congress will not reach a final opioid agreement until after the midterm elections.

It's a different story on the House side. The generic ballot (a general poll question that asks voters whether they will vote for Democrats or Republicans for Congress—historically a good predictor of the House popular vote) has Democrats up by nearly nine points. It seems likely at this point that Democrats will win control of that chamber in November, regaining a majority in the House of Representatives for the first time since 2010.

Further, since all 435 members must campaign for reelection every two years, and because this year the stakes are especially high, the House is even less likely than the Senate to take action on any big pieces of legislation.
Republicans currently control all three branches of government, and if Kavanaugh is confirmed, the Supreme Court will become even more conservative. Any shift to Democratic control of the House will certainly change the dynamics of U.S. politics.

During the midst of all of this, the value movement has been marching on. Congress’ impact has largely been contained to the Bipartisan Budget Act, which passed February 9. The legislation contained several important healthcare provisions, including the America’s Physician Groups-endorsed CHRONIC Care Act and updates to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Several MACRA oversight hearings were also held in the House of Representatives on the Merit-Based Incentive Program (MIPS) and the fallibility of alternative payment models.

The administration’s impact on the value movement has been far bolder. Health and Human Services Secretary Alex Azar made value-based care one of his top four priorities after he was sworn in on January 29, 2018. Further, Azar named Adam Boehler, current Director of the Center for Medicare & Medicaid Innovation (CMMI), as the Senior Advisor for Value-Based Transformation and Innovation.

This year’s federal rulemaking process has also seen the Centers for Medicare & Medicaid Services (CMS) propose bold steps aimed at accelerating the value movement. Those steps include limiting the amount of time Medicare accountable care organizations (ACOs) can spend in upside-only risk arrangements and offering new reimbursement codes for coordinated care and related services.

Post-November, we will enter the so-called “lame duck” period. It is unlikely that we will see much action in the healthcare space on the part of Congress. However, that same time period will mark the release of several final rules, including the Medicare physician fee schedule and the Medicare Shared Savings Program, which will codify CMS’ updates for 2019.

As always, APG and the APG Federal Affairs staff stand ready to assist our members through this tumultuous time. We will continue to advocate on your behalf in our nation’s capital, whatever the outcome of the 2018 midterms may be. Want to get more involved in Federal Affairs? Be sure to join APG Advocates, our member advocacy program. For more information, go to apgadvocates.org.
Crystal balls are not very accurate, but who can resist peering into their depths to catch a glimpse of what might be? The way the world is changing, though, perhaps we don’t need crystal balls at all.

Google and Amazon now know so much about us—tracking our daily commute, our shopping patterns, our preferences and preoccupations—that we receive notices when we vary from the patterns that they so assiduously monitor. As these and other companies apply their data management expertise to personal health information and transform healthcare services into a consumer-friendly process, significant disruption of the current healthcare market should ensue. Middlemen and high-margin/low-efficiency providers should beware.

But how much change will come, and how soon? Can these companies’ entry into the healthcare market overcome the traditional system’s tectonic-level resistance to change? Will Amazon, Google, and other giant technology firms become the chief disruptors of the status quo?

Consider the numbers. Amazon has teamed up with JPMorgan Chase and Berkshire Hathaway to create a much-talked-about venture aimed at delivering cheaper, better healthcare to their employees—a pool of 1.2 million members diverse in socioeconomic status, geography, and age.

Although the focus for now is only on these employees, the venture could provide Amazon with a fertile testing ground for new and disruptive healthcare approaches, prior to a full-scale market release. And with 310 million active customers and five million online sellers, Amazon has a huge potential market.

**A ‘CONSUMER REVOLUTION’?**

Some believe the hiring of surgeon Atul Gawande, MD, as CEO of this new partnership is an extension of Amazon’s successful playbook. The company has historically moved into market sectors and standardized offerings. This makes comparison and competition far more transparent to consumers—the hallmark of the Amazon model. Like Amazon, Gawande is focused on using standardization to scale up healthcare. Amazon could create a healthcare platform for the initial base of 1.2 million users and then attract additional consumers once it has proven the concept. As it gains momentum, it would be able to standardize providers’ offerings on that platform and create transparent and competitive markets for consumers to shop for healthcare services—just as they shop for virtually every other consumer good on Amazon’s site today.

Amazon also excels at improving customer experience in areas where it has been an afterthought. This is worth noting because one of the most frequent complaints lodged by managed care enrollees concerns poor provider attitude and lack of service.

In fact, observers have long predicted that consumerism would be the key disruptive influence to transform the American healthcare system. In 1997, Harvard economist
Regina Herzlinger forecast that a “consumer revolution” would transform the healthcare system with high-deductible plans linked to more transparent cost and performance data.

Twenty years later, though, those attempts have had marginal impact. That’s largely because “consumer-driven” plans merely shifted cost onto consumers without improving care, and all-payer-claims-databases have failed to capture public attention and use.

ONE RING TO RULE THEM ALL

Amazon has the potential to change all that. Through the convenience of its “Prime” services, the e-commerce giant could take the current coverage exchange model in healthcare and super-charge its impact. Or it could simply become the one master provider of services under the Prime banner, and completely disrupt the health insurance industry. It could be an ironic twist on the concept of “single-payer” healthcare.

OPPOSITION TO CHANGE

This isn’t the first time the company has entered the healthcare fray. In 1999-2000, Amazon tried to break into the pharmacy market by purchasing Drugstore.com, but the morass of middlemen, regulatory red tape, and opacity in the system stalled its efforts.

Today, Amazon has regrouped. Not only has it brought two big employers to the table with its JPMorgan-Berkshire venture, but in June, it also announced it was buying online pharmacy PillPack Inc.—a much bigger entity than Drugstore.com.

But several hurdles exist. Opposition to change is stiff. Regulators are likely to oppose disruptive innovation, and they will certainly scrutinize any efforts to circumvent existing oversight models in healthcare—models that serve to enshrine the status quo. And while a base of 1.2 million employees sounds like a lot, the distribution of those lives across the country will lessen the impact any changes will have on local markets.

Still, people will watch and take note. And all the while, healthcare costs will continue to grind upward, consuming greater percentages of the gross domestic product. The average cost of coverage for a family of four now exceeds $20,000 per year. The Amazon-JPMorgan-Berkshire Hathaway concept is taking shape and coming into focus. Ignore it at your peril. o
Can capitation work for your organization? If so, what are the drivers of success you need to understand and internalize? And why is it that some organizations thrive under this system, while others struggle to deliver on quality and cost?

The reasons why success is so varied under capitation are often complicated. To find answers, it typically requires a deeper dive into an organization and its structure. However, there are common themes at the root of most successes or failures in capitated agreements.

But first things first: Let’s start with the definition of capitation. Capitation is:

- Payment of a fixed per member, per month (pmpm) amount
- Payment in full for a given month of service
- Payment for a defined population of eligible members
- Payment for a defined range of services

Capitation is often referred to as a “budget-based” or “value-based” model. Essentially, it is a fixed amount of money that must be managed well to ensure the timely provision of high-quality, cost-effective healthcare services while also providing for a reasonable margin.

**SUPPORTING THE TRIPLE AIM**

Capitation supports the goals of the triple aim in several ways:

- Continuous quality improvement and operational efficiency
- Identification and assessment of health risks across the entire population of assigned members
- Innovation and improvement in healthcare delivery
- Identification and management of marginal/poor performers
- Promotion of appropriate utilization and costs
- Detailed budgeting and variance analysis, monitoring and analysis of utilization and cost data, provider sub-capitation, and improved trend analysis and forecasting
- Increased member satisfaction

**SIX REASONS WHY CAPITATION CAN FAIL**

Below are just a few of the most common reasons why providers fail at capitation:

1. When provider organizations enter into a risk relationship, they often jump in too soon, without sufficient financial reserves, knowledge, expertise, or advance planning to improve their chances of success.

2. When senior leaders accept a capitation agreement but are happy with the status quo, they are typically unwilling to make the necessary cultural shift. Younger physicians are more apt to embrace the change, but older physicians may just want to “stay the course” until they retire.

**“Why is it that some organizations thrive under capitation, while others struggle to deliver on quality and cost?”**
3. When senior leadership embraces capitation—but is not willing to make the necessary infrastructure improvements to manage risk—success is rare.

4. If senior leadership is more concerned about preserving relationships and keeping their colleagues happy rather than confronting marginal/poor performers and focusing on improving quality and reducing cost, the capitation model will flounder.

5. Capitation is not productive if senior leadership does not establish and support the integral working relationship between quality and payment. This requires committing to standards of practice or medical guidelines, performance measures, monitoring, and reporting.

6. This model will not be beneficial if senior leadership does not deploy mechanisms that ensure accurate encounter data. Submission of encounter information is critical. It is essential to managing capitation, provider performance, and the ability to collect and report specific and required elements for both the risk-bearing provider and health plan.

ADVANTAGES OF CAPITATION

For provider organizations that have made the cultural shift to capitation—or have embraced the need for change and want to move forward—capitation makes sense from several perspectives. Here are just a few of the advantages of making the switch:

- Capitation payments are predictable, paid monthly (usually by the 15th of the month), and help cash flow management.
- Accepting capitation can incentivize health plans to steer membership toward capitated networks,
especially toward the dual-risk and global-risk networks. This increases your membership and revenue growth.

- Local healthcare delivery and decision-making results in higher quality and improved member satisfaction. It also results in greater physician satisfaction because physicians are more vested in the delivery system. They are able to get answers to their claims inquiries, feedback on utilization decisions, and resolution of disputes on a more timely and individual basis.

- Profits generated from the efficient and cost-effective delivery of healthcare services are retained at the local level, not shared with the health plans.

- Provider organizations that have embraced capitation are the future of healthcare in this country. They will figure out how to make it work and become the market leaders of the future. It is time to lead or follow—your choice.

WHAT IS RIGHT FOR YOUR ORGANIZATION?

There is little doubt that risk-based contracting, vis-a-vis capitation or some other value-based model, is here to stay and already is the preferred care delivery model throughout the country.

While there are pockets of resistance, continuing pressure from employers, government (including the Centers for Medicare & Medicaid Services), and health plans—which are all committed to the triple aim—will eventually affect every provider regardless of location or readiness. Failure to successfully transition will have consequences far beyond the investments that need to be made to embrace it now.

As with every worthy endeavor, it takes time to establish the necessary systems and structures and learn how to successfully manage capitation— including implementing mechanisms to bring provider networks into compliance. Change starts with the first step, so it is best to step up and start now.

WHERE TO START?

It all begins with your board of directors and senior management team making the commitment to move toward risk-based contracting and learning this model of business. Embrace it and start making the incremental changes that are needed, including developing a solid business plan that outlines goals, strategies, milestones, and the willingness to work with health plans to develop mutually beneficial partnerships.

Execute the business plan and ensure systems and structures are in place that support the plan’s success. Be prepared to manage dynamic and interlinking processes that require a focus on quality measures and outcomes, utilization management, data management, compliance with regulations, and fulfilling and monitoring contractual obligations. If a few senior leaders are standing in the way of needed change, consider asking them to step aside to ensure the success of the organization for the long term.

Most importantly, know that a quality provider organization with solid leadership and a commitment to success has nothing to fear from capitation.

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One call does it all.
For coordinated services that address the social determinants of health.

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- Culturally diverse providers with local expertise
- HomeMeds medication reconciliation
- Care transitions coaching
- Health self-management education
- In-home assessments

- Wraparound services like meals and transportation
- Proven results—quality and cost
- We cover California. For the rest of the nation, contact: aginganddisabilitybusinessinstitute.org

Contact June Simmons, CEO: 818-837-3775 x102 • jsimmons@picf.org

Partners in Care
www.picf.org
The explosive growth of new Medicaid members has challenged many medical groups to ramp up their clinical continuum to address a host of medical and socioeconomic factors. In an at-risk model, managing the clinical needs of Medicaid enrollees demands rigorous attention to the clinical delivery of care, hypervigilant care coordination, and a team of social workers and allied professionals who are dedicated to improving patients' health.

But even when your clinical team is in top shape, great outcomes are truly not attainable unless you address the social determinants affecting your members' health. According to the World Health Organization, social determinants of health are the environmental conditions in which people are born, live, learn, work, play, worship, and age. These conditions affect a wide range of outcomes and risks in health, daily living, and quality of life.

Essentially, your patients' zip codes play a more important role in their health outcomes than virtually anything else you can do clinically. Social determinants affect almost every aspect of the communities we serve. Poverty, homelessness, addiction, education, and even citizenship issues are daily life influencers in underserved communities.

This is a daunting reality for healthcare groups that are scored and rewarded by clinical outcomes. We can either throw up our hands and say, “These issues are out of our control—our priority is clinical care,” or we can choose to address them and find actionable services that focus on our communities.

I can understand the former sentiment because providers are not reimbursed to address social determinants of health. There is a significant investment to be made in the demonstrable tasks and resources when we make a broader commitment to our communities.

GOING ‘ALL IN’
For nearly 50 years, AltaMed Health Services Corp. has witnessed the ramifications of social determinants of health in Southern California’s underserved and minority communities.

Our first clinic was in an at-risk neighborhood in the barrio of East Los Angeles. I would walk outside the clinic and look up and down the street; I could see that improving the overall health of our patients was about more than improving access to primary care. We needed to play a larger role.

Led by the commitment of our staff, we have invested the time, resources, and money to address this socioeconomic environment. It has become part of our organization’s DNA.

Over time, you learn where you can influence social determinants and how this influence affects the health of your community. We believed that for our long-term
success, investing in programs and services focused on the most important social determinants of health would yield better outcomes and improve our communities. We decided to go “all in” and have continued to add programs aimed at the local needs of our members.

We've built initiatives at the system, community, and individual level, including:

• Free non-emergency transportation to and from our offices
• Nutritional guidance
• Chronic disease management
• Co-pay assistance
• Health plan enrollment assistance (We have been a leading enrollment entity for Covered California since its inception.)
• In-home visits
• Community health workers (promotoras)
• Offices in strategically underserved areas

In addition, we launched partnerships with local high schools to increase college enrollment and retention; scholarships to reduce financial barriers to college; school nutrition programs for elementary students; substance abuse outreach, education and treatment; HIV prevention and treatment services; and our newest focus—a civic engagement initiative.

I am most passionate about the civic engagement initiative because if our local patients are not registered to vote or have issues with immigration or citizenship, they are less likely to be active in the community and seek out healthcare services.

Can we make a difference? We launched our civic engagement campaign just before this year’s midterm California primary election. By working door-to-door in our key zip codes, among other initiatives, we helped increase voter registration in certain precincts by more than 400 percent over the previous midterm voting period. Overall, registration in these areas increased by an average of 135 percent.

HOW TO GET STARTED

Clearly, not all medical groups, physician practices, or health systems have the resources to invest so heavily in social determinant programs. To that end, here are some ways to jump-start your own programs and at least begin the process:

• Collaborate. You don't have to start from scratch. State, regional, and local resources can help you address critical socioeconomic issues in the communities you serve. Your local health department may have printed materials you can use or programs you can replicate or support.

Your partnering health plans may also offer relevant programs. For example, AltaMed has partnered with LA Care Health Plan in such areas as nutrition education, homelessness, and substance abuse. Local nonprofit organizations are also a great resource, as are regional business and chamber programs that address “food deserts” in underserved areas.

continued on page 38
Recruiting Providers: Get the Right People on the Bus

As more provider groups take on greater risk for population health management, the importance of having the “Right People” in the business grows exponentially. By the “Right People,” I am including executives, operators, medical management staff, and providers. All these people are crucial to developing and maintaining a culture that maximizes the group’s ability to effectively manage patients’ health.

In his best-selling book, Good to Great, Jim Collins describes the concept of “First Who … then What.” Collins says that executives who have ignited the transformation from good to great “first got the right people on the bus (and the wrong people off the bus).” He also says, “If you begin with the “who” rather than the “what,” you can more easily adapt to a changing world.” Finally, “If you have the right people on the bus, the problem of how to motivate and manage people largely goes away.”

THE NEED FOR BETTER RECRUITING

Although “aligned” providers are important, groups also need highly skilled individuals who are knowledgeable about the organization’s business. Groups need people who understand the why of managed care—not just the what and how—and embrace it.

Historically, many provider groups prioritized growth: enrollment, provider network, geography, and top-line revenue. Many of the reasons for the disruption of the California delegated group model 20 years ago were related to indiscriminate and undermanaged growth. Collins also says, “A company should limit its growth based on its ability to attract enough of the right people.” I believe that in the current wave of growth and consolidation, groups are being more judicious in their growth strategies. But to optimize provider alignment and culture, they still need to improve their recruiting and selection—as well as orientation and skill-building—of their new providers.

Our industry has a dual provider approach: independent practice associations (IPAs), networks of increasingly interdependent clinical practices; and employee/partner staff model groups. Recruiting and selecting providers is important in both models to achieve high performance standards.

Staff model groups tend to be more attentive and rigorous in recruitment, as they try to follow traditional HR practices in hiring new providers. IPAs are often less rigorous—adding providers who are interested in contracting for financial reasons, but who may or may not be in sync with the group’s business needs.

In both models, provider recruitment may include new and established clinicians. Established clinicians usually have a track record that can help reveal their approach to care. Although HR regulations can make it difficult to obtain
meaningful reference information, it is worth the effort to use community contacts to obtain objective data and subjective references on prospective clinicians—both PCPs and specialists.

RECRUITING FOR STAFF MODEL GROUPS

When considering physicians for a staff model group, evaluate such characteristics as:

- Work habits – punctuality and productivity
- Teamwork
- Communication and social skills
- Clinical acumen and practices
- Efficient use of resources

Self-starting and entrepreneurship traits may also be important if the group is looking to build a new practice around the candidate. Similarly, administrative and business acumen is valuable if the group hopes to strengthen its clinical administrative team.

A consultant with experience in evaluating candidates and matching them with the right organizations and jobs may be helpful both in finding the right physicians to build a network, as well as in evaluating candidates for administrative and particularly executive positions.

The interview allows for a face-to-face evaluation of the candidate, but it’s also an opportunity to make sure the candidate understands your business model. Does he or she understand and embrace your “rules of engagement”? In addition, use the interview to review your policies and expectations regarding:

- Scheduling
- Patient experience
- Team-based care
- Clinical informatics, including quality and timeliness of documentation
- Clinical quality metrics
- Use of selected specialists, hospitals, and ancillary providers
- Scope of clinical practice and population health policies, including referral and care management programs

Because of California legislation requiring a fair hearing and/or medical board reporting, groups can sometimes be reluctant to terminate “poor-fitting” physicians. That makes recruiting the right people from the start especially important.

The Permanente medical groups, which function as large staff models, serve as a good example of a best practice. Even though new Permanente physicians usually know what they are signing up for, there is also a detailed and well thought out plan for orientation and enculturation. The organization has a rigorous three-year process of vetting candidates before offering partnership. Smaller group models should be equally judicious about bringing on new physicians.

RECRUITING FOR IPAS

Selection rigor is just as important in an IPA, but too often we see acceptance of lower standards. IPAs typically pay more attention to assessing primary care physicians (PCPs), but in fact both PCPs and specialists must be knowledgeable and supportive of population health practices.

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Northeast/Mid-Atlantic
A highly effective care and practice management model is challenging today's prevailing healthcare provider paradigm—and is poised to disrupt the transfer of physician practice ownership. It maintains physician independence and equity and empowers physicians with the authority and freedom to drive how patient care is delivered.

This model was developed and refined at New Jersey-based Summit Medical Group, the nation's largest independent, physician-owned-and-governed multispecialty medical group.

**LOSS OF PHYSICIAN CONTROL IS TRENDING**

In recent years, waves of change in the healthcare industry have put unprecedented pressure on medical groups and threatened the existence of the physician-owned-and-led practice. Every year, more independent medical groups come close to their tipping point.

Today, just over half of all U.S. doctors are still practicing in groups wholly-owned by physicians, with the rest now employed by hospitals, health systems, and other entities. While some data suggest that the acquisition of independent medical groups by hospitals and health systems may be leveling off, there has been a spike in the sale of medical groups—in whole or large part—to private equity investors.

This seismic shift is not by choice. Physicians are still motivated by a “patient first” philosophy, and the vast majority believe that patients receive the best care when physicians are in control of decision-making.

However, the migration from fee-for-service reimbursement to value-based care contracts and myriad other mandated changes have created imperatives that are difficult for most physician-owned medical groups to achieve and sustain. In this environment, many are enticed by offers from “white knights.”

Rather than relinquishing control to a hospital conglomerate or a private equity investor, another alternative has emerged.

Source: AMA, May 2017
‘WHITE KNIGHTS’: RISKS VS. BENEFITS

An acquisition by a hospital/health system or the sale of a significant equity share to a private investor offers benefits to physician groups concerned about their viability. Yet each option comes with uncertainties and risks.

In February 2018, *The New York Times* published an op-ed entitled “Are Hospitals Becoming Obsolete?” As demand for inpatient care has diminished due to advances in ambulatory care, hospitals are working to reinvent themselves through diversification. The acquisition of physician practices is a key component of their survival plan, and it tethers the acquired doctors to the hospital or health system, where they are positioned to serve as feeders for other outpatient and inpatient services.

The private equity investment option is currently the focus of studies, including one by the American Medical Association. The studies are assessing private equity’s impact on the quality and cost of patient care and whether non-physician financiers—motivated by return on investment—are truly silent partners.

A VIABLE PHYSICIAN-OWNED MODEL

Rather than relinquishing control to a hospital conglomerate or a private equity investor, another alternative has emerged: aligning with a physician-owned-and-led organization with shared values and a demonstrated mastery of patient care and practice management in today’s complex healthcare industry.

Summit Medical Group (SMG) has proven to be uniquely qualified to fill this role. We do so by assimilating small practices into SMG or by establishing customized strategic partnership agreements.

Nearly a century ago, our visionary founders, William Lawrence, MD, and Maynard Bensley, MD, united in northern New Jersey to build a practice around what was then a novel concept: a coordinated multispecialty group that would conveniently and cost-efficiently provide high-quality healthcare.

Remaining true to that vision, SMG has experienced unprecedented growth and success by leveraging clinical and technological breakthroughs to deliver excellent patient outcomes—while streamlining administrative red tape, reducing redundancies, and containing costs. In fact, we can now serve the majority of a patient’s healthcare needs on an outpatient basis at every stage of life.

SMG NJ has more than 800 physicians and providers in nearly every specialty and close to 90 locations, including large comprehensive care campuses offering access to urgent care, primary and specialty care, diagnostic testing, and ancillary services. SMG NJ has two ambulatory surgery centers and partners with the nation’s leading cancer center, MD Anderson, in that center’s sole collaboration with an independent medical group.

In 2017, SMG handled more than 1.5 million patient visits and achieved remarkable success with seven value-based contracts: private payer agreements with Horizon, Aetna, and Cigna; three Medicare Advantage plans; and a Centers for Medicare & Medicaid Services Next Generation Accountable Care Organization (ACO), administered by Trinity Health. In fact, the Horizon Blue Cross Blue Shield of NJ ACO has outperformed the market in cost efficiency, achieved the best quality metrics in the state, and dramatically increased enrollment for five consecutive years.

UNIQUE PARTNERSHIPS

SMG’s physician owners and board examined industry trends and had a dialogue with numerous physician-
owned medical groups across the country—which helped to confirm that our successful model was scalable and reproducible. They recognized the potential to positively impact the quality and availability of patient care nationwide by empowering more physicians to retain crucial decision authority over the practice of medicine.

In 2014, they endorsed the creation of Summit Health Management (SHM). The vision for Summit Health Management is to refine, grow, and share SMG’s model by handling key essentials such as governance, population health management, revenue cycle management, and all of the business operations of Summit Medical Group on a larger scale.

That vision was validated with landmark agreements that formed Summit Medical Group Arizona and Summit Medical Group Oregon – Bend Memorial Clinic in January 2018.

In Arizona, SHM united with 51 providers who had recently affiliated as Arizona Primary Care. In Oregon, SHM’s partner is an independent medical group with 120 providers in 30 specialties and a distinguished 72-year history. Both groups entered into managed services contracts with SHM that facilitated their transition into Summit Medical Group entities and were tailored to their specific integration needs.

The groups now have access to the proprietary resources and expertise needed to ensure their continued vitality as physician-owned-and-governed medical groups.
MAINTAINING OWNERSHIP AND CONTROL

The following core fundamentals apply to every Summit Medical Group across all locations:

- Each group has a local physician board involved in governance, in conjunction with Summit Health Management’s physician board.
- Those who join with an ownership stake in their practice are able to maintain that ownership interest and may purchase units in the management company, based on specific criteria.
- An ownership incentive track is available to physicians employed by SMG.
- The culture is based on collaboration. Each group freely shares learnings and best practices for the benefit of all national SMG patients, physicians, and staff.

“Across the country, physician groups are contemplating whether they continue independently or partner with large hospital systems or corporate entities. Our goal is to provide colleagues with all of the resources needed to sustain thriving independent physician groups.”

Under this model, Summit Health Management and Summit Medical Group are empowering physicians to deliver better, more coordinated healthcare with greater cost efficiency and convenience in multiple states.

By emphasizing innovation and optimizing state-of-the-art clinical and information technology tools, our groups can avoid administrative pitfalls, streamline bureaucratic burdens, and reduce time- and cost-draining care redundancies. They can also uphold a guiding principle that has been the bedrock of medicine for centuries: Physicians know what's best for their patients.

Jeffrey Le Benger, MD, FACS, has spent 15 years as Chairman of the Board and CEO of Summit Medical Group. He is a practicing surgeon and is Board-certified in facial plastic and reconstructive surgery and otolaryngology—head and neck surgery.
Bayhealth Physician Alliance LLC is a clinically integrated network in Dover, Delaware, and is part of a two-hospital system in the central part of the state. Formed in August 2013, we have grown over the past five years to include 270 clinicians and 53 practices in 35 medical specialties.

PARTICIPATING IN ALTERNATIVE PAYMENT MODELS

To scale our capacity, Bayhealth joined with the clinically integrated networks and physician organizations of five health systems to create a regional Track 1 Medicare Shared Savings Program (MSSP) accountable care organization (ACO). The ACO began operations in January 2016 and currently has 50,000 attributed Medicare beneficiaries. It anticipates moving to take risk in MSSP Track 1+ beginning in January 2019.

To improve market position relative to larger-scale contracting opportunities, Bayhealth, along with four other Delaware health system representatives, is exploring development of a statewide “super ACO.”

Most recently, we led our health system's decision to take risk in five clinical episodes as part of the voluntary Bundled Payments for Care Improvement – Advanced program. Bayhealth staff is spearheading preparation for a successful launch this month.

HELPING CLINICIANS SUCCEED

One of our most significant impacts has been through our role in the HealthVisions Delmarva Practice Transformation Network (HVD-PTN). This network was created following a four-year, $5.1 million grant from the Center for Medicare and Medicaid Innovation (CMMI) in 2015. HVD-PTN is a collaboration between Bayhealth and Peninsula Regional Medical Center.

HVD-PTN assists clinicians in transforming their practices to succeed under the Medicare Quality Payment Program and other value-based systems. The network has completed the third quarter of Year Three and continues to see progress on all Transforming Clinical Practice Initiative (TCPI) aims, including improving quality outcomes, reducing unnecessary utilization, and lowering costs of care.

Overall, HVD-PTN has enrolled 2,415 clinicians and graduated 781 clinicians in 169 practices to participation in alternative payment models. It maintains a current active enrollment of 1,554 clinicians.

In addition, 100 percent of eligible HVD-PTN practices participated in Year One of the Merit-Based Incentive Payment System (MIPS)—a stepping stone to future participation in alternative payment models. Using data from individual practice electronic health records (EHRs), the Maryland and Delaware health information exchanges (CRISP and DHIN), and the Advisory Board, HVD-PTN has made strides in quantifying outcomes performance, cost savings, and utilization improvements.

The goal is to transform practices into learning organizations that understand the value of actionable data—and how to act on it.”
REDUCING UNNECESSARY TESTING AND COSTS

So far, HVD-PTN has achieved 99 percent of its clinical outcomes target, 100 percent of its reduced testing target, 69 percent of its hospitalization reduction target, and 97 percent of its cost savings target. In all, HVD-PTN has quantified over $14 million in savings by reducing unnecessary readmissions and testing.

To achieve these results, the network has utilized the TCPI Change Package to help practices implement strategies demonstrated to support quality patient care. These include a focus on:

- Patient and family engagement
- Data management
- Team-based care
- Performance improvement methods
- Population management
- Improved access
- Evidence-based guidelines utilization
- Medical neighborhood development

Services are delivered by a staff of practice advisors who act as coaches and facilitators through biweekly, one-on-one meetings with the practice team. Their visits are supplemented by regular webinars that are available on the network’s YouTube channel. HVD-PTN also works closely with the ACOs based in several large health systems where their specialists are enrolled. This ensures that it aligns with ACO and clinically integrated network activities—reducing overlap and increasing performance.

With a year left in the grant, HVD-PTN is increasing its focus on ensuring the sustainability of its work with the enrolled practices. The goal is to transform practices into learning organizations that understand the value of actionable data—and how to act on it.

Using simple Plan-Do-Study-Act tools and the data available in its own EHRs, HVD-PTN is helping practices to see they can be in control of their future success in alternative payment models—while maintaining and improving patient care and outcomes.

Evan Polansky, JD, MBA, is Executive Director of Bayhealth Physician Alliance LLC.
APG Member Spotlight
Primary Care Rooted in Relationships

BY DUNCAN REECE

Meet Alice. Alice is 60 years old and lives in a shelter in Seattle. She has significant challenges in caring for herself. She is in a wheelchair, has multiple chronic medical diagnoses—including morbid obesity, heart failure, diabetes, and bipolar disorder—and she must manage up to 25 medications each day.

To make matters worse, Alice has significant financial limitations, is dually eligible for Medicare and Medicaid, and does not have a support network to help her navigate through her life.

In early 2017, Alice was referred to Iora Primary Care by a nurse case worker who identified that her primary care needs were not being met. Upon arriving, Alice met her care team of a personal physician and a health coach, and her broader team of a behavioral health specialist and nurse.

Alice joined us with out-of-control blood pressure, a complex array of prescriptions, and a range of deeply concerning medical and psychosocial issues. Undaunted by Alice’s challenges, her care team began to build a relationship. They asked questions often ignored in a traditional primary care visit:

- Who is Alice?
- What does she want out of life?
- What obstacles are in her way?
- How can we help remove these obstacles and help her meet her goals?

HIGH-IMPACT, RELATIONSHIP-BASED CARE

At Iora, asking these questions is part of what we call high-impact, relationship-based primary care, which allows us to care for patients in a fundamentally different way than traditional primary care. With Alice, we learned that six months earlier, she had moved from Atlanta, where she did not have a PCP. She was not used to a care team valuing her perspective and goals.

The team members got to work. They consolidated her medication list and helped her enroll in all the programs available to her through her insurance benefits. Mobility was a challenge, so they provided regular Lyft rides so she could see them as often as she needed.

In addition, Alice accessed Iora’s psychologist to discuss her depression. The team also partnered with the shelter’s nurse case manager, activated a social worker from her Medicare Advantage plan, and escalated her case with Adult Protective Services to address the circumstances of her housing situation.

For Alice and millions of Americans, high-impact, relationship-based care is the key to addressing diverse goals, interests, and needs. At Iora, we have the time, respect, and team necessary to tailor our services to each patient’s specific needs. While building relationships is a low-tech intervention, relationship-based care requires a sophisticated infrastructure. Three core components differentiate
Iora’s relationship-based care: people, payment, and process.

**PEOPLE**

First and foremost, each patient is paired with a team of people, including a provider, a health coach, nurses, Operations team members, and a behavioral health specialist. The teams can spend more time with their patients, and each provider has a panel that is a fourth the size of the typical primary care provider.

All team members, not just the doctor, are empowered to impact patient care, and teams are deeply connected to the hospitals, specialists, skilled nursing facilities, and organizations in the community.

Health coaches are one of the unique ways we build relationships with our patients. Health coaches spend more time with their patients and get to know them in a way that is rare in modern healthcare. They help identify and set goals that are meaningful to the patient and beneficial to their health. Coaches also can unearth the obstacles and social determinants of health that keep patients from achieving their goals.

For example, a health coach can sit with a patient and review meals and dietary goals, discuss changes in family dynamics, ask about transportation concerns, or serve as a resource and guide. Health coaches also call patients regularly to follow up on their progress and are on call when patients are in crisis.

**PAYMENT**

A necessary core design principle is in the payment we accept. Iora operates primary care practices where our principal business is globally capitated risk contracts with Medicare Advantage plans. This means we take complete accountability for the quality, health, and cost of our patients’ entire medical experience.

Unique to our approach is the partnership with our insurance payers—which extends well beyond payment. With aligned incentives, we co-develop specialist networks, quality improvement processes, data exchanges, and marketing campaigns. We even collaborate to build software to improve our patients’ lives.

**PROCESS**

To support all the workflows between Iora care team members, patients, the healthcare system, and community, we created a robust set of process investments that is completely unique in healthcare today. This process includes a culture rooted in excellent customer service and respect for colleagues, as well as proprietary software.

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**RESULTS OF RELATIONSHIP-BASED CARE**

- Net Promoter Scores are at or above 90 (compared with industry average of 3).
- CAHPS scores rank the highest of any provider among our peers in the markets we operate.
- Patients save 30 percent on out-of-pocket drug costs.

For example, we built our own electronic medical record (EMR), Chirp. Designed as a collaborative care platform, Chirp resembles a customer relationship management (CRM) system more than an EMR. Building modern software allows us to seamlessly integrate with transportation software providers, population management dashboard tools, artificial intelligence, and other administrative systems to make Chirp the single workflow tool for our care teams.

**ALICE’S BEST HOPE**

Iora’s high-impact, relationship-based care works. We have seen 40 percent decreases in hospitalizations, our quality scores rank well above 4 Stars, and our patient retention rates are 95 percent. Importantly, patients, their loved ones, and caregivers are taking notice and voting with their feet—we are doubling our patient size every year.

Recently, in Iora’s daily morning “huddle,” Alice’s nurse noted that Alice felt abandoned by the staff at the shelter where she lives. She was also struggling to keep a wound clean and was using the ER to help change her diapers. The team worked together and came up with a plan to invite Alice in for periodic health coach visits. The plan was to have the health coach work with Alice to teach her how to change her diapers and teach herself care that would potentially prevent future ER visits, reduce her feeling of isolation, and support her self-confidence with dignity.

Together, Alice and Iora have decreased Alice’s reliance on the healthcare system by 20 percent, controlled her blood pressure, and mobilized an action plan to get her out of a difficult housing situation. The road ahead is hard, and there might not be a fairy tale ending, but there is hope. Iora is Alice’s best hope.

Duncan Reece is Executive Vice President of Market Operations for Iora Health. Based in Boston and founded in 2010 by Rushika Fernandopulle, MD, MPP, Iora is transforming healthcare, starting with primary care. Iora care changes everything—the team, outcome-focused payment, customer service, and the technology that supports patient care. Learn more about how Iora is successfully improving the lives of patients while lowering costs at iorahealth.com.
The Impact of ACO Patient Engagement: From ‘What’s the Matter With You?’ to ‘What Matters to You?’

BY STEPHEN SHORTELL, PHD, MPH, MBA, HECTOR RODRIGUEZ, PHD, MPH, AND JEREMY RICH, DPM

Accountable care organizations (ACOs) promote coordinated and integrated care to ensure that patients—particularly chronically ill individuals—get the right care, at the right time, in a cost-efficient manner. Healthcare delivery organizations, researchers, and policy experts recognize the importance of improved patient engagement and activation. People use such phrases as “Participatory medicine,” “It’s all about the patient,” and “Taking control of your care.” However, how ACOs actually improve patient-centered care has been understudied in the literature.

That’s why Stephen Shortell, PhD, MPH, MBA, and Hector Rodriguez, PhD, MPH, at the University of California, Berkeley, led a Patient-Centered Outcomes Research Institute (PCORI) project entitled, “The Comparative Impact of Patient Engagement and Activation in Accountable Care Organizations (ACTIVATE).” The research project was in collaboration with two large ACOs: DaVita HealthCare Partners (DHCP) in the greater Los Angeles area and Advocate Health in the greater Chicago area.

The findings from this three-year project highlighted that adult patients with diabetes and/or cardiovascular disease (CVD) who received care from practices with high patient-centered cultures had better physical and emotional functioning than patients whose care came from practices with less patient-centered cultures.1 ACO patients with physical and mental health comorbidities also had better physical functioning when receiving care in patient-centered practices.2 Furthermore, engaged patients—as measured by the widely used and validated Patient Activation Measure (PAM)—had better emotional, physical, and social health outcomes.1,2

Here, Jeremy Rich, DPM, Director of the HealthCare Partners Institute for Applied Research and Education, interviews Shortell and Rodriguez to help shed light on pragmatic ways to enhance the documentation, evaluation, and dissemination of ACO patient engagement. The researchers share their insights, thoughts, and beliefs into ways to meet the quadruple aim of better health, better care, lower cost, and improved patient-provider engagement.

"Adult patients with diabetes and/or cardiovascular disease who received care from practices with high patient-centered cultures had better physical and emotional functioning."
What is an engaged and/or activated ACO patient? What is an essential attribute of an authentically engaged person?

The Patient Activation Measure used for the PCORI project captures the attributes of authentically engaged persons through four “levels” of patient activation. Individuals in the lowest level are passive participants in healthcare decisions. Patients in the second level have the knowledge and confidence to take a more active role, but have not yet done so. In the third level, patients play an active role in making healthcare decisions with their providers. The highest level is a patient who has the knowledge and confidence to take action about his or her healthcare, even during times of stress. Individuals are thought to move through these stages in order, although stages may change with time, and stressful circumstances can lower patient activation.3,4

At times, the term “person-centered” care replaces the word “patient.” Some individuals state they are “not less of a whole person” because, for example, they have diabetes or a cardiac condition. How would health delivery organizations get these folks viscerally “fired up” about their wellness and mitigate “raised eyebrows?”

Patients do not appreciate being defined by their medical conditions, as the healthcare system has done for years. Most of them prefer a patient-centered approach to care management. Patient activation can be hindered by social factors, including homelessness, food insecurity, financial insecurity, and limited social support,5 so a major way to get patients “fired up” is by helping them remove social barriers that prevent them from being activated.

Providing whole-person, patient-centered care for complex patients with multiple chronic conditions and challenging social circumstances can be a major challenge because of the diverse expertise, strong primary care-specialty coordination, and extensive care management needed. Given these anticipated challenges, ACOs and other delivery systems must be resilient to barriers and effectively manage resistance to change to move toward patient-centered care.

Your project examined patient engagement in higher and lower patient-centric clinics, particularly in adults with diabetes and/or cardiovascular disease. Can you share the HbA1c and LDL metrics, and what did you find in comparing primary care practices with high versus low patient engagement activities?

When we embarked on the research study, we hypothesized that patients of practices using more patient engagement strategies would have better clinical outcomes over time, compared with patients of practices doing minimal patient engagement activities.

Interestingly, we found no relationship between what practices are doing to engage patients with diabetes and/or cardiovascular disease in their own care and changes in clinical outcome indicators, including HbA1c, blood pressure, and LDL cholesterol. One reason for this is because practices did not fully implement these activities in routine patient care. As a result, the efforts did not have an overall impact on clinical outcomes for the average patient with diabetes and/or CVD.

Based on your research, what is the main reason that ACO patients and their care teams do not engage in their health and wellness? Does this differ with culture, community, linguistic isolation, socioeconomics, health literacy, etc.?

We found that many care teams are under time pressures to achieve various clinical measures tied to value-based payments, so they do not spend the time or feel they have the time to better engage with patients about what truly matters to them. Our findings also indicate that Spanish-speaking Latino patients reported generally high activation, but difficulty with English diminished these patients’ experiences of chronic care.6

This highlights that practices should be better prepared to capitalize on the relatively high activation of Spanish-speaking patients with Spanish-language and culturally relevant patient engagement programs and support.

Some organizations have local patient-stakeholder-caregiver councils, while others use employed teammates to elicit feedback on care delivery. What are the opportunities and potential challenges for these councils?

Feedback from patients, clinicians, and staff is needed to ensure that research questions and instruments are relevant. Patient advisory groups were central to executing our research protocol and to interpreting formative results. We met with patient advisors by conference call twice per year to share results and elicit their input and feedback.

We also asked patients to discuss their experience with patient activation and engagement in the context of the care they received at the ACOs. The logistics of getting patients together were sometimes challenging. At DHCP, to maximize patient participation, the patient advisory groups took place at the same location as patients’ diabetes shared medical appointments. We held meetings after the appointment and provided a meal.

continued on next page
In our project, we achieved relatively high patient survey response rates above 50 percent. This was due in large part to our advisors’ willingness to sign a letter encouraging their fellow patients to participate in the survey at both baseline and follow-up.

In addition, frontline clinicians and ACO leadership provided input on the study protocol, reviewed data, and were instrumental in disseminating feedback reports to the participating practices. Key clinician and staff stakeholders assisted in recruiting participants for our practice culture surveys by informing their colleagues of the survey and the benefits of participation.

Finally, clinic leaders assisted in recruiting all participants in the site visit interviews. In short, without the critical feedback and facilitation from patients and clinicians/staff, we never could have completed the project.

Why do you think few ACOs collect patient engagement and patient-reported outcome measures? What can be done to enhance adoption in a pragmatic way and promote “buy-in” from leadership?

Routinely assessing patient-reported outcomes (PROs) and social risks among patients with diabetes holds high potential for staff to intervene proactively—preventing acute problems and associated costs from urgent care visits, emergency room utilization, hospital admissions, and readmissions. Few ACOs routinely collect data on patient activation, PROs, or social risk because data collection is expensive, response rates tend to be low, there are so far no financial incentives tied to the “meaningful use” of PROs, and there is little guidance and information on how to use these data to inform treatments.

In terms of promoting adoption of patient-centered data collection with ACO leadership and key stakeholders, PRO measures will eventually be required by CMS and other payers as part of value-based payment models. Important concepts of organizational change management will help in implementing PROs. First, use the external requirements to create a sense of urgency for changing the status quo. Another change management concept that would facilitate adoption of PROs in routine clinical care is “building a guiding coalition” of middle managers, clinicians, and staff to provide feedback on implementation—including how to interpret and use PRO data to refer patients to supportive services or make treatment adjustments.

PRO data will only improve patient care if these key stakeholders actually use the data to improve care, so their involvement in designing and implementing routine PRO reporting systems is critical. The guiding coalition can also help build support for adopting PROs across the organization and continuum of care.

Jeremy Rich, DPM, is Director of the nonprofit and independent HealthCare Partners Institute for Applied Research and Education in El Segundo, California. Stephen Shortell, PhD, MPH, MBA, is the Blue Cross of California Distinguished Professor of Health Policy and Management, Dean Emeritus, Professor of the Graduate School, and Co-Director of the Center for Healthcare Organizational and Innovation Research (CHOIR) at the School of Public Health at UC Berkeley. Hector Rodriguez, PhD, MPH, is the Henry J. Kaiser Endowed Chair in Organized Health Systems, Professor of the Division of Health Policy and Management, Chair of the PhD Program in Health Policy, and Co-Director of the Center for Healthcare Organizational and Innovation Research (CHOIR) at UC Berkeley.

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2019 Calendar

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Theme: Changes in Healthcare/Political Environment and Direct Contracting in Medicare
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Editorial and advertising due Friday, June 14, 2019

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New Alternative Payment Models
Regional Focus: Southeast & Puerto Rico
Editorial and advertising due Friday, August 16, 2019

For editorial guidelines, visit apg.org/editorial or email Valerie Okunami at journalofapg@gmail.com
Think locally. Local programs work. Remember, social determinants are often tied to zip codes. Do you hire people from the neighborhoods you serve and pay them a livable wage? You can partner with your local high schools or local elected officials to address many health-related causes, support staff recruitment, and build your brand at the same time.

Again, many local programs already up and running could benefit from your support and engagement. Local health fairs and farmers markets can mean a world of difference to some communities. Or think about the effort you may put into a special holiday program to support communities in need, and then consider replicating it every month.

Build a culture of engagement and commitment. Join boards of local organizations to share your clinical insights and public health knowledge. Launch internal programs to raise awareness, such as collecting clothes and toiletries for your local homeless population. Your staff or contracted physicians may already be engaged in some civic or social programs. Do you know who they are and how you could leverage their efforts?

Start small. Social determinant programs can begin with a single effort. Your needs assessment may have already identified key issues that affect your members' health. Pick one that seems within reach for your organization, such as a diabetes program. This could include nutrition education and outreach, restaurant collaborations to offer alternative menus, partnerships with your local elementary schools, or partnerships with local elected leaders and businesses.

No single social program is a magic bullet. It takes time, commitment, and resources to launch programs that build on one another.

If you engage your patients and community, your group will benefit. You will earn improved goodwill along the way, and your brand will stimulate enthusiasm among important stakeholders. Your members will be less likely to disenroll. Most importantly, you will elevate the overall health and wellness of your community—one patient at a time.

Cástulo de la Rocha is President and CEO of AltaMed Health Services Corp., the nation’s largest Federally Qualified Health Center. He serves on the Board of America’s Physician Groups and is a Senior Fellow at the UCLA School of Public Affairs.

Recruiting Providers...continued from page 21

It is worth getting as much information as possible about physicians’ clinical practices before bringing them on board. Additional criteria for IPA physicians include:

- Experience with capitation and other alternative payment models
- Willingness to be exclusive (this applies to PCPs and increasingly to specialists)
- Willingness to participate in all product lines, including Medicaid, if that is part of the group's current or future business plans
- Using clinical technologies to improve patient care
- Compliance with the group’s documentation requirements
- Meeting access and service standards
- Acceptance of referral and care management program policies

A KEY QUESTION

When evaluating a new provider—especially a new physician who is joining a contracted practice—ask yourself: Is this individual choosing to be part of this risk-managing group? Or is the provider being forced in?

New clinicians joining an existing contracted practice too often get an automatic pass. Instead, they should undergo the same assessment and vetting process as any newly contracting physician. It is risky to blindly accept them with the assumption that existing physicians have appropriately screened and oriented their new hires.

In the past 30 years, our delegated group model has come a long way in size, complexity, and infrastructure. Continued success in risk-based population health management requires a skilled and dedicated clinical force—and equally sophisticated recruitment and selection of those clinicians.

Many large companies now use consultants with reliable personality assessment tools. Careful screening and orientation processes will ensure that your organization is composed of people who understand and embrace your mission and vision. When you start with the Right People, you will be able to motivate them—and effectively manage care.

Bart Wald, MD, MBA, is President of PA Health Leadership Consulting and Medical Director for the California Quality Collaborative (CQC). He is a recognized leader in physician group development, with extensive executive experience in health plans, hospitals, and physician groups.
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