

AMERICA'S PHYSICIAN GROUPS

COLLOQUIUM ISSUE

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Analytics, p.26

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Puerto Rico/
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Raúl F. Montalvo-Orsini, MD, MBA
 Connecting the dots in chronic care: keys to success

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From the President

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



Members and friends,

Welcome to the Colloquium 2019 edition of the *Journal of America's Physician Groups*. I can't recall ever seeing our nation's capital as busy as it is these days. While the politics of impeachment and the 2020 elections are squeezing a lot of air out of Washington, there's still plenty going on ... and APG is right in the middle of it!

Congress has done a phenomenal job in agreeing that surprise billing and skyrocketing pharmaceutical costs are on voters' minds and need to be addressed. Agreeing on solutions? Not so much. Not surprisingly, while both sides of the aisle have the "best plans" to get it done, little progress has been made.

As both providers and consumers of healthcare, our members want to see common-sense solutions to America's health system challenges, and our team in D.C. is keeping watch on these top-tier issues. Yet our focus remains centered on the value-based care movement.

Many of you have pointed to the long delay by the Centers for Medicare and Medicaid Services (CMS) in paying the 5% bonus for participation in advanced alternative payment models (APMs). We tackled this issue head-on, and with eight other organizations, sent a letter urging CMS to pay the 2017 performance year bonus as soon as possible.

Our efforts and influence paid off—CMS responded with a statement indicating that payments would begin immediately. Not only does this demonstrate a strong commitment to groups and providers who invested in taking risk, it also demonstrates the power of physician groups speaking in one voice.

And with your support, that voice is growing stronger. While speaking at a recent conference at America's Health Insurance Plans (AHIP), CMS Administrator Seema Verma said, "If we are serious about reducing costs, we must also accelerate our adoption of a value-based payment system. Continuing to pay based only on the volume of services is neither sustainable nor affordable for the American people. Value-based care is the future of healthcare."

That's why we're here at the Colloquium—to shape the future of healthcare through the lens of value-based care. We're here to cover the issues that matter to you: new models of care, the high cost of pharmaceuticals, artificial intelligence, social determinants of health, and even an exclusive listening session with CMS.

So, no matter where you are on the journey to risk, you're in the right place at Colloquium 2019. And if you couldn't make it, I hope you will consider joining us at Annual Conference 2020.

As always, stay tuned and stay in touch. The value-based train is moving, folks, and we'd love for you to join us! ○

A handwritten signature in black ink, appearing to read "Don Crane".

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are related to
engagement rather
than cost or quality

Source: Transforming Care
for Patients as Consumers,
December 2018.

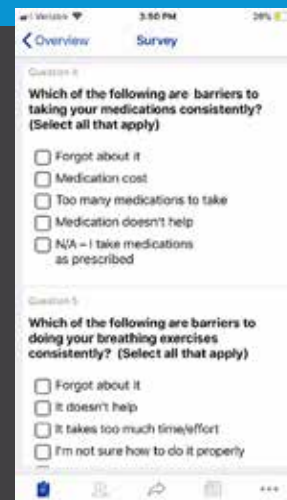
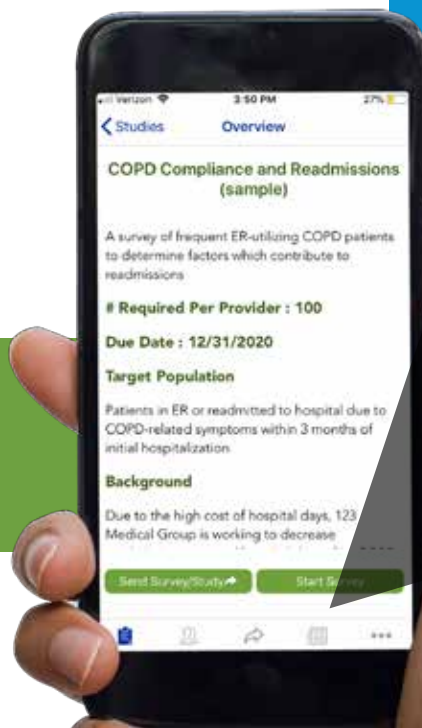
41%
say HCPs are the
desired source
for study info
(more than double
the second highest
source).

Source: A Research!America
poll of U.S. adults conducted
in partnership with Zogby
Analytics in May 2017.

“I like being asked about my COPD and that I have help when I need it most.”
– COPD Patient

“Studies are important, if it doesn't help me now it will help others later. Let me know what other programs are right for me.”
– Depression Patient

“I know I need a colonoscopy so thanks for reminding me of the importance and walking me through next steps.”
– Colorectal Cancer Screening Patient



News and Events

I AM APG ADVOCACY

November 11, 2019
12:30 – 1:30 p.m. EST
Lunch at Colloquium

December 17, 2019
1 – 2 p.m. EST
WebEx

CLINICAL QUALITY LEADERSHIP COMMITTEE

November 11, 2019
11 – 1 p.m. EST
Colloquium

WEBINAR WEDNESDAY

December, 11, 2019
2 – 3 p.m. EST
WebEx

2020 APG ANNUAL CONFERENCE

May 28 – 30, 2020
Marriott Marquis San Diego Marina
San Diego, California

BEYOND AGING HEALTH FAIR IN OLYMPIA

Physicians of Southwest Washington (PSW) hosted its first annual Beyond Aging Health Fair on Oct. 1, 2019, at the Lacey Community Center in Olympia, Washington.

The free event aimed to bring PSW's network of physicians closer together with community residents and encourage older adults to live a healthy lifestyle in mind, body, and spirit. The fair featured a life-sized "colon" designed to promote colorectal cancer awareness, free chair yoga sessions, interactive health screening booths, free health seminars led by local physicians, Medicare Advantage information, and more. ○



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Policy Briefing

Preventive Measures That Protect Against Surprise Billing

BY BILL BARCELLONA, EXECUTIVE VP, GOVERNMENT AFFAIRS, AMERICA'S PHYSICIAN GROUPS



“Here are two thoughtful examples from APG members that help patients avoid balance billing situations.”

APG members have been proactive in solving surprise billing problems through prevention. While Congress continues to debate legislative solutions to this problem, here are two thoughtful examples from APG members that help patients avoid balance billing situations.

HIGH-TOUCH ADVANCE PATIENT EDUCATION IN OREGON

While I was attending our Pacific Northwest Regional meeting in Portland, Oregon, I struck up a conversation with Lee Espey from Salem Health Hospitals & Clinics. Lee told me how he observed a nurse in their OBGYN clinic counseling a patient during the initial intake for an expectant mother about the various costs involved in future visits, labs, and delivery—and where she might expect to see separate charges from hospital-based providers. Lee followed up and introduced me to his colleagues at Salem Health, and we had a great discussion about how a healthcare provider can help patients avoid the potential pitfalls of out-of-network charges.

Salem Health uses a “global billing” process for the entire prenatal, delivery, and postpartum services package for OB care. The staff schedule a review appointment with patients to go over coverage details, potential charges, and out-of-pocket exposure. Each service is listed individually, as are all the provider types that participate in the facility-based procedure, including anesthesiologists, radiologists, surgeons, and pathologists. They take the time to explain how these individual professionals come together during the surgical procedure and that billings are often separate from each provider.

Salem Health also uses a simple, understandable insurance verification and precertification form for review with each patient prior to a scheduled procedure. For a standard vaginal delivery, including postpartum visits, all costs and providers are broken down and explained. The contact numbers for the various professional providers are listed on the back so that patients can verify additional costs in advance. It's an effective tool to take the “surprise” out of the OB process, and Salem Health patients report high levels of satisfaction and understanding.

BUILDING A CULTURE OF PHYSICIANS AS PARTNERS

Farther down the West Coast in Southern California, the MemorialCare Health System addressed the issue of surprise billing of patients receiving care at their in-network hospitals by working directly with each of its hospital-based physician groups and taking the lead toward a solution that benefited patients.

MemorialCare requires its contracted hospital-based physician groups (ER, Anesthesia, Pathology, and Radiology) to also contract with the same health plans and health insurers—thus avoiding the classic “surprise billing” scenario when a patient seeks covered care at an in-network facility and then receives a bill for professional services from an out-of-network provider. As a matter of practice, MemorialCare also includes a “reasonableness clause” in its professional services agreements, which prevents physicians from being forced to accept less than market rates from insurers. MemorialCare’s proactive approach pays off by generating higher patient peace-of-mind and physician satisfaction.

It’s sometimes challenging for MemorialCare and other hospital systems to achieve 100% conformity in network contracting between health insurers and hospital-based providers. A recent article in *Modern Healthcare* magazine lauded MemorialCare and other systems for use of the conformity policy, which greatly reduces the potential for surprise billing to occur. Integrated systems like MemorialCare are touting high percentages of in-network billings against their total revenue, which makes them more attractive to employers, patients, and payers.

These examples highlight the power of paying attention to system-level gaps that can hurt patients. Both Salem Health and MemorialCare sought proactive processes to help their patients avoid the problem of surprise billing. No legislation needed. ○



Federal Policy Update

Amidst Gridlock, What's Next for Healthcare Legislation?

BY ANU MURTHY, DIRECTOR OF FEDERAL AFFAIRS, AMERICA'S PHYSICIAN GROUPS

As this magazine goes to press, the 116th Congress is back after a brief fall recess, and the administration is shoring up its defenses for a crucial battle over impeachment. Rumor and innuendos swirl around us. But one thing we at America's Physician Groups know is that no matter what is going on politically, the business of government and the people will keep moving forward.

Healthcare has remained a leading issue in the 116th Congress, and momentum is continuing around several key proposed bills. This fall, the House and Senate are poised to consider legislation surrounding drug pricing, surprise out-of-network billing, and various “extenders,” among other topics.

With the 2020 presidential election cycle in full swing, attention is on the Trump administration as it works to uphold its promise to lower healthcare costs. However, the heightened friction between President Trump and House Democrats makes bipartisan cooperation a tall order in a divided Congress.

On healthcare though, both Congress and President Trump have sufficient motivation to show some meaningful progress before the elections. Special-interest lobbying and ideological sparring make the end result hard to predict. Here's what to look for in the months ahead:

STARK LAW

The Trump administration has proposed new exemptions and safe harbors to the Stark Law and Anti-Kickback Statute to spur more physicians and healthcare facilities into value-based care arrangements. The Department of Health & Human Services' (HHS) proposed changes to the Stark Law, the Anti-Kickback Statute, and the Civil Monetary Penalty Law—announced as part of the Regulatory Sprint to Coordinated Care—would represent some of the most significant changes to these laws in the last decade.

The reforms, in the form of proposed rules from the Centers for Medicare and Medicaid Services (CMS) and HHS' Office of Inspector General (OIG), aim to update the 1989 Stark Law that bans physicians from referring patients to facilities in which they have a financial stake. The proposed regulations would create a permanent exception to the law to shield legitimate value-based deals from penalties.

“Unfortunately, the looming threat of liability under the Stark Law has discouraged many providers from entering into value-based arrangements in the first place,” CMS Administrator Seema Verma was quoted as saying, upon the release of the proposed rules.



“On healthcare, both Congress and President Trump have sufficient motivation to show some meaningful progress before the elections.”



Currently, CMS provides waivers for value-based care arrangements, but only for Medicare-based payment models such as accountable care organizations. The proposal would allow for similar types of exceptions for other models that are in Medicare or in the private sector.

SURPRISE BILLING

Congress is looking to address the large out-of-network bills some patients unexpectedly receive from doctors and hospitals when care is deemed to be out of network.

Private equity firms that have taken over physician staffing firms and emergency services at many hospitals are accused of foisting huge bills on patients by virtue of the fact that patients typically don't shop around when in an emergency health situation. There is bipartisan support to take the patient out of the equation and create some guardrails on how providers will be paid in these situations.

The Senate Health, Education, Labor and Pensions (HELP) Committee passed a bill that would benchmark out-of-network charges to the

median negotiated rate. The House version added a special-interest loophole in the form of limited arbitration for providers seeking higher reimbursement. The Senate is discussing adding arbitration in a compromise measure, and other House committees have yet to weigh in. Under Rep. Richie Neal (D-MA), the Ways and Means Committee in particular could end up expanding arbitration.

A \$13 million dark-money ad campaign aimed at killing the legislation suggests that private equity-owned players think loopholes won't go far enough. While surprise billing legislation passed the Senate HELP Committee 20-3, two of the dissenters were Sens. Bernie Sanders (VT) and Elizabeth Warren (D-MA), both key Democratic presidential candidates for 2020.

It appears that partisanship is responsible for not wanting to give President Trump a win on healthcare. The combination of this reticence and the special interest lobbies picking off support could doom an otherwise commonsense plan to not saddle patients with hefty healthcare bills.

continued on next page

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DRUG PRICES

This was supposed to be the one area where something would get done, even with drug companies spending record amounts on lobbying. With cutting prescription drug costs being a rare bipartisan issue, it seemed like everyone had an interest in curtailing escalating drug prices—except drug companies.

A bill originating from House Speaker Nancy Pelosi (D-CA) includes an arbitration panel determining costs—this time as a resolution to negotiations between the government and drug companies on certain medications. The Pelosi bill expands the number of drugs covered under these negotiations and then opens the benefits up to all patients, including those covered by private insurance.

But none of that may matter now. The White House/Pelosi negotiations, which were heating up at one point in the summer, have stalled. President Trump is still eager to do something on drug prices (“The president will not be outflanked on the left on drug prices,” White House official Joe Grogan told conservatives in July). But much of the administration’s energy is on fighting Pelosi on impeachment, rather than working with her on prescription drug pricing reform.

THE AFFORDABLE CARE ACT

The Trump administration took major political heat for opposing the Affordable Care Act (ACA) in a high-stakes lawsuit. Last December, a district judge upheld a challenge from nearly two dozen GOP-led states, saying the ACA is unconstitutional. In July, the 5th Circuit Federal Court of Appeals heard arguments and could rule on the future of the ACA any day now.

It has been recently reported that the administration originally intended to embrace all of the ACA—including its protections for patients with pre-existing conditions—until an influential group of conservative advisers convinced President Trump earlier this year to do exactly the opposite.

This reversal sheds new light on how the Trump administration has struggled to uphold and message its healthcare plans following Congress’ failure to repeal and replace the ACA in the summer of 2017. It also suggests at least some Republicans close to President Trump are concerned about the potential

political backlash and likely chaos if the court rules to strike down the ACA.

No matter how the appeals court rules, determining the legality of the ACA will almost certainly be taken up by the Supreme Court—making it a ripe issue for the upcoming elections.

MEDICARE FOR ALL

The concept of Medicare for All as a panacea for our nation’s healthcare woes remains at the forefront of the Democratic candidates’ debate answers and stump speeches.

Defending Medicare for All are Sen. Elizabeth Warren (D-MA) and the person who “wrote the damn bill,” Sen. Bernie Sanders (I-VT). Both Sen. Amy Klobuchar (D-MN) and Mayor Pete Buttigieg indicate supporting the expansion of coverage along the lines of the ACA—not single-payer healthcare, which they believe is too costly and takes choice away from the American people. Former Vice President Joe Biden continues to question how Medicare for All would be financed.

While Sen. Sanders confirmed that taxes would be raised to pay for his legislation, Sen. Warren has declined to answer the same question with a “yes” or “no” response.

IN CONCLUSION

There is no doubt that the current state of gridlock is impeding progress on proposed healthcare legislation, and we will be impacted as politicians, voters, and consumers. As we head into 2020, voters are sure to ask, “Hey, does your dog just bark, or does it actually bite?” with respect to the well-intentioned bills to help patients. Eventually, Congress and the administration are going to have to show the people that they really care about the patient by taking the next steps forward with the proposed bills.

Fortunately, there is still significant progress being made in the movement from volume to value in the form of new Center for Medicare & Medicaid Innovation (CMMI) payment models, proposed regulatory rules, and executive orders. Rest assured that your Federal Affairs team here at APG, led by Don Crane and Valinda Rutledge, continue to meet with leaders, advocate on your behalf, and strive to bring the value-based movement to the forefront of the healthcare ecosystem. ○



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Chronic Care: Connecting the Dots for Success

BY RAÚL F. MONTALVO-ORSINI, MD, MBA



“We have seen a significant reduction in readmissions and ER visits, as well as an increase in simplified drug regimens and compliance.”

The care for chronically ill patients has become a great challenge for governments and healthcare organizations. A small percentage of patients consume a large number of services, and many of these services are redundant and high-cost.

According to the Agency for Healthcare Research and Quality, approximately 5% of the population is accountable for 59% of healthcare costs. These patients have been labeled “super-users,” “super-utilizers,” or “high-cost, high-need.” Their patterns on seeking care at different sites—combined with a lack of appropriate care coordination and a lack of effective communication between payers, providers, patients, and caregivers—lead not only to a cost burden, but also to lower quality of care and poor outcomes.

In addition, dual diagnoses of chronic medical conditions and mental illness are often not connected, and social determinants are often not addressed.

THE NEED FOR HIGH-TOUCH CARE

When we allow chronically ill patients to navigate the healthcare system without coordination, we see fragmented care, multiple hospital admissions and readmissions, and health deterioration.

Adults living in Puerto Rico have multiple lifestyle-related risk factors and a high prevalence of chronic diseases—namely, cardiometabolic and psychological conditions. High prevalence of obesity, diabetes, hypertension, arthritis, cardiovascular diseases, and depression has been reported and indicates social and health disadvantages. Disparities in common chronic conditions also exist. Here are a few prevalence numbers:

- Hypertension: 42% in Puerto Rico, 31% in U.S.
- High cholesterol: 39% in Puerto Rico, 36% in U.S.
- Diabetes: 16% in Puerto Rico, 10% in U.S.
- Coronary heart disease or myocardial infarction: 9% in Puerto Rico, 6% in U.S.

In addition, 66% of island residents have a self-reported body mass index (BMI) consistent with being overweight or obese.

This population has an increasing need for high-touch, personalized services that address social determinants of health.

‘A ONE-STOP SHOP’

MSO of Puerto Rico has developed interdisciplinary chronic care clinics as an extension of our primary care service. Called Vita Care, each clinic location

is a one-stop shop to help individuals manage and improve their long-term health.

The key to this model of care is to direct members to Vita Care clinics—which function as integrated care management practice units. Here, members are holistically managed within one site, while the clinic maintains constant and active communication with the patient's primary care physician (PCP).

The clinic's interdisciplinary care team includes the following:

- Internal/family physician
- Nurse specialist
- Social worker
- Health educator
- Nutritionist
- Clinical pharmacist
- Psychologist
- Specialists in cardiology, endocrinology, nephrology, pulmonary medicine, and psychiatry

It all starts with patient selection. To determine candidates for these chronic care clinics, we developed a platform and process that considers claims costs, clinical indicators, access, and other

social factors. This interdisciplinary, coordinated approach has been very successful in improving overall health indicators and outcomes, compared with qualified non-participants.

KEYS TO SUCCESS

As a result of the Vita Care clinics, we have seen a significant reduction in readmissions and ER visits, as well as an increase in simplified drug regimens and compliance. The same electronic medical record (EMR) has been 100% adopted by each of our clinics—resulting in better communication and documentation. Overall, MSO of Puerto Rico has achieved a 7% cost reduction.

Here are the biggest keys to our success:

Transportation services

Providing transportation is one of the most important aspects. It eases the burden of commuting, diminishes missed appointments, and helps members with limited mobility.

Healthcare navigation

We coordinate services not available in the clinic—such as radiography, labs, pharmacy, and authorizations—to remove barriers to care. This helps the patient save time and allows us to improve the use of preferred networks and providers.

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Outreach visits

Our social workers perform outreach visits and home assessments. They also coordinate with government agencies and community programs so patients and caregivers can receive additional services that they may not be aware of.

Inclusion of a PharmD

This is a novel and very important factor. In general, medication management is loosely managed at the retail pharmacy counter—without effective coordinated communication among participating providers. Often, providers continue to increase dosages and add-on therapies—when the baseline problem is adherence to treatment.

In our program, the PharmD meets all our patients, is an active member of the care team, and participates in our weekly care plan meetings and case discussions. As a result, we have noticed a 6% reduction in drug costs in the managed population. By reconciling and simplifying therapy and creating pill boxes, we typically start seeing significant improvements in clinical indicators after just one week.

Mobile clinics

Puerto Rico is a small island but has a rugged topography. A significant portion of the population lives in the mountain region, and for these people, access is a real challenge that transportation alone cannot resolve.

To meet this need, we developed mobile clinics in collaboration with medical groups and PCPs that practice in those regions. Once a week, we deploy our team and resources in the office of a partnering PCP—where we receive patients from the surrounding municipalities and provide similar services to those provided in our regular clinics. This is a temporary solution while we build permanent clinics in the region.

Telemedicine

During 2019, we have incorporated telemedicine technology to provide specialized care remotely, using our team of chronic care specialists in coordination with PCPs in distant regions.

Mental health

Mental health issues impact the health status of chronically ill patients. We have identified depression

in about 70% of our diabetic population. No program can be complete without addressing the mental health situation of the chronically ill. In our program, a psychologist participates in the initial welcome visit.

In Vita Care clinics, we built a social room that is used for that initial visit, as well as for all mental health interventions. The space simulates a comfortable living room and is a welcoming, peaceful environment that promotes relaxation and trust. We wanted to create a different process in which patients would feel at ease and establish a conversation. This helps to make them familiar with the clinic and our expectations.

Nutrition

Nutrition is a fundamental piece in the management of chronically ill patients. All our patients receive an individualized assessment and nutritional plan. This plan is tailored to patients' likes and dislikes, as well as their level of financial resources.

In addition, we offer group classes and sessions where patients become teachers to other patients—an important building block to creating a culture of proper chronic disease management. The next step will be adding a kitchen or partnering with federally qualified health clinics (FQHCs) or other community programs that have already built kitchens for patient education.

IPA and PCP support

The purpose of the clinics is to empower chronically ill patients and their caregivers to manage their condition in an optimal way. Patients stay in the clinic until those goals are attained; some take longer than others.

During the process, the clinic maintains close communication with the patient's PCP, who eventually

receives a documented summary and the care plan. All the information is uploaded to InnovaMD, our provider web portal.

We recognize that IPA and PCP support are extremely important for the success of the program. We continue to pay PCPs their regular capitation while the member is in the clinic, and we incorporate the PCPs in all important treatment decisions and care plans.

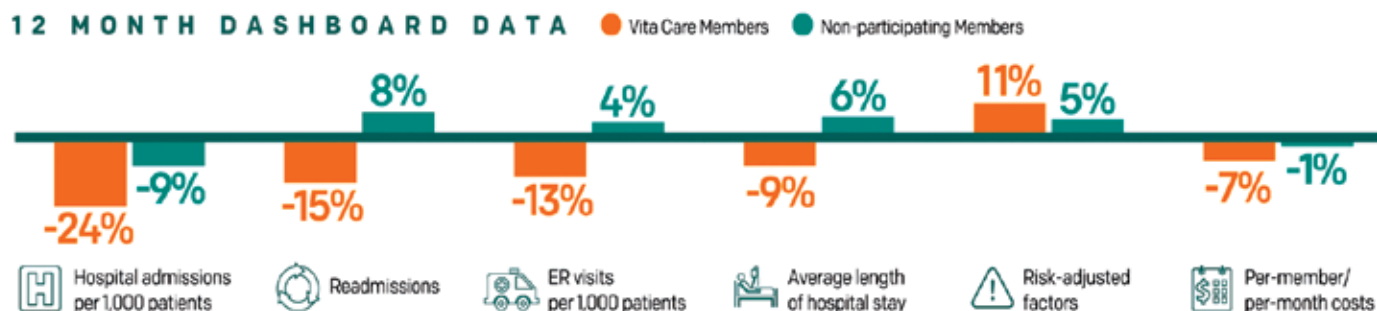
CONNECTING THE DOTS

In summary, chronic care is challenging and complex. To manage it successfully, improve patients' health status and satisfaction, and decrease the cost of care, we need a better coordinated approach.

At MSO of Puerto Rico, we built our Vita Care chronic care clinics with an interdisciplinary team and technology resources and solutions, including telemedicine. We pay a great deal of attention to social determinants, environmental and at-home factors, the mental and emotional state of patients and caregivers, nutrition and medication management, and compliance. In addition, we are in constant communication and collaboration with our independent practice association (IPA) partners and PCPs.

The success of chronic disease management is based on creating a culture of consistency and discipline—one that promotes and develops healthier behaviors and outcomes. ○

Raúl F. Montalvo-Orsini, MD, MBA, is President of MSO of Puerto Rico, LLC, and has extensive administrative knowledge of diverse health-related entities. He presides over APG's Southeast Region and is a member of APG's Executive Committee and Board of Directors.



APG Member Spotlight

Climbing the Leadership Ladder: What Female Physicians Need to Know

BY MARY WILSON, MD, MPH



“We must be excellent physicians before we can be taken seriously as leaders.”

As I look back on my time as a young female physician building my practice, I have a few recollections of being treated differently because of being female. Whether accurate or not, my interpretation of this was simple: I was a physician, and my success should be measured by the quality of care I delivered. I didn't acknowledge or give credit internally to any limitations and felt confident that those with bias were incorrect. In my young brain, I might have even thought they were out of touch!

What of my female colleagues? In retrospect, and not surprisingly, I realize that others experienced different levels and intensity of discrimination. Each of us reacts differently to bias depending on background and experience. Many modify their behavior in ways that waste time and energy. A career in medicine is a marathon that requires stamina and persistence, so any sapping of your energy takes a toll on performance. As many juggled the demands of marriage, motherhood, and a career, they often did it without the support of their peers or their organization.

I was lucky enough to have a wide range of colleagues, mentors, and leaders who helped me navigate these tricky waters. Along the way I learned great lessons that I've categorized as the three stages of my journey: the initial step into leadership, juggling family and leadership, and the challenges and rewards of senior leadership. Following are strategies I found crucial for success in each stage.

GETTING THERE

In my experience, we must be excellent physicians before we can be taken seriously as leaders. Research¹ bears this out, showing that medical excellence consistently emerges as the most important quality required of physician leaders.

I've found “soft” skills, such as communication and collaboration, to be equally important. These interpersonal skills are crucial to aspiring leaders and are ideally learned and honed early in our careers. While some have these innate talents, recognizing our gaps and developing new skills requires tremendous self-awareness.

Many women face barriers formed by unconscious bias, so it's critical to be aware of what other people in the room are feeling. Decide what you want out of a situation—while adhering to your core values—and use this awareness to find approaches that drive the results you desire.

Avoiding a sense of victimhood or defensiveness is also important, as dwelling on barriers inhibits learning. The ability to recognize, check, and act on your

emotions productively is a tall order. This was much more challenging early in my career. However, developing these good habits early on has paid dividends for many years.

When launching your career, consider the work environment carefully. Today, a newly-minted medical doctor is likely to spend at least some time employed by someone else. In fact, 47.4% of practicing physicians were employed in 2018, while 45.9% owned their practices.²

I was fortunate to choose to practice as a Permanente physician. Providing care to the patients and members of Kaiser Permanente offered the right environment for me, aligned with my values, and supported my needs as a physician. The organization also champions diversity and women in leadership—support that helped me in my career and as a leader. You can't get the best solutions from people without honoring that diversity—in the people around you, in your teams, and in yourself.

Finally, bear in mind the compensation associated with a chosen specialty. While most offer equal pay for men and women, long-term compensation growth is often linked to a physician's ability to take on leadership and thrive in that role.

SUCCEEDING IN MID-CAREER

Ascending the leadership ladder requires tackling new challenges. That can include speaking up for yourself—and for others. It may mean confronting difficult situations in a thoughtful way. Again, acknowledge the feelings of others involved when difficulties arise. Assume good intentions and be persistent. If you encounter biases, confront them in the moment.

During this busy mid-career stage, physicians who want a family should seek a supportive work environment and be clear about their need for flexibility. As a doctor, you cannot expect to work only the hours that your kids are in school. Patients deserve to be seen when they need to be seen.



However, to achieve work-life balance, there must be flexibility on both sides. For example, working four days a week instead of five, or covering day shifts for colleagues while they cover for you on nights and weekends, can provide much-needed flexibility.

As you juggle family and career, take care of yourself—there are a lot of people relying on you during this stage. On the home front, understand that perfection isn't possible, regardless of your role. Give yourself permission to be “good enough.”

EMBRACING THE JOY OF LEADERSHIP

Moving into senior leadership roles brings a shift in job satisfaction.

As a pediatrician, I derived joy from one-on-one interaction with patients and their parents. As my leadership responsibilities grew, I saw fewer individual patients. However, I discovered other sources of gratification and growth as a leader, mentor, and coach.

While it's true that leadership can be lonely at times, it's also true that none of us accomplishes anything alone. Avoid insulating yourself by staying engaged

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Next-Gen Enterprise Analytics to Leap Into Personalized Care

BY JEAN DROUIN, MD

Big data is not a new conversation. In fact, analytics revolutions are already underway in industries from logistics to banking. UPS, Amazon, JP Morgan, and FedEx are all major parts of the big data conversation.

UPS is using advanced analytics for process optimization—directing its technology so UPS drivers rarely, if ever, have to turn left. Banks like JP Morgan use big data to pre-authorize credit cards almost instantaneously. Retailers like Amazon use advanced analytics to personalize offerings to their users. Infrastructure like this provides added convenience for customers and integrates seamlessly into their lives. It also helps companies cater specifically to each consumer's wants and needs.

Retail, logistics, and banking are prime examples of making big data analytics actionable and using them to improve customer service. These industries have achieved success by investing in three critical components of the big data revolution:

- Data and architecture
- Systems of intelligence
- Delivery

They are compiling massive, integrated, secured datasets and using advanced artificial intelligence and machine learning to generate real-time insights. These insights are then delivered to the user in a tailored and personalized way.

It's time the healthcare industry embraces this same approach. The current process of combining data is inefficient and cumbersome. Clinicians and operators alike are inundated by analytics vendors offering a single-use case and requiring the customer's own data to offer any value. Moreover, response times are slow; it can take weeks to months to link, clean, and prepare data.

The biggest issue is that in healthcare, we generally lack a universal, integrated view of a patient's journey at anywhere near the level of detail or timeliness needed to deliver the personalization and customer experience that we have grown accustomed to in other facets of our lives.

How can healthcare organizations provide quality care if they don't have access to complete, accurate patient information and longitudinal performance data?

BREAKING DOWN DATA SILOS

While big data and analytics are making their way into healthcare, we're still experiencing the major roadblock that is interoperability and cross-industry information-sharing.



“When it comes to improving care delivery, artificial intelligence and machine learning have the potential to impact care from both sides.”

With the prevalence of the point-solution model, there is little communication between vendors, institutions, or industry sectors. Providers aren't gaining access to data collected by life science organizations, for instance, or even from other providers.

We are about to enter an age of new possibilities in this area. For instance, the U.S. Department of Health and Human Services (HHS) is opening up access to datasets from government agencies and state partners.¹ At the same time, organizations are working with partners who bring the capability to unite siloed datasets—and organize and make sense of them in ways similar to those deployed in the banking and consumer industries.

With the right tech stack and architecture, it is now possible to aggregate traditionally siloed patient-level data (claims, clinical, prescription, social data), and then clean and link this data to government and commercial claims. It can also be combined with individually attributed social and behavioral data—enabling a far deeper understanding of a patient's needs.

Access to patient-level data is step one; pairing that data with a predictive analytics engine is step two in offering more personalized care.

DRIVING ACTIONABLE INSIGHTS FOR PERSONALIZED CARE DELIVERY

When it comes to improving care delivery, artificial intelligence and machine learning have the potential to impact care from both sides—personalizing care recommendations for patients and improving the way provider performance is measured and assessed, prompting sustained behavior change.

Personalizing care delivery

The power of big data for care personalization lies in the ability to look at the multitude of metrics and data points that make a patient unique—and then compare that patient to millions of other patients across the country to identify patterns and predict the best care possible for that patient.

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Of essence here is the ability to run such analyses in minutes to enable timely interventions that lead to the best outcomes.

For example, 60% of health outcomes are driven by socio-behavioral determinants of health (SBDoh),² but less than 10% of healthcare expenditures address them. By using machine learning to predict outcomes based on SBDoh data from a larger patient population—not just their own patients—care providers will be better equipped to inform and assess health based on location, transportation needs, access to care, and other factors.

Physicians can also leverage predictive analytics to determine a patient's optimal care journey. Longitudinal data helps inform how patients may react to certain methods of care—predicting things like medication adherence, number of in-patient days, and more. This provides physicians with the knowledge and ability to better plan for care and avoid unnecessary treatment.

Physician performance: A more accurate picture

Machine learning can also help to improve quality and cost through a case-mix adjusted view of clinical performance.

Machine learning has the power to generate trusted provider benchmarks by identifying expected performance values specific to their patient panel's characteristics. When compared with other providers who treat patients with the same characteristics, these insights can be used to highlight specific performance gaps and areas where they outperform the average.

Physicians may worry that traditional approaches to measurement don't reflect the specific challenges associated with their case mix index. But an expansive database paired with advanced analytics allows clinicians to be measured against their specific case mix—precisely accounting for the level of difficulty associated with caring for their patients.

THE RIGHT INSIGHTS AT THE RIGHT TIME

Large data archives and systems of intelligence alone won't have an impact unless the insights they

generate are delivered into the workflow in a timely and actionable manner. Too often, vendors hold customers hostage to reports or proprietary portals, rather than focusing on enabling their customers to consume insights in the most effective and efficient way.

It's important that we learn the lessons from the introduction of electronic medical records (EMRs). With EMRs, the collection of clinical data has been crucial, but it has come at great cost in terms of clinician burnout and the interaction between clinician and patient being reduced to looking at screens.

THE FUTURE OF BIG DATA ANALYTICS IN HEALTHCARE

Retailers like Amazon deliver predictive analytics to personalize offerings to their users, and banks use real-time risk adjustment to approve credit cards. They do this not through point solutions, but because they have made massive investments in enterprise analytics platforms that deliver the needed power, speed, and precision—and a vast amount of comprehensive consumer data.

Providers, payers, and life science companies will need to make the same commitment to enterprise analytics platforms that can deliver actionable insights across a range of use cases—rather than tinkering with point solutions limited by small datasets. With that commitment, they will be able to fully unlock the promise of more personalized, effective, and delightful care powered by big data. ○

Jean Drouin, MD, MBA, is the Founder and CEO of Clarify Health Solutions, which delivers advanced analytics and digital solutions that empower physicians, health systems, payers, and life sciences organizations to optimize patient care and clinical trials. Dr. Drouin has written and spoken extensively on the role of big data and analytics in delivering better outcomes. For more information, visit clarifyhealth.com and follow us on Twitter @ClarifyHealth.

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How Smart Leaders Stay Out of Harm's Way: Part 3

BY RUSSELL FOSTER AND SHEILA STEPHENS



Russell Foster



Sheila Stephens

This is the final article in a three-part series on how to overcome compliance and operational deficiencies in a time of expanding government oversight. The other articles were published in the Spring 2019 and Summer 2019 issues of the Journal of America's Physician Groups.

As discussed earlier in this series, the rapid growth in Medicaid and Medicare Advantage membership in recent years has stretched the infrastructures of many managed care organizations (MCOs) to the breaking point.

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

In this series, we highlight the 10 most common compliance and operational issues we encounter when engaged in an audit or assessment (regardless of the organization's size). These issues reduce efficiency, effectiveness, and profitability, and they expose the enterprise to:

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

In this piece, we will cover the final four issues: 7, 8, 9, and 10.

TOP 10 COMMON ISSUES NEGATIVELY IMPACTING HEALTHCARE ORGANIZATIONS

1. An organizational culture that supports the philosophy that 80% is good enough
2. A Board that is disengaged or uninformed
3. An administrative structure that is heavily siloed
4. High turnover of key executive, senior, and supervisory level staff
5. Provider contracts that are not fully vetted as to reasonable and operational implementation
6. Policies, procedures, and processes that are poorly documented, reviewed, and communicated
7. Insufficient internal controls in place to identify and mitigate significant weaknesses in core processes
8. Understaffed and underfunded compliance departments that cannot aggressively pursue their duties

“Compliance goes beyond just ensuring privacy, following regulations, and having applicable policies and programs.”

9. Weak internal data integrity and/or reporting
10. Third-party recovery activities that are not robust enough to recapture overpayments within a reasonable period of time

ISSUE 7: INSUFFICIENT INTERNAL CONTROLS

Most MCOs only have a few requisite policies and procedures in place in their finance and accounting department, along with an anti-fraud policy or plan. Where policies exist, we often find them out-of-date, not fully implemented, simply not followed, or not used to identify and resolve weaknesses in core processes. In addition, most don't have audits and accountability to ensure that internal controls are monitored and reported.

Beyond the finance and accounting areas, internal controls are further eroded and even less consistent. Areas such as claims and utilization management have a variety of auditing functions, often required for regulatory reporting. However, our compliance audits and organizational assessments reveal that many MCOs simply monitor and audit to meet requirements—rather than use the findings as a measure of departmental and individual performance and accountability.

In contrast, we find that best practice organizations not only have a variety of controls in place, but they also pay attention to internal controls—using them as “instruments” to guide the organization to safer financial harbor, less-risky practices, and higher levels of compliance.

To summarize: When used appropriately, internal controls throughout the organization provide an MCO with an early warning system that can identify and mitigate core weaknesses.

ISSUE 8: UNDERFUNDED COMPLIANCE DEPARTMENTS

A compliance department is supposed to ensure and safeguard an MCO from non-compliant policies, processes, and practices. However, all too often we find the reason is simply to meet a regulatory requirement. The authority needed by the compliance staff has been adversely impacted to the point of ineffectiveness.

Further, we find situations where other departments, which may have more political power, take actions that mitigate compliance efforts. This undermines the entire organization's efforts in internal controls and risk management.

Most readers would agree that selecting and hiring quality compliance staff members is essential to ensuring a program congruent with the size and complexity of the organization. However, there is one more component needed: *listening* to that compliance team and using its input and knowledge for critical decision-making in all other areas of the organization.

Compliance goes beyond just ensuring privacy, following regulations, and having applicable policies and programs. Compliance requires an “organizational state of mind” that supports a philosophy of doing it right the first time. It should ensure that:

- Claims are paid accurately within industry standards and regulatory requirements
- Denial letters contain all of the appropriate content, in a clear and concise manner
- Quality monitors are in place and reported
- Potential quality issues are identified, tracked, and trended
- Corrective action is taken when needed
- Contracts contain all required language

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- Provider networks are intact, and changes are monitored and reported
- Members receive information regarding language assistance and grievance and appeal rights
- Network providers know how to assist members with language assistance and grievances and appeals

Compliance departments weakened by lack of authority or insufficient staffing are not able to serve the organization as they should. This weakens the entire organization and may ultimately harm it financially.

Non-compliance is costly. It creates rework and additional regulatory audits, and it promotes non-compliance-based decision-making. Rework is costly because production costs are doubled or tripled. Regulatory audits are costly because they divert resources—which can lead to reduced production in critical operational areas. And decisions that do not consider the compliance impact are costly, as they frequently promulgate errors and avoid the “do it right the first time” mantra.

ISSUE 9: WEAK INTERNAL DATA INTEGRITY

Organizations with minimal or weak data retrieval systems and processes typically can't produce cogent data that is timely and easily translated into information. This has a far-reaching negative impact on the MCO and its ability to quickly identify and respond to potentially adverse events or processes.

Weak or untimely data is often due to lack of clear or undeveloped protocols related to terminology, validity, and reliability. Data integrity can also be compromised by an ineffective validation process and poor audit procedures.

When MCOs do not conduct validation audits (audits of the audit trails) and perform upstream and downstream validation, they risk not identifying gaps that create mishaps in data integrity. This is further complicated—and the organization further compromised—when the MCO does not have a clear “change control” process.

The lack of attention to data integrity as it relates to change control is like waiting for the other shoe to drop—because it will. It will drop every time there is a change or an update. Even small changes can cause a domino effect.

Collecting and analyzing data is essential for all areas of the organization, including:

- Contract management
- Payment and recovery strategies
- Utilization management
- Quality monitoring and reporting
- Provider performance

Developing short- and long-term strategies based on the data should provide a strong decision-making foundation for the MCO. But if the data is weak, incorrect, inconsistent, or untimely, it creates a data integrity risk for the organization and is of minimal value.

ISSUE 10: THIRD-PARTY RECOVERY ACTIVITIES

It is not uncommon for us to see an MCO that has very robust claims processing procedures and practices—but also has poorly defined policies, procedures, and processes for recovery of overpayments within the required timeframe.

Recovery efforts that are ill-defined, poorly organized, and untimely are a waste of the organization's time and money. The net results rarely provide a return on investment. Lack of attention to overpayments and timely and compliant recovery can cost an organization hundreds of thousands of dollars each year.

Organizations that do not develop recovery efforts within a well-developed recovery unit—with experienced staff; well-defined protocols, procedures, and processes for timely reporting and identification of overpayments; and procedures that are ready for immediate implementation—are at significant risk for financial losses and non-compliance.

We know that errors will occur even with an effective overpayment avoidance program. We support a strong overpayment avoidance practice, and we particularly recommend that MCOs have a well-defined payment integrity program. However, we continue to see far too many organizations that have not entrusted sufficient resources to ensure a robust overpayment recovery program.

This concludes our series. We hope you found our comments challenging, and we look forward to hearing from you with any questions or comments. ○

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Tackling the Next Frontier in Healthcare: Social Needs

BY BRIAR ERTZ-BERGER, MD, NICOLE FRIEDMAN, AND TIMOTHY S. HO, MD



Briar Ertz-Berger, MD



Nicole Friedman



Timothy S. Ho, MD

Addressing social needs is the next frontier in healthcare. Unmet social needs, such as food insecurity, inadequate or unstable housing, and lack of access to transportation account for more than 60% of health outcomes. These gaps in social care increase the risk of chronic health conditions, reduce an individual's ability to manage these conditions, increase healthcare costs, and lead to poor health outcomes.

A recent survey conducted by Kaiser Permanente found that Americans view social needs as critical to their overall health.¹ The survey found that:

- Americans view social needs as an integral part of health—with 89% saying safe and stable housing is very or extremely important to health. In addition, 80% say reliable transportation is very or extremely important, and 82% say balanced meals are very or extremely important to health.
- Social needs serve as a barrier to health. A third of respondents reported experiencing stress related to social needs, and 28% of respondents reported having a social need act as a barrier to care in the last year. In addition, 39% frequently or occasionally experienced stress over accessing food or balanced meals, and 35% experienced stress over housing.
- Most Americans want their medical providers to ask about social needs, with 97% of respondents saying their providers should ask about social needs during medical visits. Only 10% said they would feel nervous or annoyed by such questions.
- Social needs are predictors of physical and mental health. Americans who report experiencing an unmet social need in the past year are more than twice as likely to rate their health as fair or poor (16%) compared with those who did not experience an unmet social need (6%).

Growing evidence shows that addressing health-related social needs by enhancing links between clinicians and community services can improve health outcomes and reduce costs. In response, health systems in the United States increasingly are working to integrate social care. But the pace of progress has been slow and accountability diffuse.

“Thrive Local will be a comprehensive and far-reaching network connecting healthcare providers and social service agencies.”

AN ENTERPRISE-WIDE SOCIAL CARE PROGRAM

At Kaiser Permanente, with a large national footprint serving more than 12 million members, each region historically had taken a different approach to addressing social health. Efforts were fragmented, unmeasurable, and not designed for scale. Most importantly, the impact of addressing social health on clinical outcomes and the total cost of delivering care was unknown.

To address these challenges, Kaiser Permanente recently launched an enterprise-wide social care program to standardize how we screen for social care gaps—and how we refer patients to community-based organizations to address these gaps.

Announced in June, Thrive Local will be a comprehensive and far-reaching network connecting healthcare providers and social service agencies to address pressing social needs. Designed in partnership with the technology company Unite Us, the network will be built in close collaboration with nonprofits, government agencies, and other health systems and health centers. The goal is to create a unified community-wide resource that can be replicated across the nation.

The program includes three main elements, including:

1. A cloud-based resource directory providing up-to-date and searchable information on a wide range of social services and public benefits, along with eligibility information, hours of operation, and other key information
2. Geographic “Community Partner Networks,” including community-based organizations (CBOs) and public agencies that healthcare providers can refer to
3. A technology platform allowing for bi-directional, closed-loop referrals and integration into electronic health record systems and CBOs’ client management systems

Through the network and technology platform, care-delivery teams will receive information from the community organizations about whether patients’ social needs have been met and if other resources are required. This system of referrals and feedback will improve and streamline the patient’s care experience.

EVOLVING CARE DELIVERY

From the physician’s perspective, these systems and networks are critical to delivering effective health outcomes to patients. The Thrive Local program is designed to evolve care delivery from acute episodic care to a system focused on prevention and coordinated care management that fully takes into account the social determinants of health.

Kaiser Permanente Northwest has been on the forefront of addressing social needs for its members, piloting a robust social needs screening and referral system over the past three years. It will be the first region to implement the full social care program.

For example, prior to the launch of Thrive Local, a Northwest Permanente physician connected Joyce Bigelow, an 85-year-old Kaiser Permanente member and retired nurse in Vancouver, Washington, with housing resources and other social services after learning that Bigelow had begun living out of her truck after her husband died. The physician discovered that Bigelow was homeless during an exam that included a routine social needs screening.

Within the next three years, the goal is to roll out the Thrive Local program across all eight regions that serve Kaiser Permanente’s 12.3 million members across the nation. It is clear that systemic change will require the participation of the whole community. As such, the program must link to many kinds of organizations, settings, and health systems.

In the Northwest region alone, over 250 community-based organizations, as well as public and private agencies, joined in the launch of Thrive Local. Efforts are underway to optimize the program to support statewide initiatives to build a robust community health network. ○

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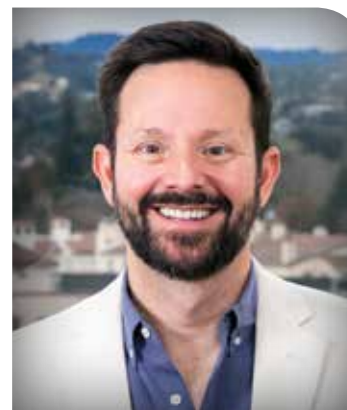
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The Opportunities of Technology-Enabled Risk-Sharing

BY ROBIN LLOYD

Over 10% of the U.S. population is now covered by an accountable care organization (ACO), and the number of risk-adjusted lives is growing at roughly 15% to 20% each year. To date, risk adjustment has primarily consisted of payers retrospectively reconciling work done with payments owed.

With the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, the Merit-Based Incentive Payment System (MIPS) on its heels, and advanced alternative payment models (APMs) offering more incentives, thriving under value-based payment models is a complex but increasingly viable path for providers. With the right technological assistance, clinicians can better understand clinical and operational risk, how to intervene and manage it, and how to maximize appropriate reimbursements to ensure organizational stability and growth.



THE GULF BETWEEN RISK AND REWARD

Managing risk is complicated, especially when it moves from retrospective to prospective in clinical settings. Common risk-sharing contracts need forecasting and monitoring to provide effective benchmarking prior to that first contract year—influencing payments going forward. Access to risk expertise becomes essential. A cultural shift in providing care may also be needed to align new care initiatives around risk and avoid administrative burnout of clinicians.

Technologically speaking, the data itself must be harnessed, understood, and delivered where and when it's needed. Under risk-sharing contracts, providers need to rely on data and analytics to address care and quality gaps and produce positive outcomes. Without the right data and analytics, providers can't predict—or even notice—when an undiagnosed condition presents a material risk for a more costly care episode downstream. Accessing, leveraging, and surfacing the data required to successfully participate in value-based models at the right time, to the right user, can prove difficult.

Achieving optimal outcomes under risk also relies on integrating care management into the access to this data. While there is significant opportunity to address risk at the encounter level, an even greater opportunity comes from patient outreach.

Any results from new, intelligence-driven outreach efforts on risk-related conditions are a boost to clinical and financial outcomes. Providers can know when and why to check on patients at a much deeper level, especially when socioeconomic factors are contributing to overall patient population risk.

The final piece is clinical documentation gaps. The Centers for Medicare and Medicaid Services (CMS) assigns risk scores to patients based on

“With the right technological assistance, clinicians can better understand clinical and operational risk.”

approximately 10,000 acute and chronic diagnoses. CMS combines this data with patient characteristics, including social determinants of health, demographics, and interaction factors (the combination of certain chronic diseases) to arrive at a risk adjustment factor (RAF). This RAF dictates the reimbursement for that patient's total care. The care team documents diagnoses data during (or immediately after) the exam so coders can submit accurate, timely claims.

Many provider organizations attempt to capture this information manually—increasing administrative strain on physicians already facing endemic burnout. Any documentation solution needs to account for, and possibly relieve, that burden.

THOUGHTFUL DEPLOYMENT FOR IMPACTFUL, LASTING RESULTS

Successful risk adjustment enables a more complete understanding of the population's underlying risks, which can fuel better care and cost management. Whether participating in government programs (Medicare ACOs and shared savings programs) or taking on private risk-sharing contracts with payer partners, organizations should obtain a complete picture of their patients' acuity. This is

critical to ensure proper reimbursements, effectively manage costs of high-risk members, and deliver quality care.

As provider organizations expand their risk-share footprint, the challenge in most of these organizations is that they have been set up to operate within fee-for-service. Some providers will immediately begin to attempt to capture risk gaps at the point of care. However, point-of-care risk capture is neither easy to implement nor a silver bullet, and there are no off-the-shelf solutions.

Even under the well-defined models of value-based care, every provider organization is different. Effective point-of-care workflows need pre-encounter and coding team support with the appropriate technology and processes.

Consider the following:

PRE-ENCOUNTER

Prior to presenting information at the point of care, a sufficient amount of diligence is needed, especially when accounting for quality and risk. Analysis of historical data can identify gaps in risk capture for

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each member and can be used to create a stratified list of members to be scheduled for a visit.

However, the massive volumes of patient data available can make this untenable—let alone in situations where one physician is operating alone. This is where artificial intelligence comes in: A clinically trained natural language processor (NLP) can process the full medical record, identify quality and risk gaps, and present these gaps so the care team can review them prior to the encounter.

With an appropriate team and technology, physician administrative work can be limited to the cases with the highest machine-identified confidence for a final decision. Meanwhile, staff can verify lower-confidence suggestions of risk and quality gaps, and then conduct targeted patient outreach and schedule appointments.

POINT OF CARE

A successful point-of-care solution should deliver gaps to the physician and allow the gaps to be closed—without leaving an electronic health record (EHR)-centered workflow or inhibiting a physician's focus on the patient.

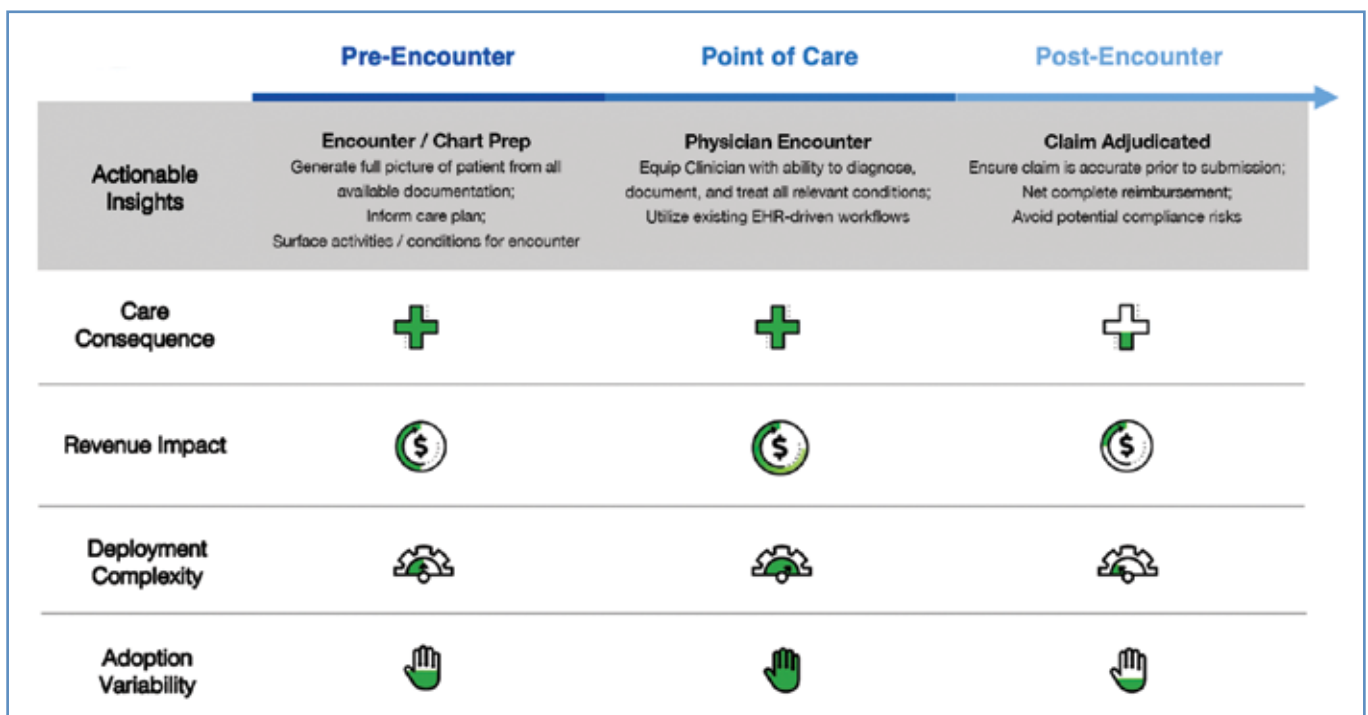
But a successful point-of-care workflow cannot stop there. It must also facilitate the capture of outstanding risk conditions through accurate documentation in the EHR. This is where re-centering risk on the patient and patient experience—without additional physician administrative work—pays off.

Through this approach, physicians can refocus attention on patients, with the confidence of insights from the full patient record to proactively ask about relevant chronic conditions. Patients no longer have to aggressively re-emphasize their conditions when visiting for ostensibly unrelated cases. The morale lift of this from a patient perspective *cannot* be understated.

POST-ENCOUNTER

Historically, the challenge with risk capture is that documenting risk conditions is insufficient and performed by payers, far from the point of care. Clinically, a patient record is similarly limited by this insufficiency. If conditions are not reliably documented, they cannot be used to address the patient's needs on subsequent visits. At the same time, if data is thoroughly documented but inaccessible, it's effectively moot. Any circumstances where providers could have intervened are continually missed.

To have an effective clinical and financial impact, providers must document and code the proper International Classification of Diseases (ICD) diagnoses



on outbound claims. In some Medicare Advantage (MA) contracts, there is a retrospective timeframe during which coding “catch-up” can be conducted. However, in many non-MA arrangements, the code must be captured and put on the claim before initial submission. If the code fails to make it onto the claim, the work conducted by clinicians will not yield results.

Identifying uncoded but documented work can be a burdensome process, requiring coders to sift through the entire EHR. Thankfully, by leveraging technologies such as natural language processing (NLP), the coder only needs to verify identified code opportunities—prioritizing the capture of risk gaps and ensuring that outbound claims are accurately coded in a timely manner.

Finally, ongoing updates to analytics, based on new patient encounter information, can help identify additional gaps and promote a continual improvement process. The clinical opportunity to use outreach to address conditions early and improve care is not only possible—it’s an integrated element of any risk adjustment program at a provider organization.

Note that while each phase is an important component to establishing a successful risk capture program, providers cannot expect to reach this level of maturity overnight. Developing a plan must account for organizational readiness, long-term goals, and population needs. However, through thoughtful

selection of an “entry” point into addressing risk, provider organizations can lead with easier early adoption of workflows. This allows for an early return on investment that can help organizations subsidize subsequent steps in the full-risk adjustment workflow adoption process.

MOVING FORWARD

Risk adjustment isn’t the exclusive purview of payers anymore. Going forward, as a rapidly growing share of the U.S. population is covered under value-based care arrangements, provider organizations will need to stop seeing these models as “maybe one day” and start recognizing them as the future of healthcare.

With the right tools and transition planning, the adoption of value-based care doesn’t need to be a burdensome process. Successful examples of risk-based provider contracting and risk-adjustment technology solutions are a reality today—built on two decades of healthcare IT innovation and lessons learned in clinical environments.

When you reduce nonclinical work, center organizational initiatives on the patient, integrate effectively with workflows and existing technology, the health of populations and the financial stability of an organization will follow. ○

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Climbing the Leadership Ladder...continued from page 25

with all levels of your organization. Acknowledge and celebrate the contributions and successes of your team. Cultivate relationships—inside and outside your organization—with those who can provide honest feedback, encouragement, and support.

Never view a specific position as your end goal—remain open to new challenges in whatever form they take. Moving from an established leadership role in Southern California to Executive Medical Director of The Southeast Permanente Medical Group in Atlanta took me out of my comfort zone. It created new challenges, new learning opportunities, and new relationships. This wonderful experience has taught me much about medicine, leadership, and myself.

Finally, I encourage women at all stages of their careers to never, ever sell themselves short. Go for your dreams and goals, get help from friends and peers, and embrace the joy of leadership. As you climb the career ladder, remember to look behind you and lend a helping hand to those who are still coming up. Set an example that will foster the next generation of leaders who are crucial to the future of medicine. ○

Mary Wilson, MD, MPH, is President and Executive Medical Director of The Southeast Permanente Medical Group.

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