AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

915 Wilshire Boulevard, Suite 1620
Los Angeles, CA 90017
213.624.2274
www.apg.org

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America's Physician Groups' National Standards of Excellence™ is an annual, comprehensive survey of capitated, coordinated care infrastructure for America's Physician Groups' accountable physician organizations. SOE® is designed to show how well-equipped and structured our physician organizations are at achieving better patient experience, better population health management, and better overall affordability.

The following rigorous categories represent the 2018 America's Physician Groups' National Standards of Excellence™, with Domains 1-5 publicly reported.

Domain 1 — Care Management Practices : Clinical system supports for quality and efficiency on a population scale.

Domain 2 — Information Technology : Funnel for accurate, actionable information to support clinical decisions and coordinate team care.

Domain 3 — Accountability and Transparency : Response to the public demand for objective information regarding performance, patient service, and regulatory compliance.

Domain 4 — Patient-Centered Care : Critical components of access, convenience, cultural responsiveness, and customized individual care.

Domain 5 — Group Support of Advanced Primary Care : to make the patient-centered medical home a system-wide model and to revitalize the discipline of primary care.

Domain 6 — Administrative and Financial Capability : to manage complex relationships, diverse revenue streams, innovative payment alignment, and risk. In short, the domain demonstrates how our physician groups are responding to sustainable healthcare reform. (Informational only—no public reporting)

DOMAIN 1 — CARE MANAGEMENT PRACTICES

1. **High Complex Case Management**

   This area covers how your high complex case management program is staffed (RN, CLSW, BH professional, pharmacist, nutritionist, dietician, lay community healthcare worker, etc.) and whether these professionals have specified panel management responsibilities. Further, we determine if your program has incorporated data-based tools to identify and communicate with high acuity patients in order to assess important transition or disease states like hospital discharge, recent hospital readmission, frail elderly, severe asthma, recent cancer diagnosis, congestive heart failure, diabetes with HbA1C >9, NICU "graduates," chronic obstructive pulmonary disease, and severe mental illness.

Los Angeles Office	915 Wilshire Blvd, Suite 1620, Los Angeles, CA 90017	(213) 624-2274
Sacramento Office	1215 K Street, Suite 1915, Sacramento, CA 95814	(916) 443-2274
Washington, DC Office	1501 M Street NW, Suite 640, Washington, DC 20005	(202) 212-6891

2. **Hospitalist and SNFist**
   This segment reviews the use of dedicated inpatient physicians who work exclusively in hospitals to deliver medical/surgical and/or newborn intensive care unit (NICU) inpatient care. We study a range of topics from percentage of hospitalists used to employment relationship. Additionally, we ask if you have a formal program for skilled nursing facility (SNF) oversight, linked to your care coordination personnel and systems, and whether there is oversight for those SNF residents housed outside of your office area (>30 miles from your official office location).

3. **Concurrent Review**
   This part looks at your physician organization's employment of on-site, in-person concurrent review nurses at affiliated hospitals for utilization management.

4. **Post–Hospital Discharge Continuity and Care Coordination**
   In this area, we assess your programs around post–hospital discharge and care coordination in efforts to reduce avoidable or unplanned readmissions and ED visits. Specifically, we want to learn about how your nurse, case manager, hospitalist and primary care team work together in care coordination for the patient and what processes are used to offer continuity of care to optimize utilization management resources.

5. **Generic Drug Prescription**
   This section discusses your use of generic prescription drugs within the provider organization, and your process for reviewing primary care practitioners' specific, individual use of generic drug prescriptions.

6. **Authorization Request**
   This segment looks at the areas for special medical authorization requests like high-cost injectables, insulin pumps, implantable devices, investigational/experimental testing, wound care, and complex durable medical equipment.

7. **Outpatient Advanced Illness Management and Palliative Care**
   We review your organization's outpatient program related to advanced illness management and palliative care. We would like to understand better the referral process and level of palliative care specialty consultation availability for primary care physicians and the level of outreach to patients and their families.

8. **Quality Collaborative**
   Physician organizations who actively participate in a quality collaborative (whether local, regional, or national) tend to focus on quality and performance measurement initiatives and involve their providers to participate. Collaboratives have been sponsored by Institute for Healthcare Improvement (IHI), Integrated Healthcare Association (IHA), National Quality Forum (NQF) and Pacific Business Group on Health/California Quality Collaborative (PBGH/CQC).

9. **Employee Wellness**
   It is important to foster community wellness and focus on your employees' health outcomes. This section serves to discover the degree to which this takes place within your organization.

10. **Disaster and Public Health Preparedness**
    We determine if your physician organization has a formal disaster readiness plan for provider deployment and continuity of care for patients in the event of a significant infrastructure disruption (e.g., viral contagion, earthquake, flood, fire, major power outage, terrorist act, biological catastrophe, or epidemic).

11. **Social Determinants of Health**
    Through research from the Robert Wood Johnson Foundation, we understand that the foundation for our health begins in our homes, schools and neighborhoods. For us to address care management practices thoroughly, we need to identify social and economic factors which affect our patients' health so that we can help them connect the dots to coordinate their healthcare.

DOMAIN 2 — HEALTH INFORMATION TECHNOLOGY

1. **Preventive, Screening and Chronic Care Registries**
   We assess whether your physician organization uses preventive, screening and chronic care registries to create periodic "action lists" for primary care patients, highlighting missing or overdue services, out of range results, and other concerns warranting primary care engagement. You will be asked to list what kind of registries your organization uses and how many commercial enrollees are in each one.

2. **Patient Engagement**
   This question gauges how your provider group communicates with patients through web-based visits, secure e-mail and patient web portals, text messages, voice messages, and other social media outlets. Is this communication bi-directional?

3. **Advancing Care Information**
   Having phased out the "Meaningful Use" program in national performance measurement, this domain asks about your physician organization's participation in the Advancing Care Information (ACI) category under the Merit-Based Incentive Payment System (MIPS) of the Quality Payment Program (QPP) under the Medicare Access & CHIP Reauthorization Act (MACRA). Additionally, we assess if your providers participate in Electronic Health Record (EHR) reporting as part of the Quality Category (e.g., eCQMs) under the MIPS program, or do they receive credit for e-Measure reporting under the VBP4P ACI domain in IHA's CA Value Based P4P program.

DOMAIN 3 — ACCOUNTABILITY AND TRANSPARENCY

1. **Financial Standards**
   This question asks what financial standards are followed by your organization (e.g., positive tangible net equity, positive working capital, percentage of claims paid timely, positive cash to claims ratio, etc.)

2. **Patient Satisfaction**
   Patient engagement and satisfaction are critical to the overall patient experience. We believe that if a physician organization participates in a patient satisfaction survey and shares physician- specific patient satisfaction data, the organization is committed to improving the overall patient experience through knowledge and transparency.

3. **Accountability and Transparency**
   Here, we aim to evaluate how provider organizations participate and report clinical quality measures. Again, does your organization attempt to review such data individually with practitioners for full accountability and transparency for quality patient care?

4. **Practice Variation**
   By reviewing individual clinician performance data to educate physicians about performance measurement benchmarks and health outcomes, a physician organization is properly positioned to improve the quality of the delivery care model. In this section, we are looking at your organization's processes to reduce practice variation, and as such, improve clinical performance through data sharing.

5. **Performance Incentives**
   This area focuses on whether your provider organization uses a performance-based compensation or bonus program for their individual physicians. What are the maximum potential earnings for performance-based financial awards, and do these bonus programs apply to primary care and specialty care physicians?

6. **Authorization Turnaround Time**
   Processing of urgent per-service authorizations is critical in optimizing coordination of care and for accountability purposes. As such, this section serves to determine how quickly organizations process urgent prior authorizations and if automated processes are in place.

7. **SOE® Reporting Transparency**
   In line with our efforts to be transparent to our membership and the public, we report the Standards of Excellence™ results on our website through the Star Chart. By participating in SOE®, each physician organization confirms their authorization to publish the aggregate results.

8. **Provider Satisfaction**
   This question aligns with our belief that provider organizations who encourage internal surveys of physician satisfaction are following accountability and transparency parameters to understand how physicians feel about their individual organizations' procedures and performance.

9. **Patient Rights**
   We are looking to see if your organization's policies and procedures include a formal policy statement affirming patients' rights, responsibilities, and privacy assurance.

10. **Hospital Liaison**
    As healthcare reform and accountable care organization (ACO) concepts develop, the stakes and balance between physician organizations and hospitals are changing. Thus, we are interested in learning how current best practices demonstrate increases in synchronized efforts between inpatient and ambulatory realms.

DOMAIN 4 — PATIENT-CENTERED CARE

1. **Direct Patient Electronic Communication**
   In this question, we assess whether primary care physicians offer direct electronic communication to their patients for HIPAA-compliant, secure information, and the percentage doing so.

2. **Timely Access**
   This segment reviews how physician organizations survey or monitor appointment availability and timely access to patient care, such as through same-day access services. We look for certain methodologies like "secret shopper" calls, office manager attestation, and periodic provider organization inquiries.

3. **Same-Day Access**
   In evaluating same-day access, we look at "advanced access," daily reserved scheduling, or integrated/urgent care walk-in clinics to meet same-day requirements. We ask our physicians for the percentage of primary care physicians offering these desirable services based on discipline (family medicine, internal medicine and pediatrics).

4. **After-Hours Access**
   In this section, we ask questions regarding urgent care connectivity and data interoperability between the urgent care and primary care office. Additionally, we want to learn more about the patient's after-hours access to the primary care physician or electronically integrated urgent care. Specifically, we ask if Saturday appointments are available (for at least four hours).

5. **Culture and Language**
   To help decrease health disparities and increase competency in culture and language, we ask our physician organizations about their efforts to educate providers and staff on cultural competency. Additionally, we inquire about the various language interpretation services offered by the provider organizations, either through telephonic interpretation services and/or spoken language interpretation services.

6. **Complaints and Grievances**
   Here, we ask our provider organizations if they have a formal staff function to receive, document, and respond to patient complaints and grievances.

7. **Preventative Screening**
   For optimal care coordination, we would like to know if our providers are sending out reminders (mail, phone, e-mail, or portal) to patients regarding recommended preventative screenings.

8. **Home Support for Seniors and Persons with Disabilities**
   In dealing with this disadvantaged and frail population for patient-centered care, we are looking to our physician organizations to offer home services for patients with access, communications, and transportation difficulties, based upon age and condition. Specifically, we also identify the type of personnel deployed into homes and what customized services are offered to the patient.

9. **Shared Decision-Making**

   As a matter of physician organization policy, we ask our provider organizations if they offer shared decision-making protocols (guideline-based and consistently applied written, spoken, or video materials identifying choices, risks, and benefits) for specific planned procedures.

10. **Patient Access**

    Aligned with the patient-centered care model, we evaluate whether provider organizations offer 24-hour telephonic nurse advice line as a best practice. Further, we ask if practices use this service to notify primary care physicians of the contact the following day.

11. **Patient Advisory Committee**

    Evidence shows that one of the key factors in achieving patient-centered care at the organization level is having a patient advisory committee ("Patient-Centered Care. What Does It Take?" *The Commonwealth Fund Report*, Sept. 30, 2007). This section focuses on how your physician organization uses a patient advisory committee to influence priorities and strategies to improve patient-centered care, while involving the patient and community.

DOMAIN 5 — ADVANCED PRIMARY CARE

1. **Team Care**

   This very critical area of team-based care focuses on how the physician organization is designed to support the care team to advance primary care at the front-line practice sites. Specifically, we look at what types of tasks are delegated to non-physician team members to determine if everyone is working at the top of their license, and if the staff team members have electronic communication in the EHR to perform such tasks.

2. **Information Systems**

   This section determines if your provider group has certain office workflows built into the information systems to prompt primary care physicians on point of care, chronic illness and preventive care. Further, we assess if there is data interoperability within the centralized clinical system and/or EHR to enable primary care physicians to coordinate care with specialty physicians and vice versa. Finally, it is encouraged that the care management team offers cultural and language competencies to support the patient population.

3. **Payment Alignment**

   With some exceptions, reducing the payment disparity between primary care and specialty physicians has become a key recruitment and retention strategy for advanced primary care. In this area, we aim to learn how our physician organizations offer performance-based earning opportunities for their primary care physicians and what strategies are currently being employed in business administration, information technology, or practice coaching to help the front-line primary care practices.

4. **Leadership**

   Provider organizational leadership and governance are critical to advanced primary care. As such, we ask probing questions to determine the level of executive team leadership at each medical group and/or IPA.

5. **Personal Health and Family Support**

   In valuing primary care, we believe that bridging personal health care, family and community support is vital to support our primary care physicians. Thus, we ask our physician groups about what types of personal and professional support are offered to their practicing physicians, and if formal physician satisfaction surveys are conducted to appropriately and regularly assess how physicians are doing in their practices.

6. **Community Engagement**

   With advanced primary care, community outreach is significant in helping students and trainees understand the benefits of primary care when making healthcare career choices.

7. **Practice Coaching**

   Through primary care practice transformation, the use of practice coaches is an effective and systematic method of disseminating scalable learnings throughout an organization. Specifically, we ask our medical groups if they are undergoing practice transformation and whether they employ practice coaches within the primary care practices.

DOMAIN 6 — FISCAL AND ADMINISTRATIVE INFRASTRUCTURE

Organized systems of care require extensive administrative supports for the clinical, epidemiological, social and technical endeavors designed to achieve the Triple Aim on a community-wide scale. In addition, these systems require sophisticated financial capabilities to align and sustain incentives that stimulate and reward the behaviors and performance oriented toward those goals. While many of these features are currently required in the delegated model, some organizations have created added features and local customization. Around the country, most developing systems will need to incorporate similar capabilities in order to fulfill the expectations of healthcare payment reform.

This domain specifically looks at the following components to determine the fiscal and administrative infrastructure of a physician organization:

1. Structure
2. Financial Standards
3. Multiple Revenue Streams
4. Prior Authorizations for Services
5. Process Claims and Disbursement Payments to Providers
6. Payment Methodologies
7. Member Eligibility
8. Variable Benefits
9. Formal Customer Service Department
10. Formal Network Relations Department
11. In-House or Contracted Contracts Officer
12. Audited Annual Fiscal Report
13. Division of Financial Risk Elements
14. Patient Risk Stratification
15. Individual Physician Resource Use
16. HIPAA Compliance
17. ICD-10 Activation
18. Complex PPO Care Management

A star will be awarded in each domain for the physician organization who attains the appropriate amount of points. America's Physician Groups' Clinical Quality Leadership Committee will determine the threshold settings for each domain. Thus, each year the cutoff points change per domain, based on the bell-shaped curve of how our America's Physician Groups members perform.

RANKINGS

Here are the various rankings for the public reporting of our SOE® survey:

- 5 stars = Elite
- 4 stars = Exemplary
- 3 stars = Meritorious
- 2 stars = Admirable
- 1 star = Commendable
- 0 stars = Participant

Public reporting of America's Physician Groups' SOE® results can be viewed at www.apg.org/soe.

For further information on SOE®, please contact Dr. Amy Nguyen Howell: anguyen@apg.org.

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