Welcome to the

UNC | SCHOOL OF MEDICINE
Family Medicine

2019 Alumni & Friends Weekend

A Roadmap to Value Based Care

and John T. Henley Lecture

Special appreciation to UNC Physician Recruitment for their support of this conference

On the Road to Value: Observations of a Traveler

UNC Family Medicine
October 4, 2019

TERRY L. MILLS, MD, MMM, CPE, FAAFP

MEDICAL DIRECTOR, ST. JOHN CLINIC, TULSA OK

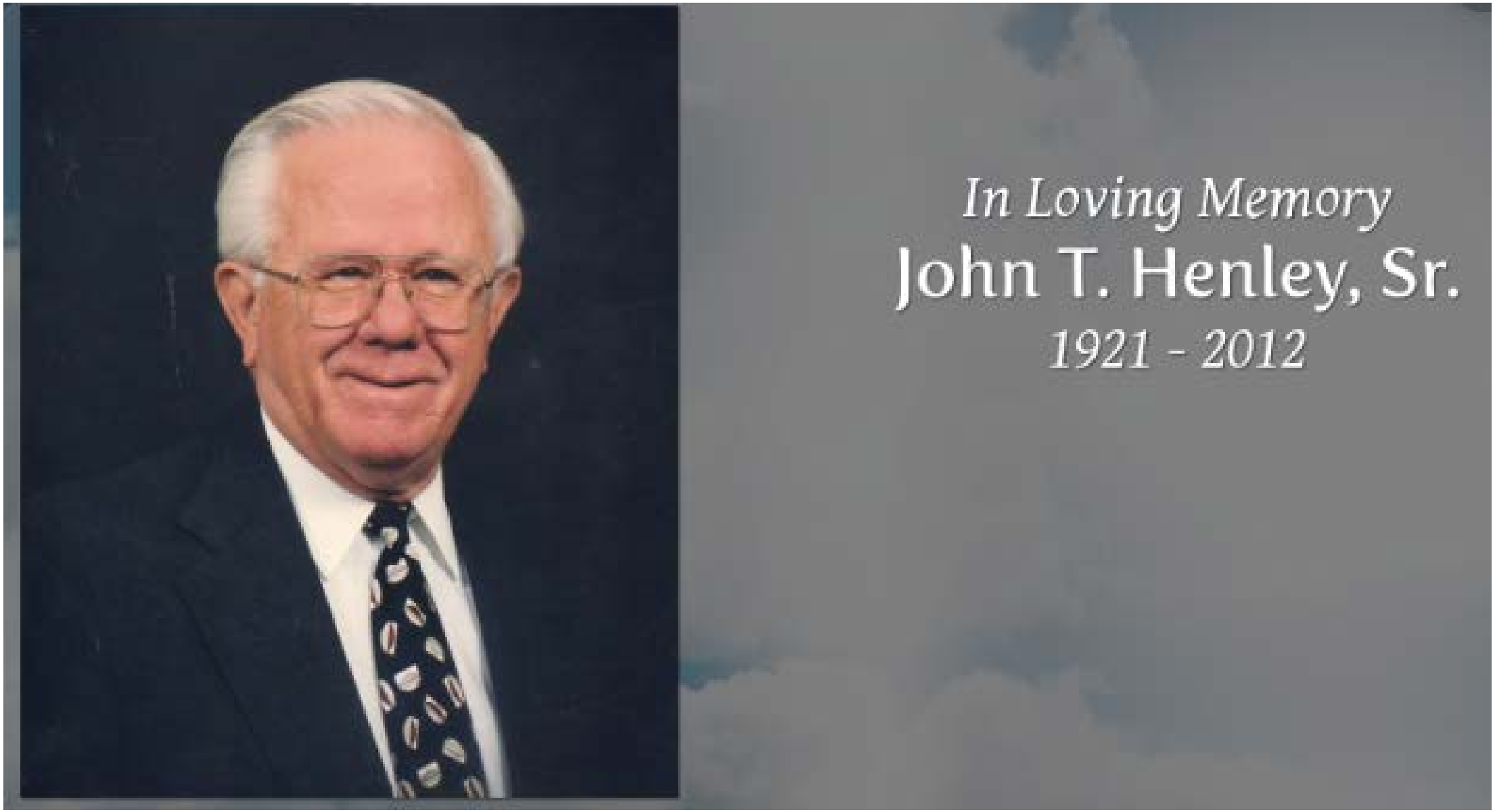
MEDICAL DIRECTOR, OKLAHOMA HEALTH INITIATIVES (ACO)

2019 UNC Family Medicine
Alumni & Friends Weekend

A Roadmap to Value Based Care

Featuring the John T. Henley Lecture, CME Conference, Dinner & Reception

for Alumni & Friends of
UNC Family Medicine
Preventive Medicine Alumni Invited


In Loving Memory
John T. Henley, Sr.
1921 - 2012

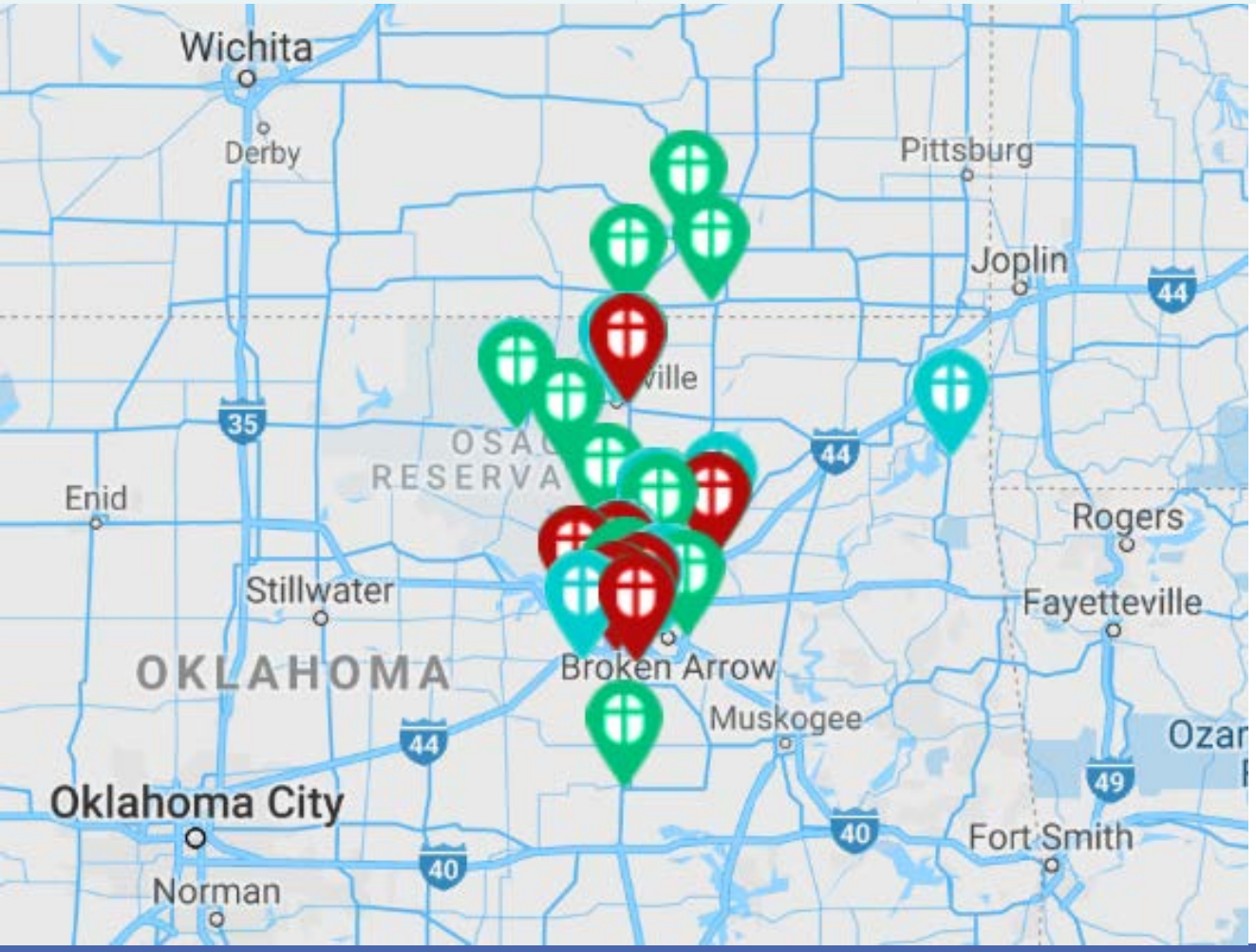
Locations | All Services | Find a Physician | Share | Search

You are here St. John Health System > St. John Clinic PulseLine 918-744-0123

St. John Clinic | ASCENSION

ONLINE SCHEDULING | OnDemand VIRTUAL VISIT

ABOUT | SERVICES/SPECIALTIES | PATIENTS | PATIENT ONLINE SERVICES | PHYSICIAN SEARCH | CAREERS | CONTACT



- Part of Ascension Health
- 600 multispecialty providers
- 150 Primary Care clinicians
- 25 locations
- 170,000 patients
- All in CPC+ (mod FFS+CM+QI)
- ½ also in ACO (shared savings)
- Owners of Community Care Senior Health Plan (capitated)

Congratu

Congratulations to
Dr. Terry Mills

The RBRVS and
Specialty Society
Committee (RUC

2009

AMA

Definitions

- Patient Centered Medical Home and Advanced Primary Care are delivery systems – it's **HOW** you deliver care.
- Population Health is **WHAT** you deliver.
- Value Based Care is **WHY** you deliver it
  - the Triple Aim in Action
  - To break the chains of transactional payment in health care

Hallmarks of Advanced Primary Care include:

Team based care

Risk Stratification

Care Management

Enhanced access

Proactive instead of Reactive

Advanced data and analytics

Continual quality improvement

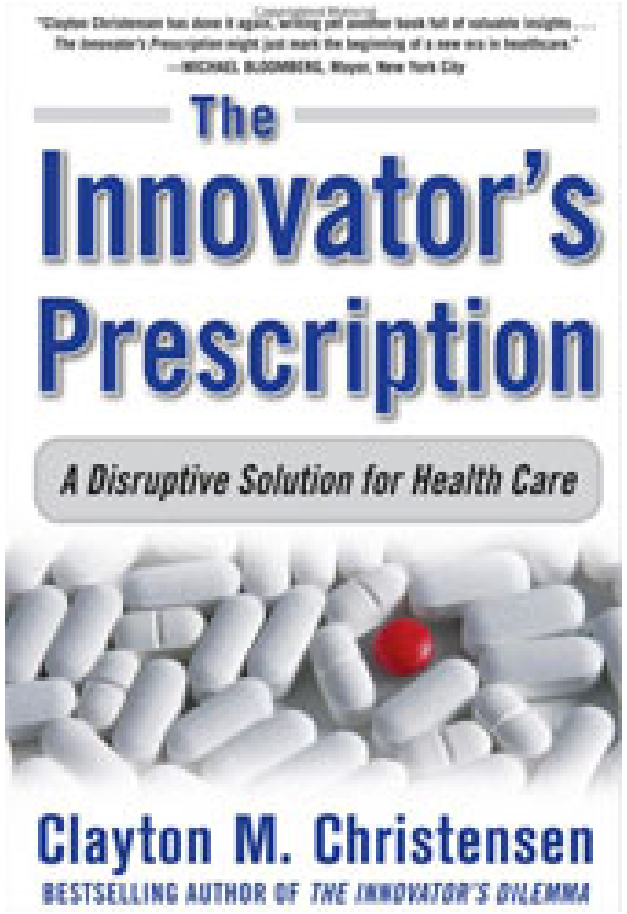
Patient Engagement

Observation #1

We are being disrupted

Disruptive Innovation

Disruptive Innovation



Clayton M. Christensen

Kim B. Clark Professor of Business Administration at the Harvard Business School

What Does She Want?

Answer:

It isn’t what healthcare is currently selling.

Absolutely Ripe for Disruption

"Absolutely its a lousy fit
but the quality's terrific."

Quality of Care

The Disruption Script

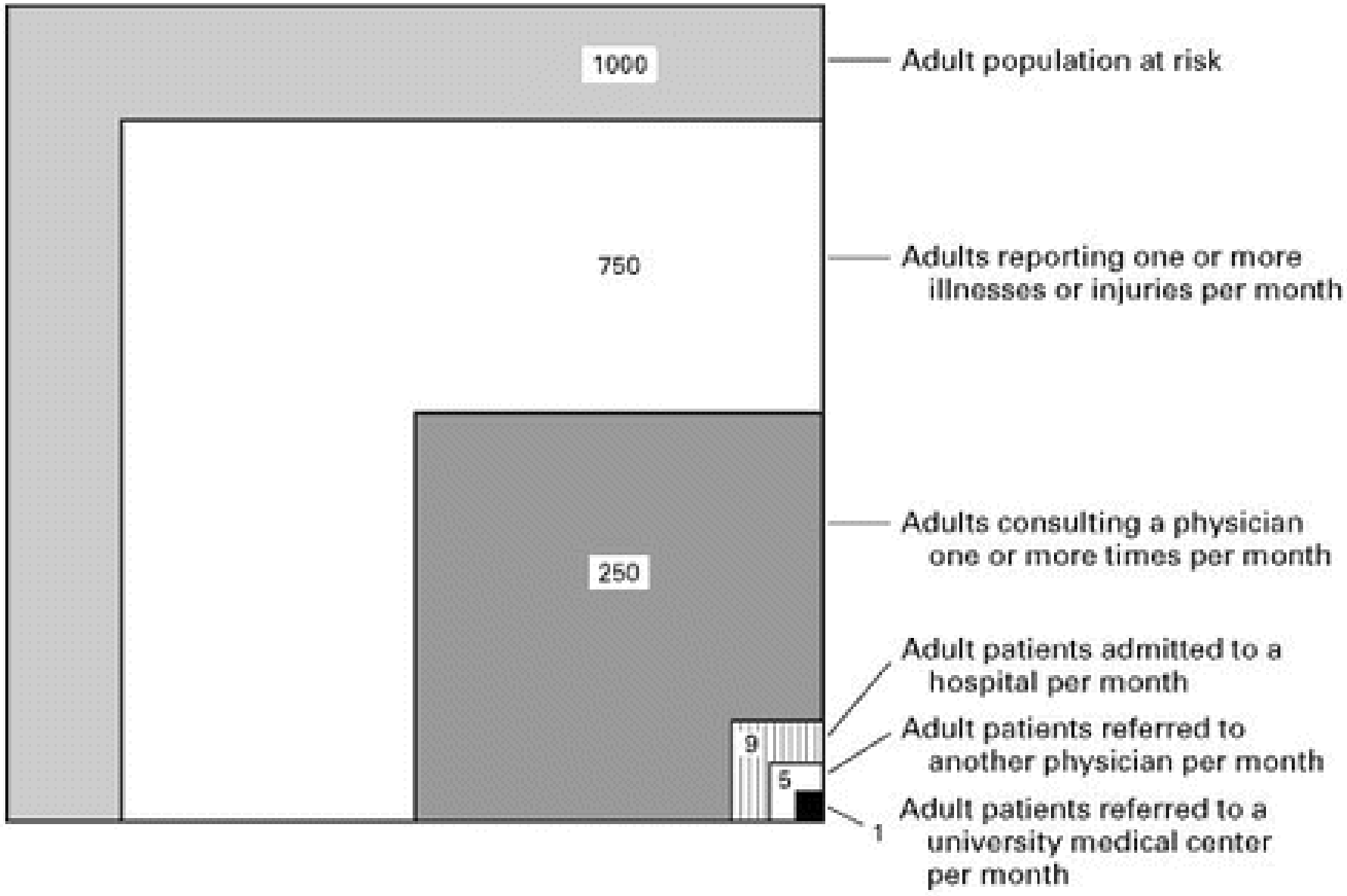
THE INCUMBENTS

- Provide product they want to sell
- Efforts focused on improving past position of main use
- Secure in self-perceived moat
- Bastion of Expertise or Quality

THE INNOVATORS

- Connect consumers with product they want
  - Very efficiently, cheaply
- Quality is known or presumed
- Cost is transparent
- Do only few things very very well.

Source: Clayton Christensen, *The Innovators Solution*



The Ecology of Medical Care Revisited
N Engl J Med 2001; 345:1211-1212. October 18, 2001

The NEW ENGLAND JOURNAL of MEDICINE

Disruption in Primary Care

Content:

- Acute Care
- Wellness and Preventative Care
- Chronic Disease Management

Location: Varied

Workflows: Varied

Cost Basis: High to Moderate

Service to Customer: Moderate to Poor

Disrupters:

- Retail Care Clinics
- Urgent Care Clinics
- Workplace Clinics
- Wellness Clinics and Medical Spas
- Online Health Communities
- Disease focused specialty clinics
- Wearable tech – Fit Bit; Apple Watch

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY
VOLUME 6: NO. 2, A59 APRIL 2009

SPECIAL TOPIC

Family Physicians as Team Leaders: "Time" to Share the Care

Table 2. Time Required to Meet Current Clinical Guideline Recommendations

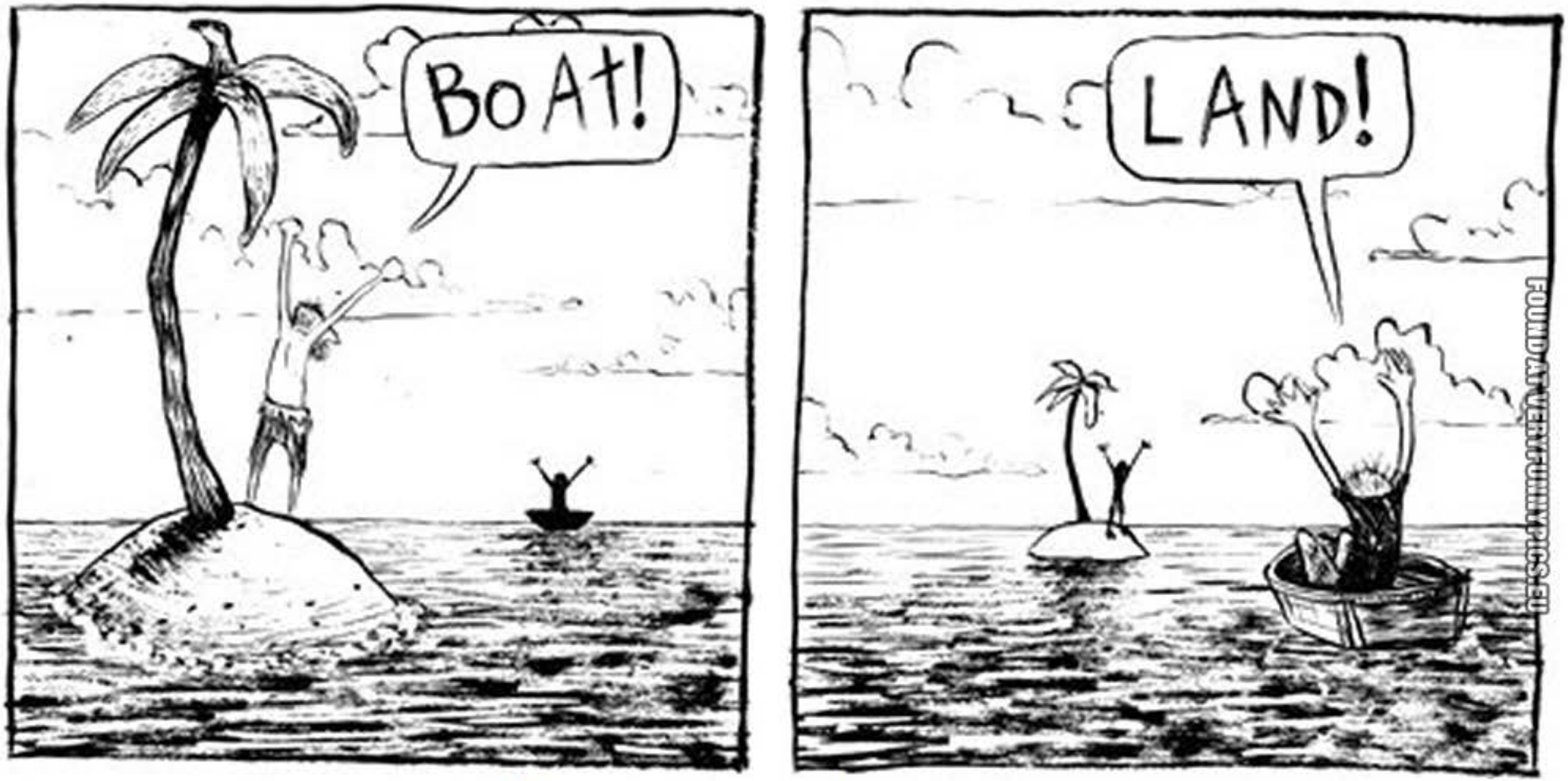
Return

Type of Visit	Hours/Day	Hours/Week	% of Clinical Time
Acute	3.7[a]	18.4	17.0
Chronic	10.6[b]	53.0	48.9
Preventive	7.4[c]	37.0	34.1
Total	21.7	108.4	100.0

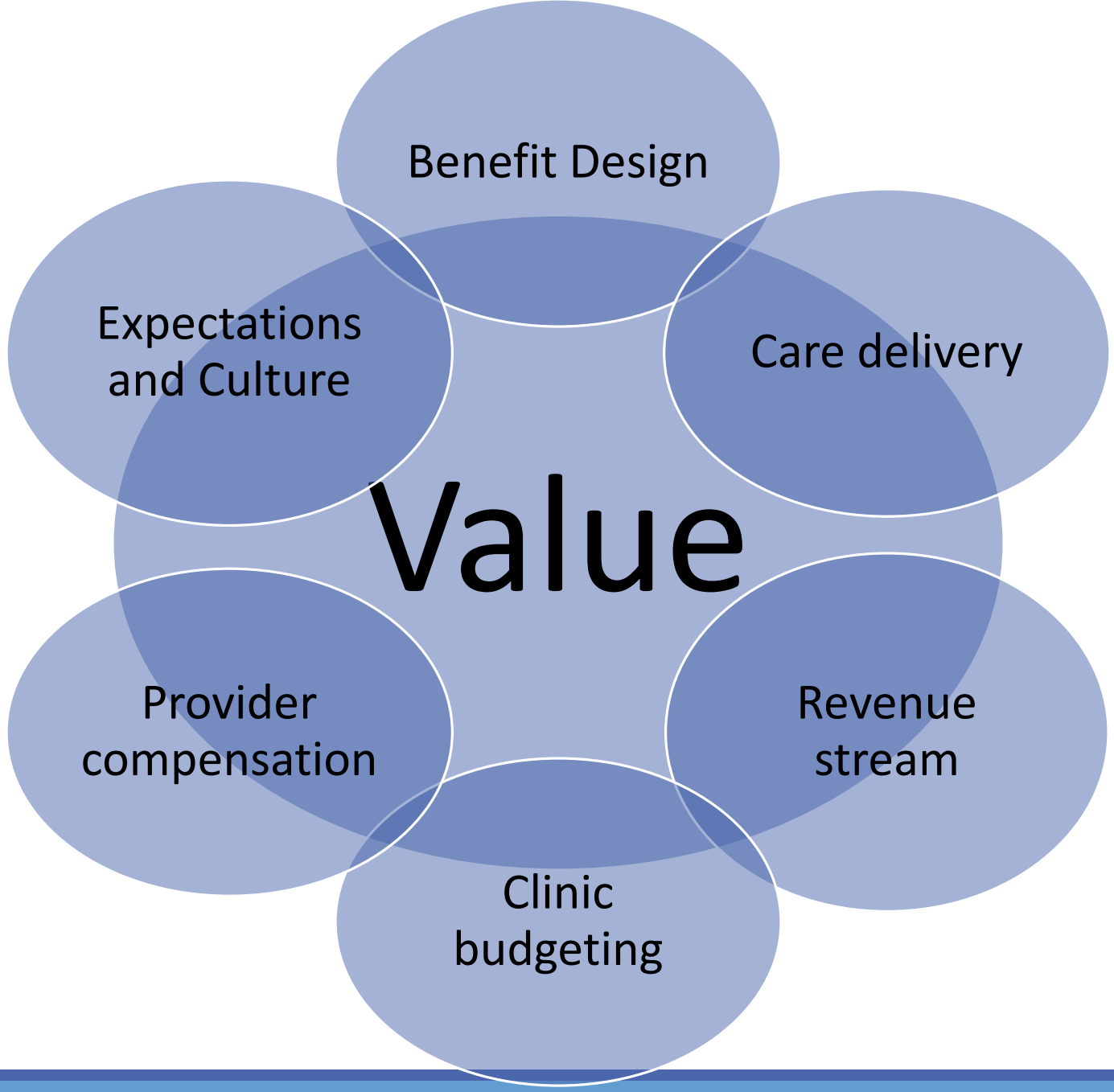
CONCLUSION: "There are not enough primary care physicians to meet the recommended care guidelines within the current model of a single physician providing all required preventive, chronic disease, and acute care to patients in his or her practice."

Observation #2

“Value” is in the eye of the beholder



Perspective…


Benefit Design
Expectations and Culture
Care delivery
Value
Provider compensation
Revenue stream
Clinic budgeting

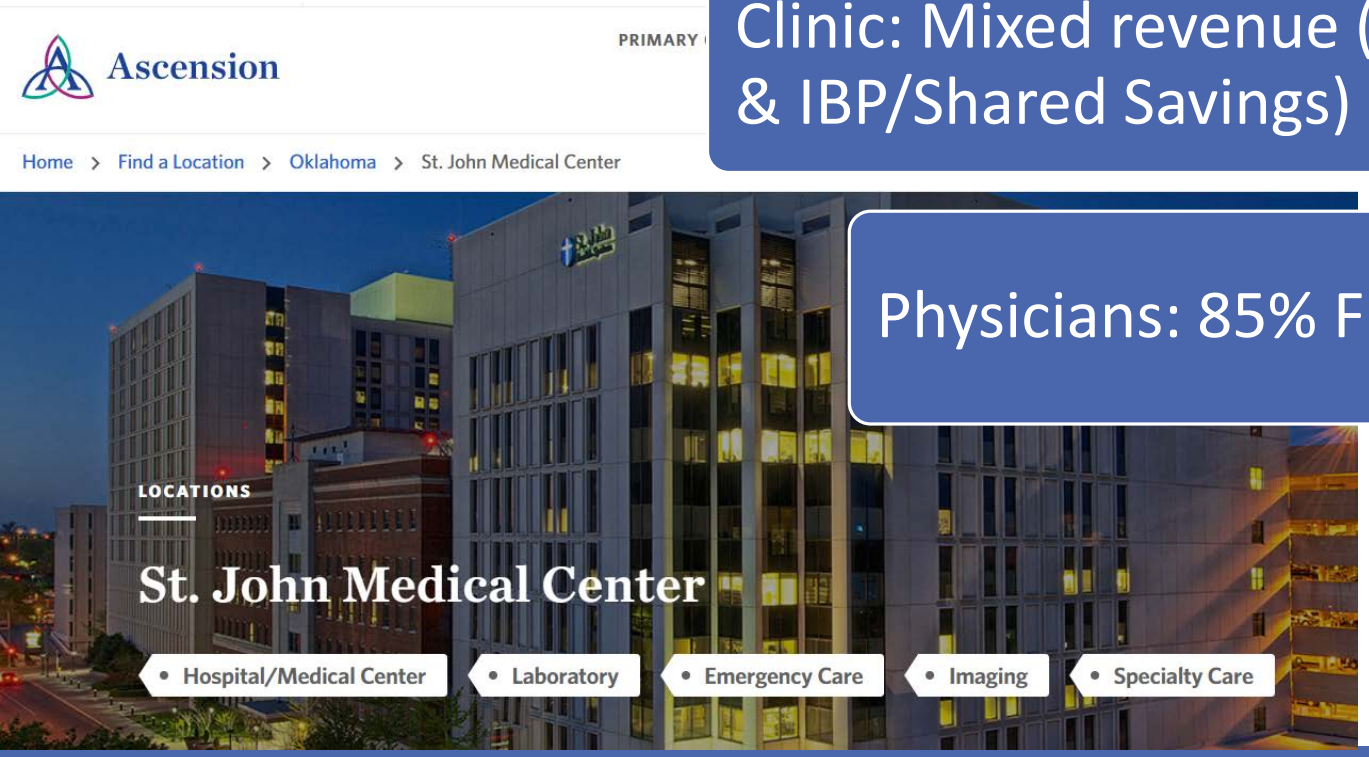
Purchaser/Employer	Predictable budget, Quality assumed
Payer	Decreased cost, Improved quality
Health System	Alternate revenue, Decreased costs
Physician	More money, Improved pt care
Patient/Customer	Self-defined Access, Lower cost

Purchasers: flat premium

Payers: FFS + CM fee + IBP/Shared Savings + Cap

Clinic: Mixed revenue (55% FFS, 45% capitation & IBP/Shared Savings)

Physicians: 85% FFS wRVU + 15% non-FFS



Non-FFS is pmpm based on panel size for Quality metrics

Define Value for Ourselves!

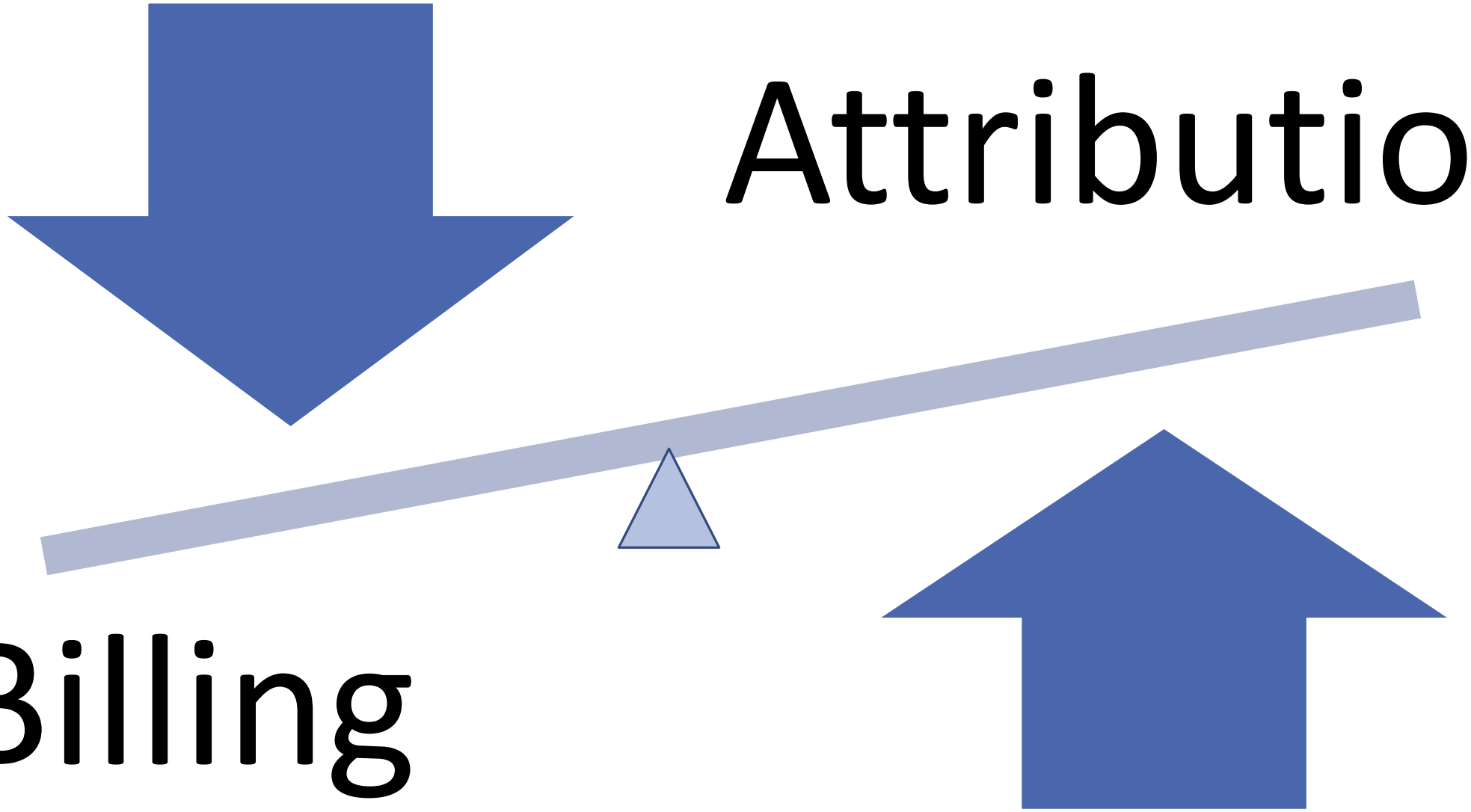
		Physician 1		Physician 2		Goal or Expected
		performace	O/E ratio	performance	O/E ratio	
QUALITY	HTN control	81%	1.0125	60%	0.75	80%
	Breast CA screening	78%	0.975	65%	0.81	80%
EXPERIENCE	How likely to refer friends and family?	92%	1.082	77%	0.91	85%
DIRECT COSTS	HCC RAF	1.03		0.93		1.0
	Total Cost of Care	$ 845.00		$ 985.00		$ 825.00
	Risk adjusted Total Cost of Care	$ 820.39	0.9944	$ 1,059.14	1.2838	

$$\textbf{VALUE} = \frac{\textbf{QUALITY}}{\textbf{COST}} = \frac{\textbf{1.0233}}{\textbf{0.9944}} = \frac{\textbf{0.8228}}{\textbf{1.2838}}$$

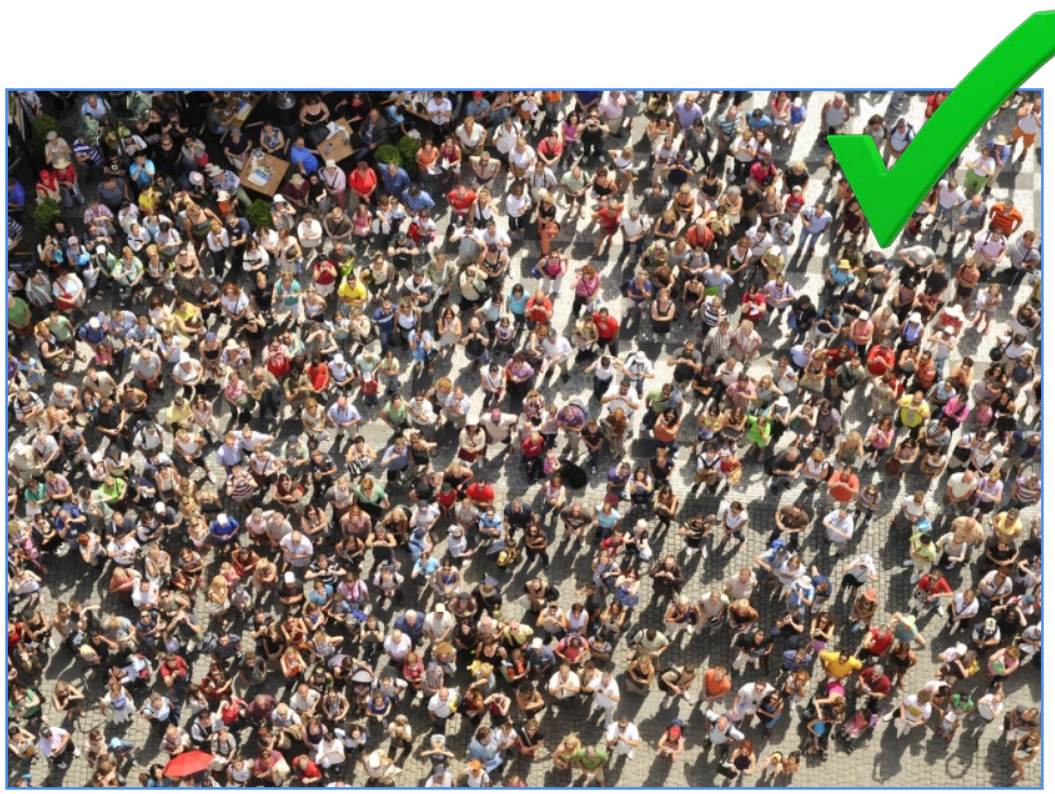
= 1.0290 **= 0.6409**

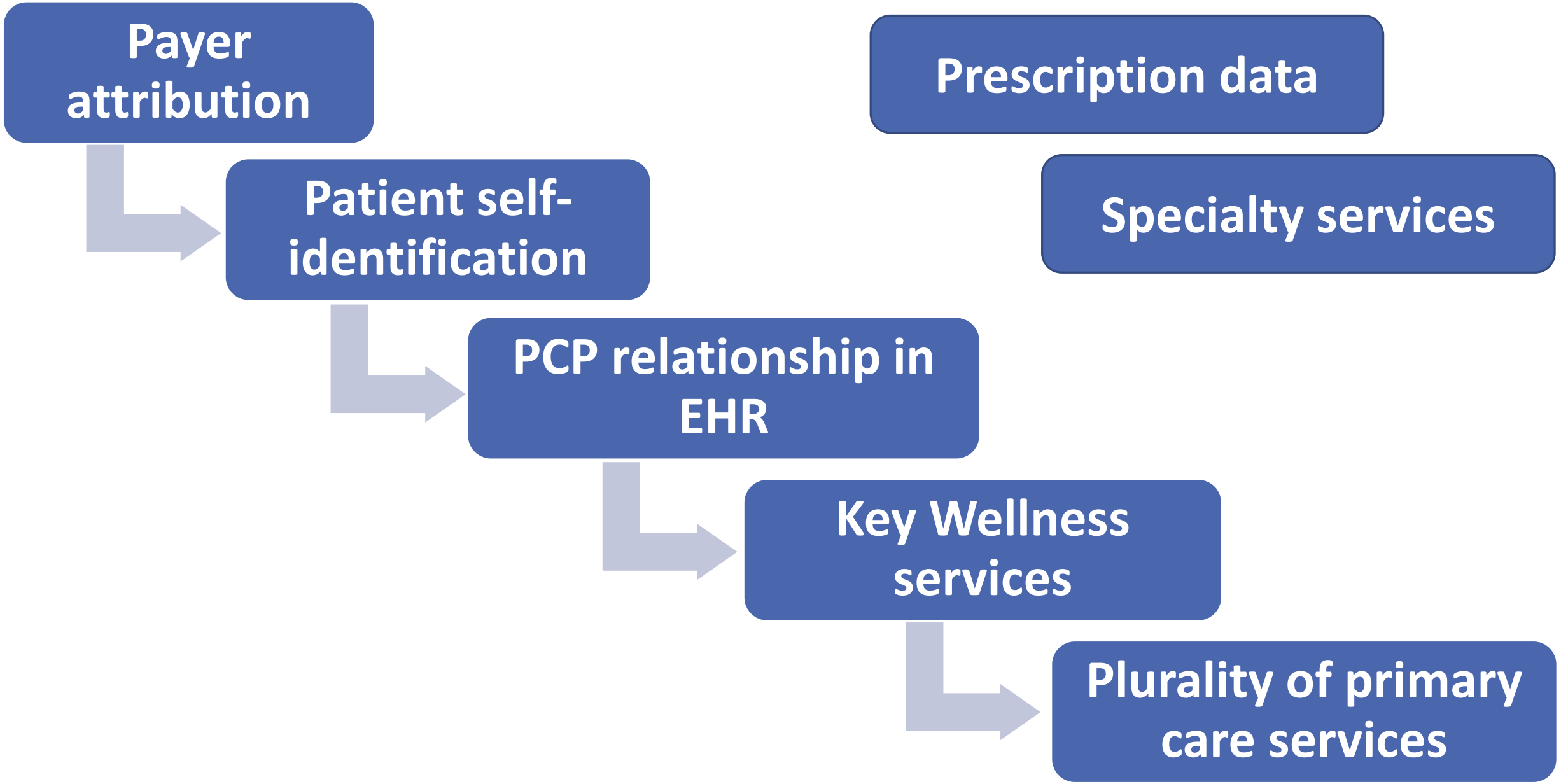
Observation #3

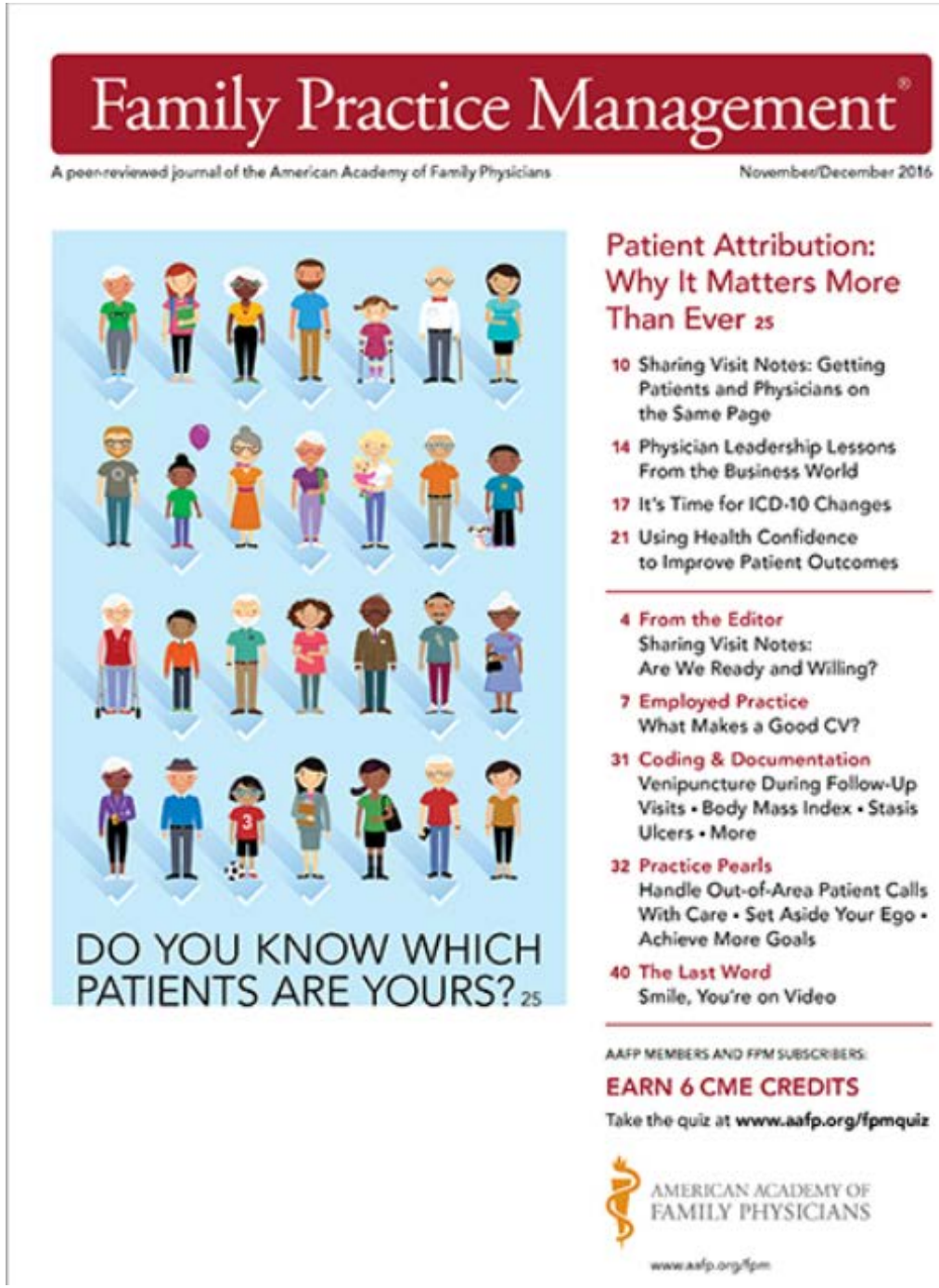
Attribution is everything


Attribution
Billing

Population Health Management




Payer attribution
Patient self-identification
PCP relationship in EHR
Key Wellness services
Plurality of primary care services
Prescription data
Specialty services



Implications

Observation #4

Risk Adjustment is the rest of everything

Payment is related to resources used to provide care.

In RBRVS, each transactional payment is paying you based on the resources needed to provide the care, patient by patient retrospectively.

Value Based care moves the measurement of the resources used from individual patient level to the population level prospectively.

RAF	Expenditure Risk
0.5	50% lower
1.0	Average
1.1	10% higher
1.5	50% higher

Allow apple to apple comparison

Promote fair payment

Encourage excellent care for the chronically ill

Reward efficiency and effectiveness

LOWER RISK SCORE

- Healthier population or person, with less risk of expense (lower cost to care for)

OR

- Falsely suggest a healthier population due to:
  - inadequate chart documentation
  - incomplete or inaccurate coding
  - patients who were not seen

HIGHER RISK SCORE

- Sicker population or person, with greater risk of expense (higher cost to care for)

OR

- Falsely suggest a sicker population due to:
  - reported diagnoses not documented
  - Over documenting (e.g., copy/paste)
  - Over coding (incorrect coding)

82-year-old male	0.543
Medicaid Eligible	0.177
Diabetes – Not Coded	N/A
Rheumatoid Arthritis	N/A
Heart Failure (HCC 85)	N/A
CKD IV – Not Coded	N/A
No Disease Interaction	N/A
Risk Adjustment Factor	0.72
Anticipated Expenditures	$6679.15

82-year-old male	0.543
Medicaid Eligible	0.177
Diabetes (HCC 19)	0.118
Rheumatoid Arthritis	0.374
Heart Failure (HCC 85) – Not Coded	N/A
CKD IV– Not Coded	N/A
No Disease Interaction	N/A
Risk Adjustment Factor	1.212
Anticipated Expenditures	$11,242.83

82-year-old male	0.543
Medicaid Eligible	0.177
Diabetes with Renal Disease (HCC 18)	0.368
Rheumatoid Arthritis (HCC 40)	0.374
Heart Failure (HCC 85)	0.368
CKD IV (HCC 137)	0.224
Disease Interaction (HCC 18 + HCC 85; HCC 85 + HCC 137)	0.182; 0.317
Risk Adjustment Factor	2.553
Anticipated Expenditures	$23,682.29

Modern Healthcare

April 12, 2019 04:56 PM

Sutter Health to pay $30M to settle upcoding allegations

ALEX KACIK

Sutter Health agreed to pay $30 million to settle allegations that the Sacramento, Calif.-based health system submitted inflated diagnosis codes to the CMS for Medicare Advantage beneficiaries, the Justice Department announced Friday.

The CMS pays private insurers a set amount per person to administer program benefits under

Observation #5

Data…
Good Grief

Paul Grundy, MD, MPH, FACOEM, FACPM

- “Godfather” of PCMH
- Founding President of PCPCC

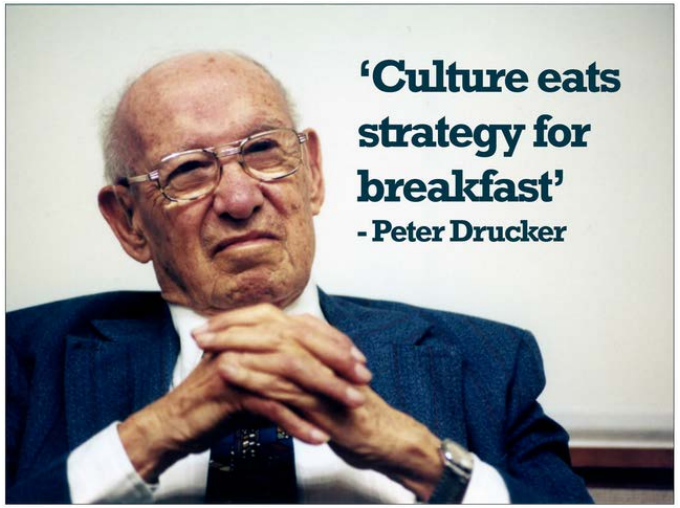
“For a culture to be ready to be grounded in data, it has to be ready to NOT be grounded in autonomy.”

Stages of Grief

KUBLER-ROSS	PHYSICIANS AND DATA
Denial	“That’s not my data!”, “This data can’t be right!”
Anger	“The measure is terrible!”, “How dare you….”
Depression	“well… ok.”
Bargaining	“… not fair”, “… more time”, “... Different measure”
Acceptance	Data is real; reflects important stuff; we can make a difference

Observation #6

Culture Eats Strategy



The beliefs, customs, arts, etc., of a society, group, place, or time.

A way of thinking, behaving, or working that exists in a place or organization.

Definition of Culture

Physician Culture

CLINICAL INTEGRATION/SYSTEMS MODEL

Group decision making

External defined work/process

Objective definition success

Long time horizon

Boundaries common

Unified goals

Action delegated to others

External motivation

Improvement = define, measure, improve

PROFESSIONAL MODEL

Autonomy in decision making

Self-defined work/process

Subjective definition success

Short time horizon

Fewer boundaries

Disparate goals

Actions arise from self

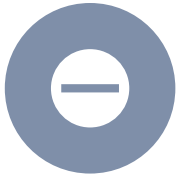
Self-motivation

Improvement = study, vigilance, work harder

Physicians: Strength & dysfunction

Compulsive and perfectionistic

High need for autonomy



Want to direct, resist control

Self esteem through work and outcomes

Sensitive if criticized

From Cowboys to Pitcrews

"We train, hire, and pay doctors to be cowboys. But it's **pit crews** people need."

Atul Gawande, MD

http://www.newyorker.com/online/blogs/newsdesk/2011/05/atul-gawande-harvard-medical-school-commencement-address.html

Expert Industry

Galen – 1980’s

Supply oriented – driven to scarce resources by injury and disease

Service Industry

1980’s - 2005

Demand oriented – driven to location and use of resources by availability

Information Management Industry

2005 – present (AND FUTURE)

Value oriented – seek and select resources based on information, value, self-determination

Our value to patients is NOT in being the source of information or knower of stuff –

But In

- INSIGHT
- WISDOM
- PERSPECTIVE
- UNDERSTANDING
- ENGAGEMENT

patientslikeme®

Already a member? Sign in.

conditions, symptoms, treatments...

Live better, together!™

Making healthcare better for everyone through sharing, support, and res

Member Stories: Paul talks about thriving with bipolar

"Our brother Stephen was living with ALS and we thought, 'there has to be a better way.' There is. By sharing our experiences, we can all contribute new data that can accelerate research and help create better treatments. Our experiences can actually change medicine... for good."

Jamie & Ben Heywood
Co-founders, PatientsLikeMe

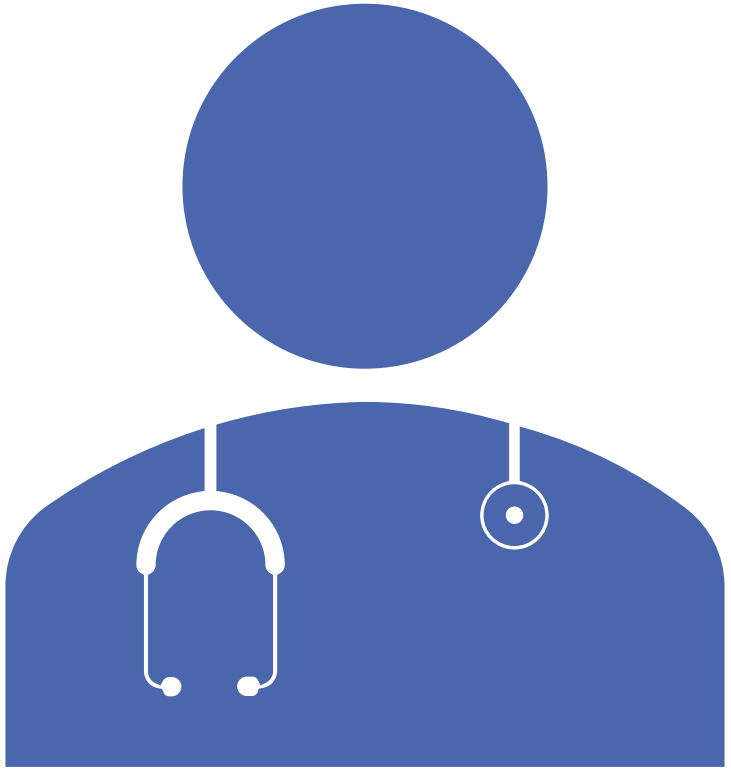
400,000 members
2500 conditions
31 Million data points

What is Diabetes Type 2?

Type 2 diabetes mellitus is characterized by insulin resistance or desensitization and increased blood glucose (sugar) levels. It is a chronic disease that can develop gradually over time and can be linked to both environmental factors and h

Common symptoms reported by people with Diabetes Type 2

Common symptoms	How bad it is	What people are taking for it
Pain		Gabapentin, Tramadol, Hy
Fatigue		Modafinil, Handicap/Disab
Depressed mood		Citalopram, Duloxetine, Fl
Insomnia		Zolpidem, Trazodone, Am
Frequent urination		Tamsulosin, Oxybutynin, U
Excessive thirst (polydipsia)		Water, No treatments, Mu
Blurry vision		Glasses / contacts, Eyegla
Anxious mood		Alprazolam, Lorazepam, C

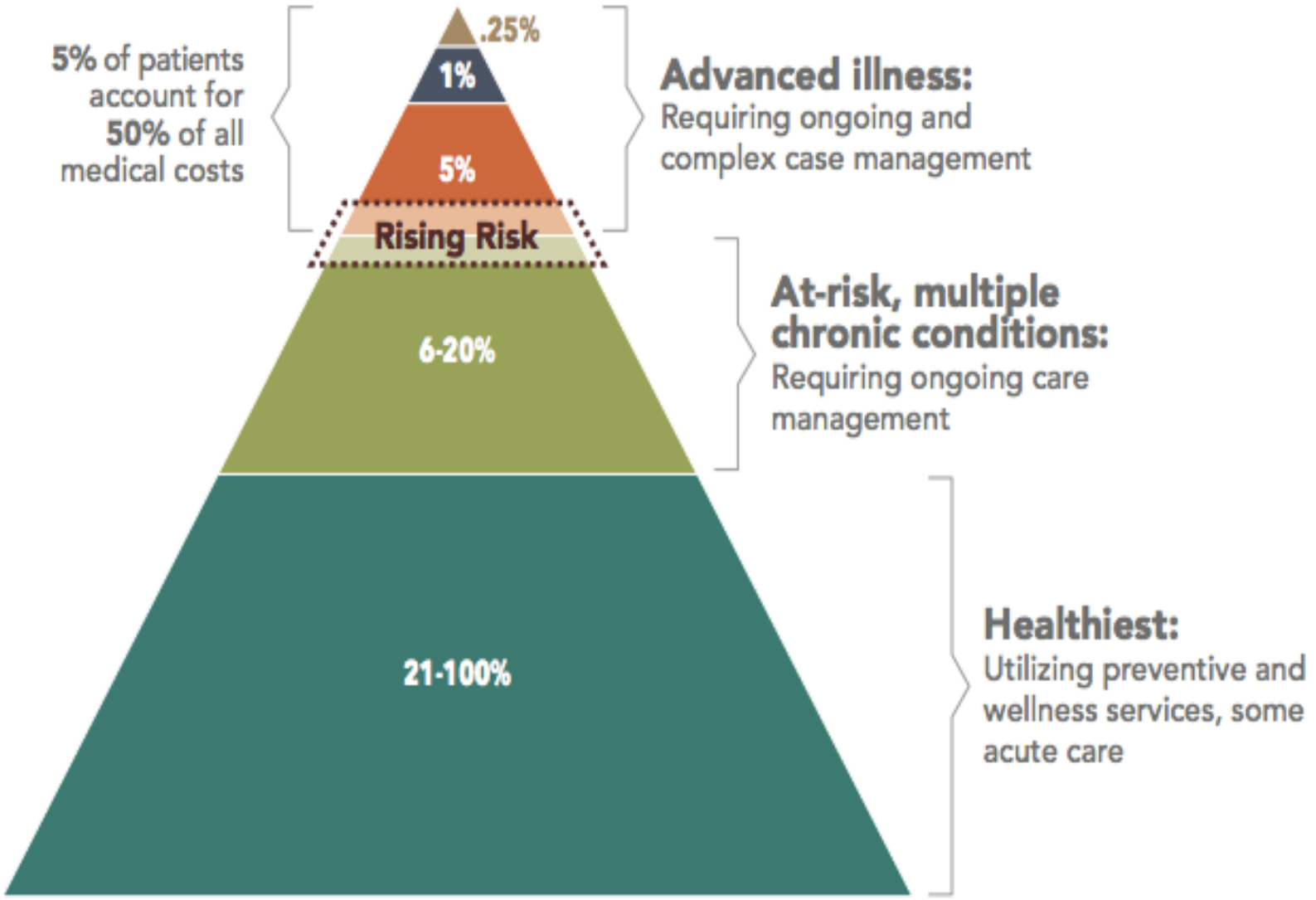


New Family Physicians are not prepared for value based care.

Observation #7

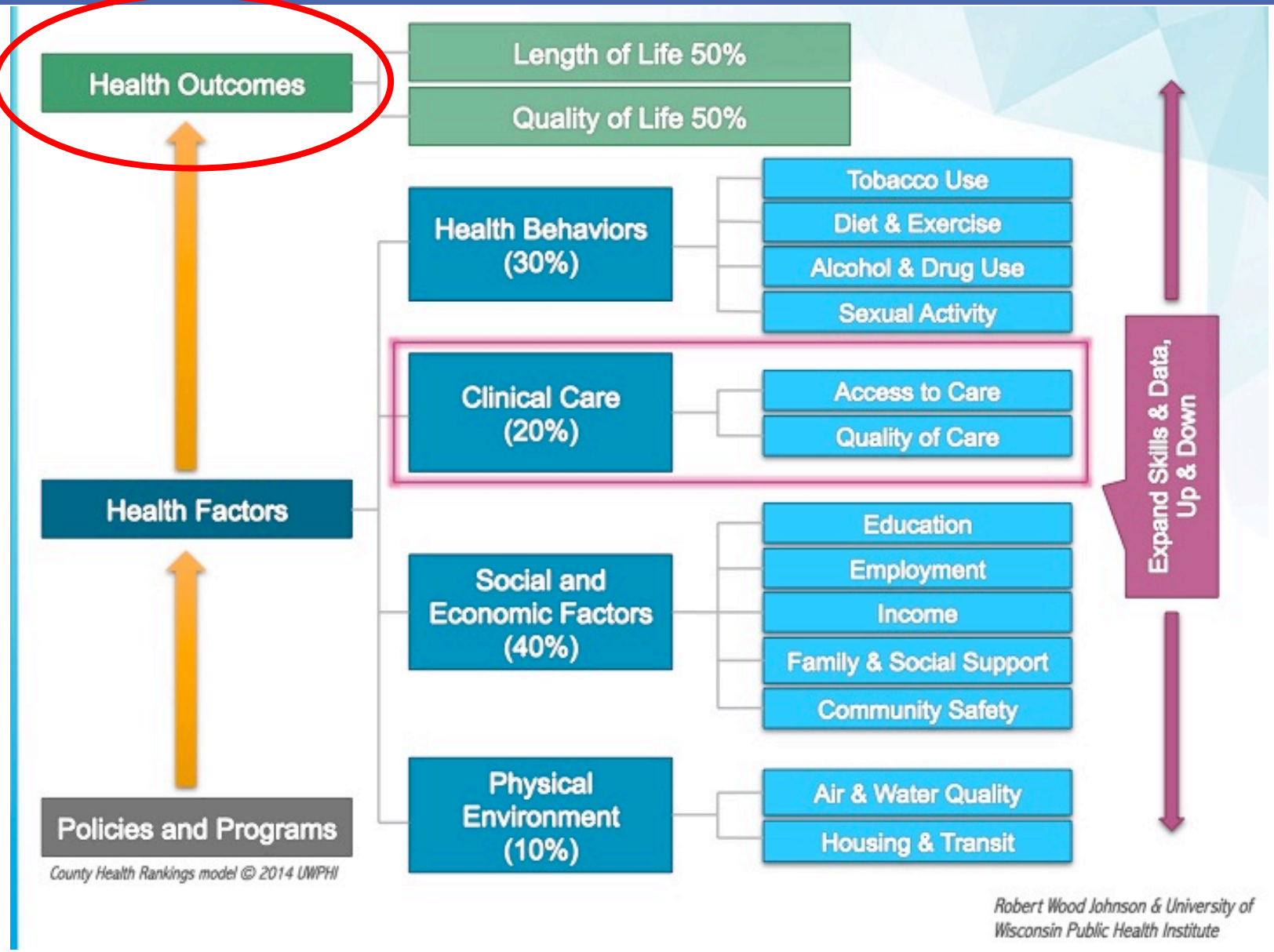
We must fully embrace Population Health

Population Health



Population Health

1. Identify
2. Stratify
3. Engage
4. Intervene
5. Measure


Health Outcomes
Length of Life 50%
Quality of Life 50%
Health Behaviors (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Health Factors
Social and Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
Policies and Programs
Expand Skills & Data, Up & Down
County Health Rankings model © 2014 UWPHI
Robert Wood Johnson & University of Wisconsin Public Health Institute

Bonus Observation

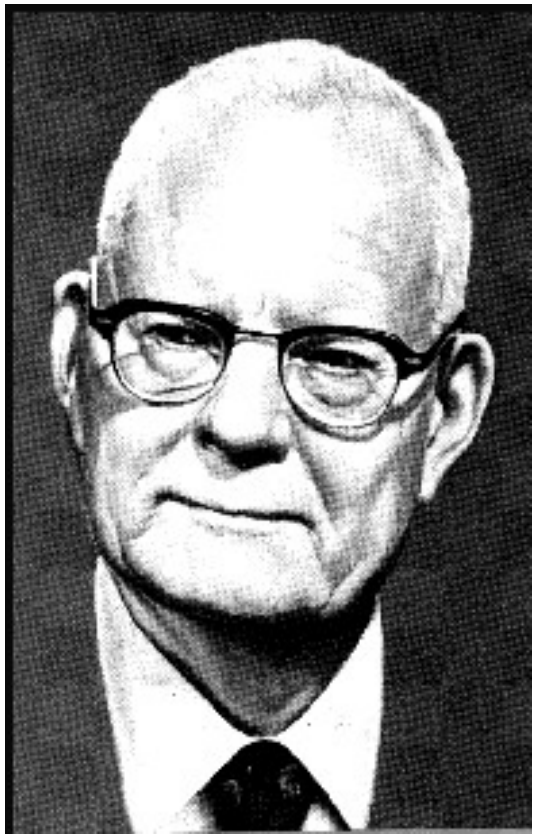
We must sequester CMS postgraduate training money

Indirect GME training funds are not just another revenue stream!

Closing

It is not necessary to change. Survival is not mandatory.

(W. Edwards Deming)



Prognistication

Inpatient hospitalization utilization declines >25% next 10 years

Procedural services shift to outpatient

Diagnostics move to retail settings

- Some estimates up to 85%

25% Primary Care services delivered by non-physician team

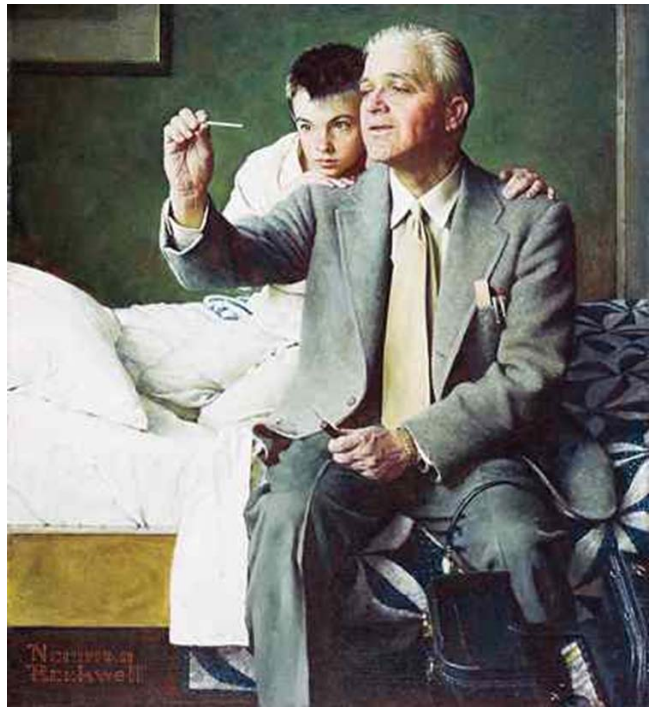
- Possibly up to 60% with full value ecosystem

Primary Care subspecializes:

- Acute Care
- Wellness/Preventative Care
- Chronic Disease Care

Team Based, Advanced Primary Care

Direct Primary Care

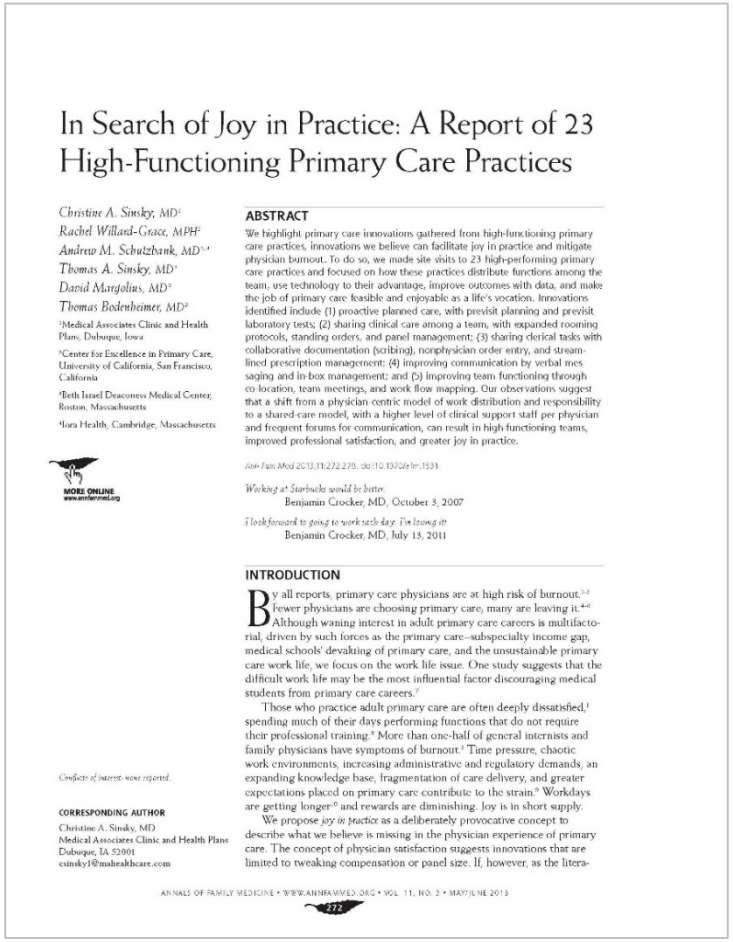


Primary Care

- Dive into palliative and hospice care – cheaper and better
- Master transitions across sites of care
- Change your frame of reference
- Choose Opportunity wisely… but you must make some choices!
- Pick your partners - based on missing competencies and increasing value

In Search Of Joy in Practice -

Moving from physician-centric model of work distribution and responsibility to a shared-care model



In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

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Rachel Willard-Grace, MPH[2]
Andrew M. Schutzbank, MD[3,4]
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David Margolius, MD[3]
Thomas Bodenheimer, MD[2]

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[3]Beth Israel Deaconess Medical Center, Boston, Massachusetts

[4]Iora Health, Cambridge, Massachusetts

ABSTRACT

We highlight primary care innovations gathered from high-functioning primary care practices. Innovations we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing primary care practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

Ann Fam Med 2013;11:272-278. doi:10.1370/afm.1531.

MORE ONLINE
www.annfammed.org

Working at Starbucks would be better.
Benjamin Crocker, MD, October 3, 2007

I look forward to going to work each day. I'm loving it!
Benjamin Crocker, MD, July 13, 2011

INTRODUCTION

By all reports, primary care physicians are at high risk of burnout.[1-3] Fewer physicians are choosing primary care, many are leaving it.[4-6] Although waning interest in adult primary care careers is multifactorial, driven by such forces as the primary care–subspecialty income gap, medical schools' devaluing of primary care, and the unsustainable primary care work life, we focus on the work life issue. One study suggests that the difficult work life may be the most influential factor discouraging medical students from primary care careers.[7]

Those who practice adult primary care are often deeply dissatisfied,[1] spending much of their days performing functions that do not require their professional training.[8] More than one-half of general internists and family physicians have symptoms of burnout.[3] Time pressure, chaotic work environments, increasing administrative and regulatory demands, an expanding knowledge base, fragmentation of care delivery, and greater expectations placed on primary care contribute to the strain.[9] Workdays are getting longer[6] and rewards are diminishing. Joy is in short supply.

We propose *joy in practice* as a deliberately provocative concept to describe what we believe is missing in the physician experience of primary care. The concept of physician satisfaction suggests innovations that are limited to tweaking compensation or panel size. If, however, as the litera-

Conflicts of interest: none reported.

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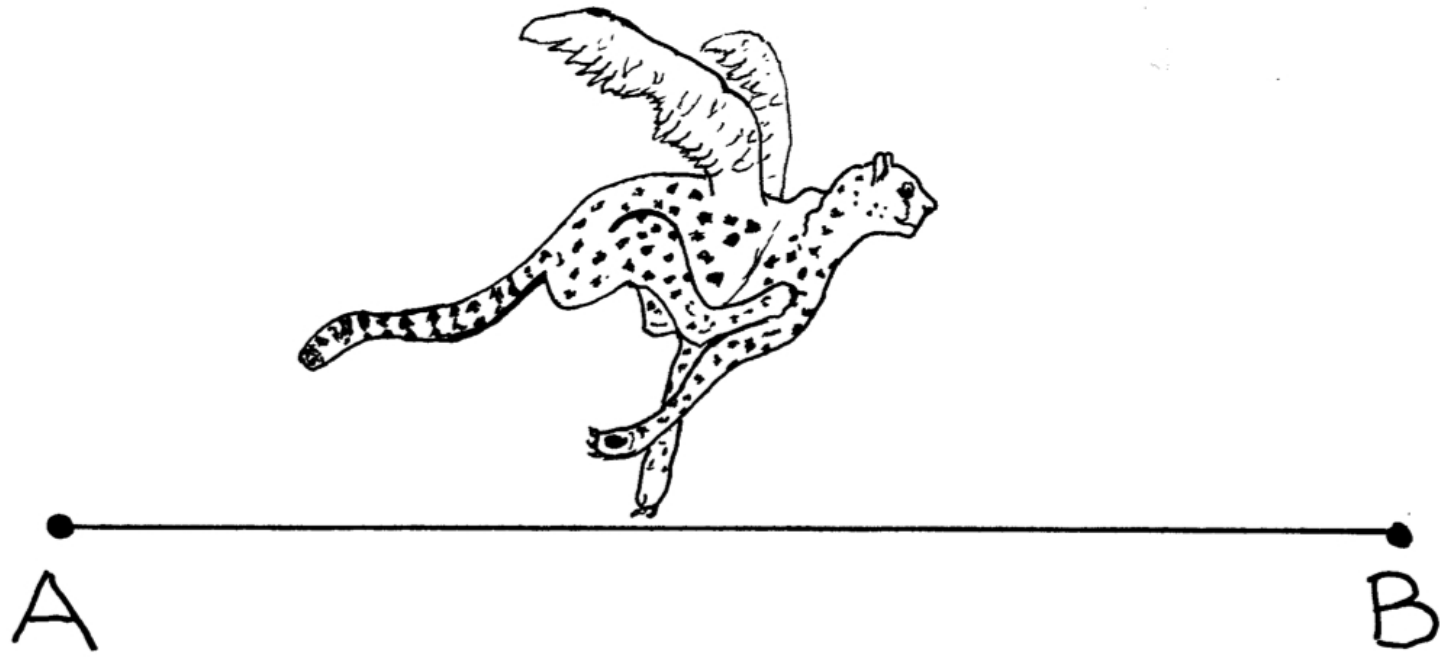
Top 5 Innovations

1. **proactive planned care,** with pre-visit planning and pre-visit laboratory tests
2. **sharing clinical care among a team**, with expanded rooming protocols, standing orders, and panel management
3. **sharing** clerical tasks with collaborative documentation (scribing), non-physician order entry, and streamlined prescription management
4. **improving communication** by verbal messaging and in-box management; and
5. **improving team functioning** through co-location, team meetings, and workflow mapping.

The fastest way from Point A to Point B?

Winged cheetah.




thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
спасибо
Баярлалаа
рахмат
dank je
tapadh leat
mochchakkeram
go raibh maith agat
dziękuję
bedankt
hvala
obrigado
sukriya
kop khun krap
grazie
arigatō
takk
dakujem
merci
мерси
terima kasih
ありがとう
감사합니다
ευχαριστώ
sağolun
taiku
хвала
trugarez
enkosi
mauruuru
blagodaram
vinaka
tack
merci
chnorakaloutioun
gracies
djiere dieuf
paldies
matondo
shukriya
dhanyavadagalu
diolch
rahmet
tanemirt
najis tuke
kam sah hamnida
xiexie
sulpay
mesi
dekuji
faafetai lava
kiitos
dankie
asante
manana
obrigada
mamnun
sobodi

View/Print Figure

Sore Throat Encounter Form

Patient's name: _____ Age: _____ Medical record #: _____

Data collection:

Symptom	Points
☐ History of fever or measured temp >100.4 F	1
☐ Absence of cough	1
☐ Tender anterior cervical nodes	1
☐ Tonsillar swelling or exudates	1
Patient's age	
☐ <15 years	1
☐ 15 to 45 years	0
☐ >45 years	−1
Total:	

Score:

0 to -1 point: Strep throat ruled out (only a 2% risk).

1 to 3 points: Order rapid strep test; treat accordingly.

4 to 5 points: Diagnose probable strep throat (52% risk); consider empiric antibiotic therapy.

Suggestive findings (cross out if negative)	Diagnostic considerations
☐ Palatine petechiae or scarlatiniform rash	Probable strep throat
☐ Contact with strep infection in past 2 weeks ☐ Duration of illness <3 days	Consider strep throat
☐ Headache ☐ Petechial rash ☐ Stiff neck	Consider meningitis
☐ Hot-potato voice ☐ Sudden/severe symptoms	Consider abscess
☐ Posterior cervical adenopathy or teenager	Consider mononucleosis

Rapid strep test: ☐ Positive ☐ Negative ☐ NA

Mono spot test: ☐ Positive ☐ Negative ☐ NA

Other history: _____

Diagnosis:

☐ Probable or confirmed strep throat _____

☐ Viral pharyngitis _____

☐ Mononucleosis _____

☐ Other: _____

Antibiotic treatment:

☐ None needed _____

☐ Penicillin V potassium _____

☐ Cephalexin _____

☐ Erythromycin _____

☐ Azithromycin _____

Symptomatic measures:

☐ NSAID ☐ 2% lidocaine gargle

☐ Sore throat spray ☐ Salt water gargles

Follow-up visit:

☐ prn only

☐ ____ days

Other treatment: _____

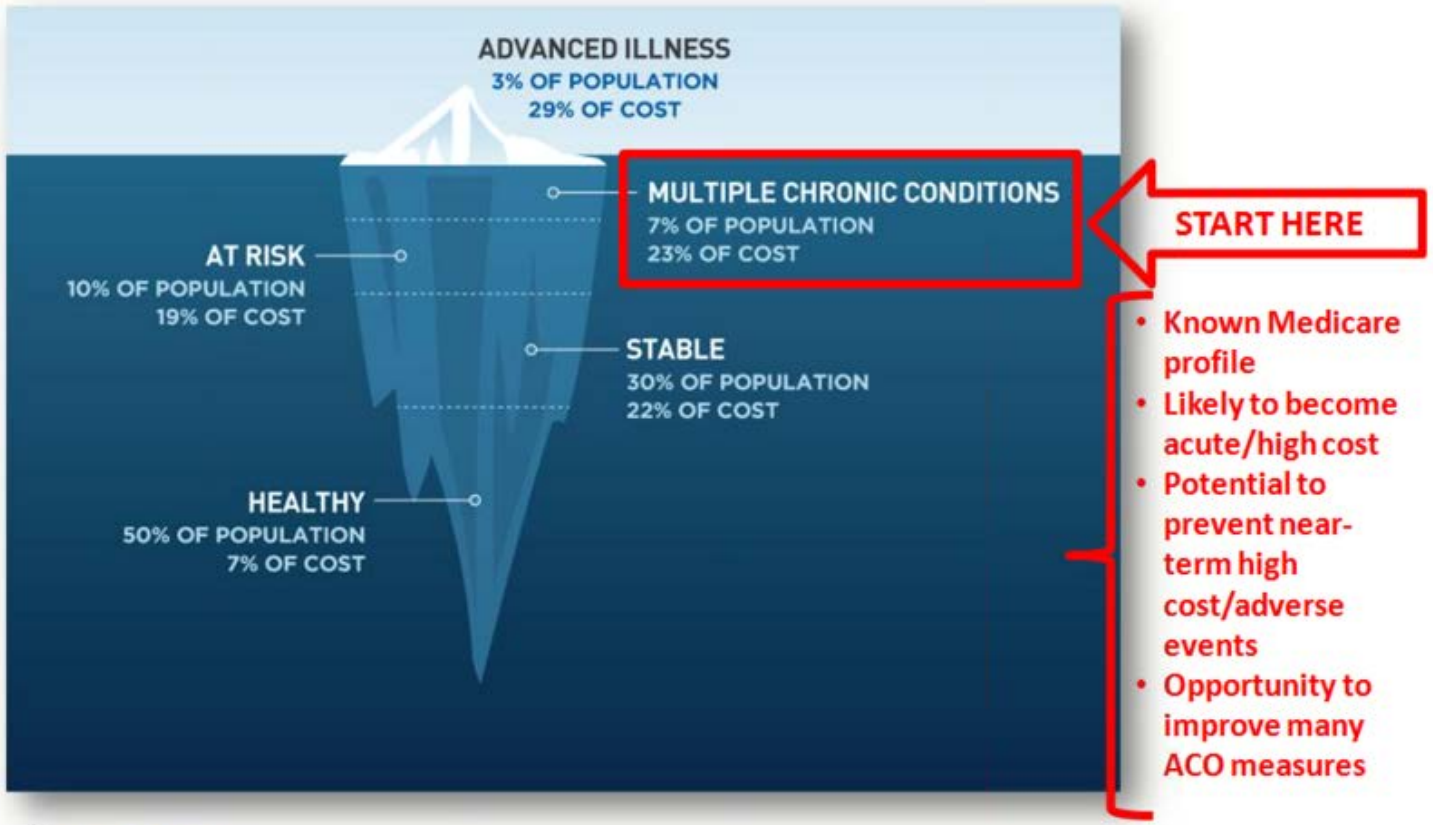
☐ Patient education handout given.

Value Based Care

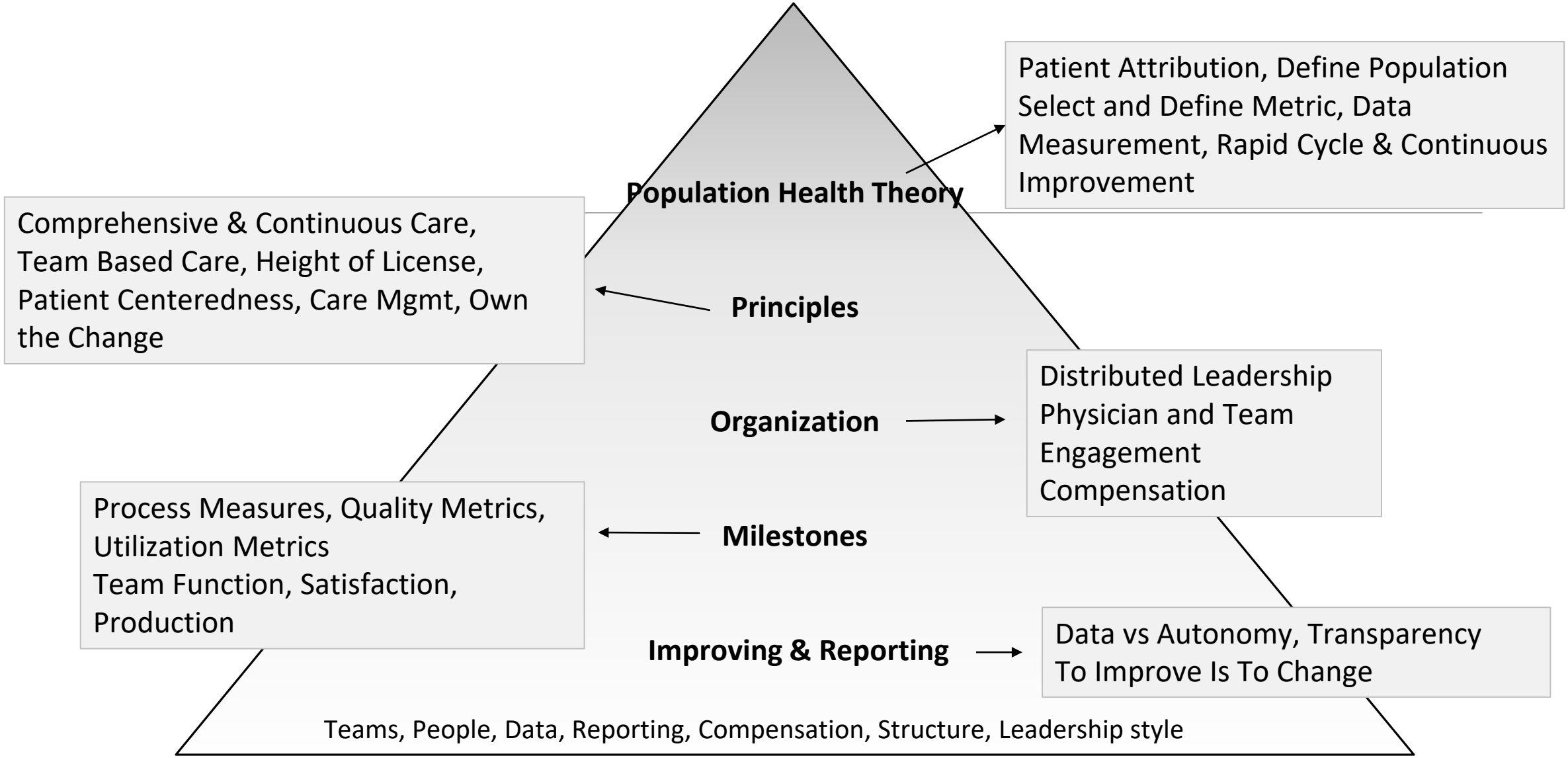
Two fundamental changes in mindset are required:

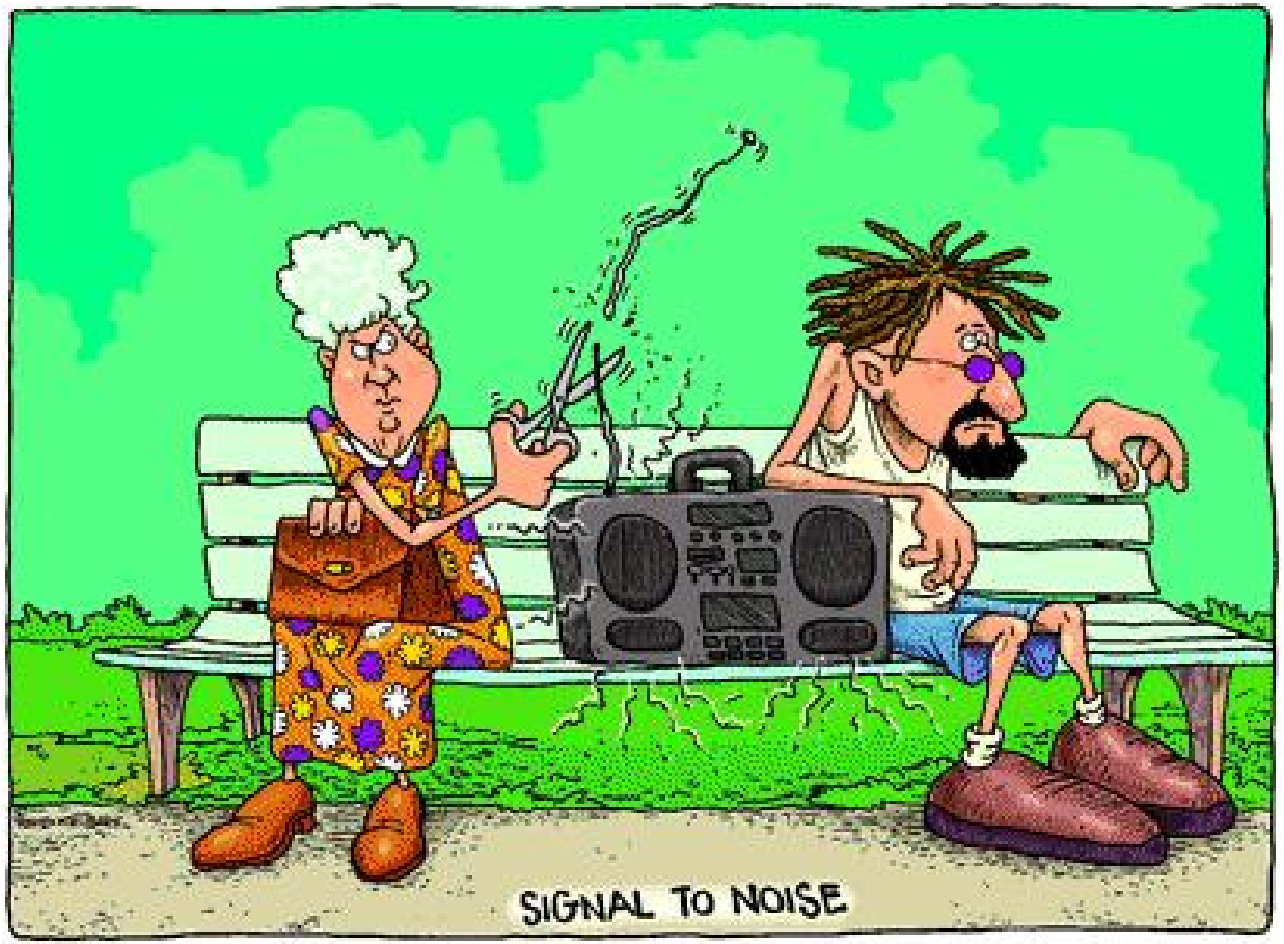
1. Must take care of everyone, all the time
2. Relentless focus on what the customer actually needs and wants… instead of what we want to give.

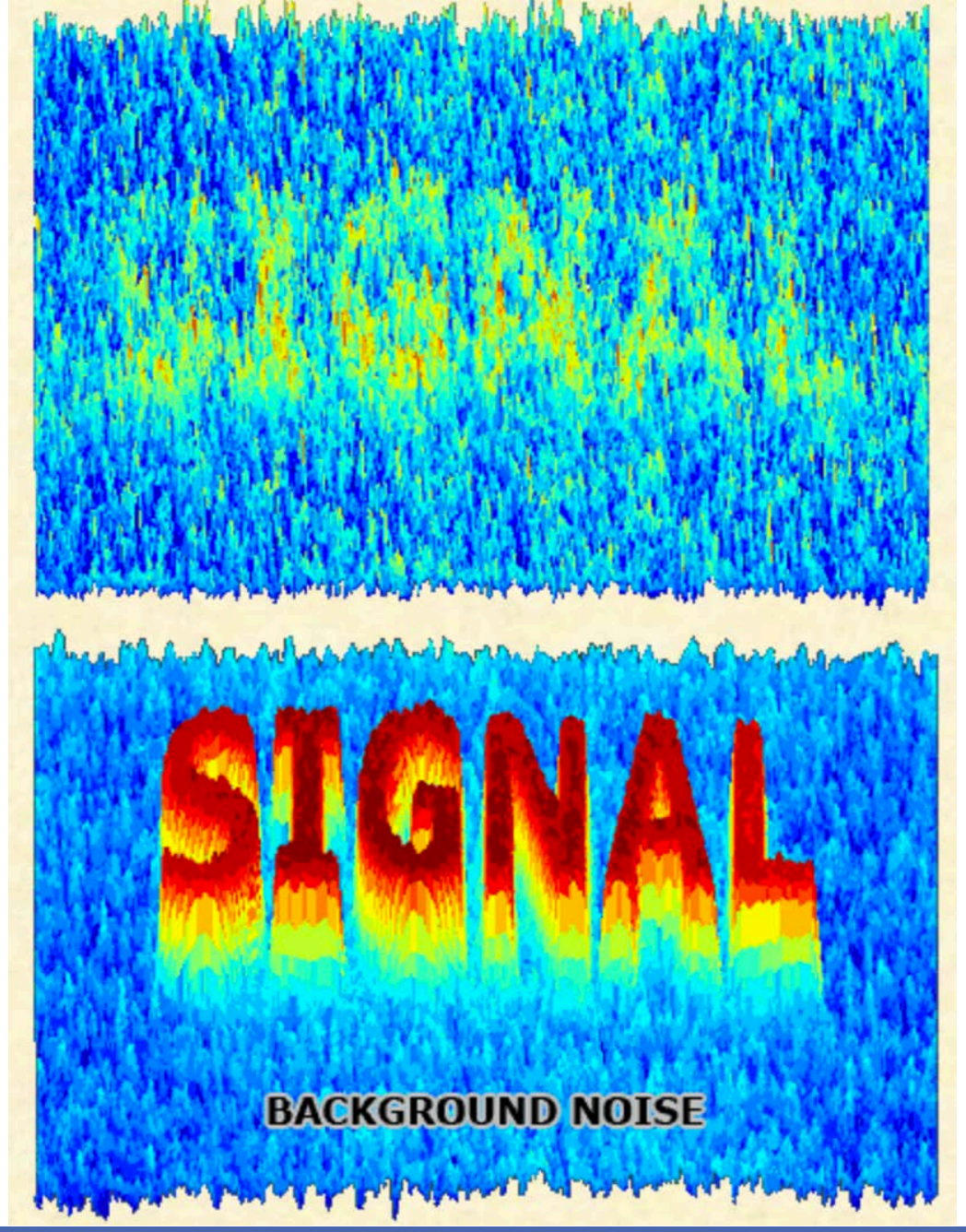
Focusing on Sickest Does Not Bend the Trend



PHYTEL


Patient Attribution, Define Population
Select and Define Metric, Data
Measurement, Rapid Cycle & Continuous
Improvement
Population Health Theory
Comprehensive & Continuous Care,
Team Based Care, Height of License,
Patient Centeredness, Care Mgmt, Own
the Change
Principles
Organization
Distributed Leadership
Physician and Team
Engagement
Compensation
Process Measures, Quality Metrics,
Utilization Metrics
Team Function, Satisfaction,
Production
Milestones
Improving & Reporting
Data vs Autonomy, Transparency
To Improve Is To Change
Teams, People, Data, Reporting, Compensation, Structure, Leadership style

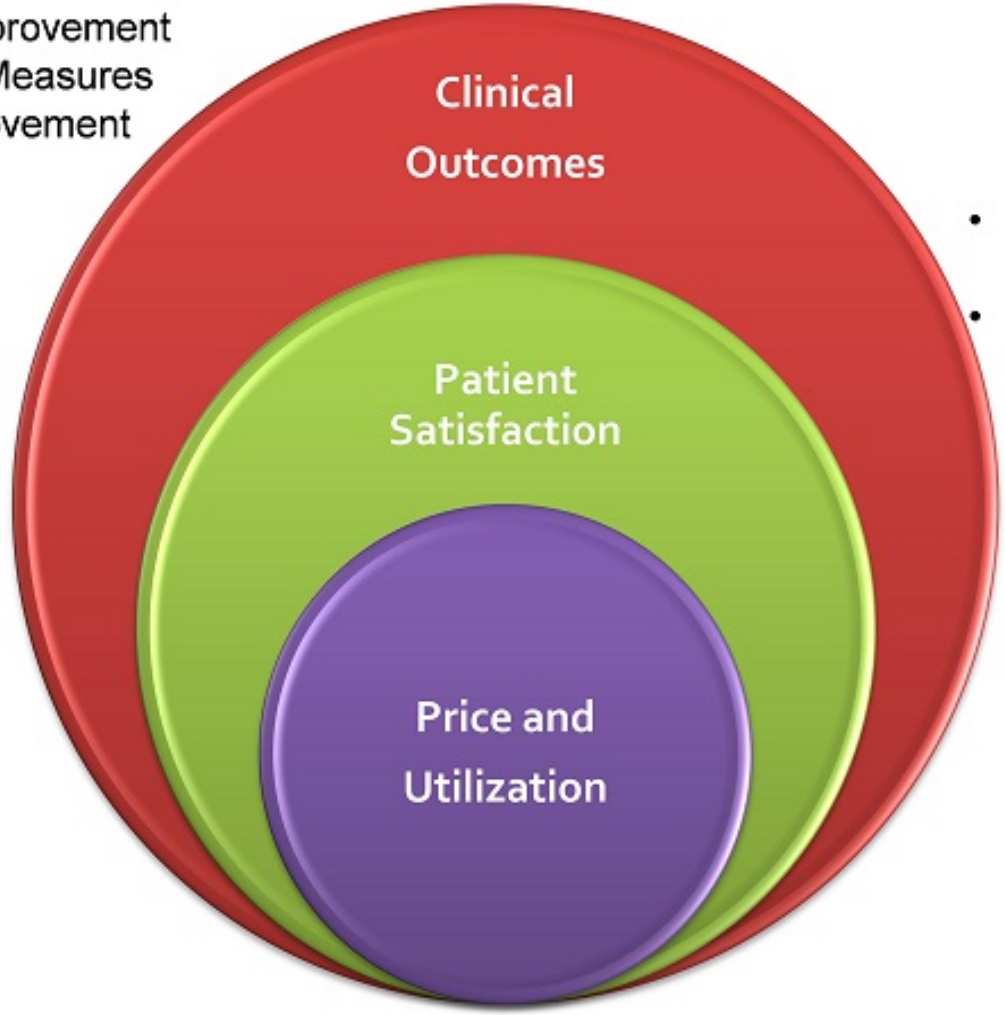

SIGNAL TO NOISE


SIGNAL
BACKGROUND NOISE

Value = (Clinical Outcomes + Patient Satisfaction) / (Price x Utilization)

Clinical Outcomes

- Care Gaps Confirmed and Closed
- Medication Optimization & Possession Ratio
- Clinical Value Improvement
- CMS and Payer Measures
- Risk Factor Improvement
- SF12 Rates



Patient Satisfaction

- Patient Satisfaction Surveys
- Patient Engagement
  - Care Program Participation Rates
  - Patient Activity & Compliance Between Visits
- Leakage Rates and Market Share Improvement
- CMS and Payer Measures

Price and Utilization

- Total Medical PMPM
- Medical Trend
- Total Rx PMPM
- Admissions/1000
- Images/1000
- ER, Urgent Care Usage
- Site of Service Management
- Readmission Rate Reduction
- CMS and Payer Measures

Consumer's View of Data

We are patronizing patients – they can't control information, or use it to spend their money smartly

- Healthcare is the ONLY part of life that I as consumer do not control my information and my choices

Privacy law and HIPPA are only barriers if you are seeing this through our own prism - as soon as the information is aggregated and in patients control it all works

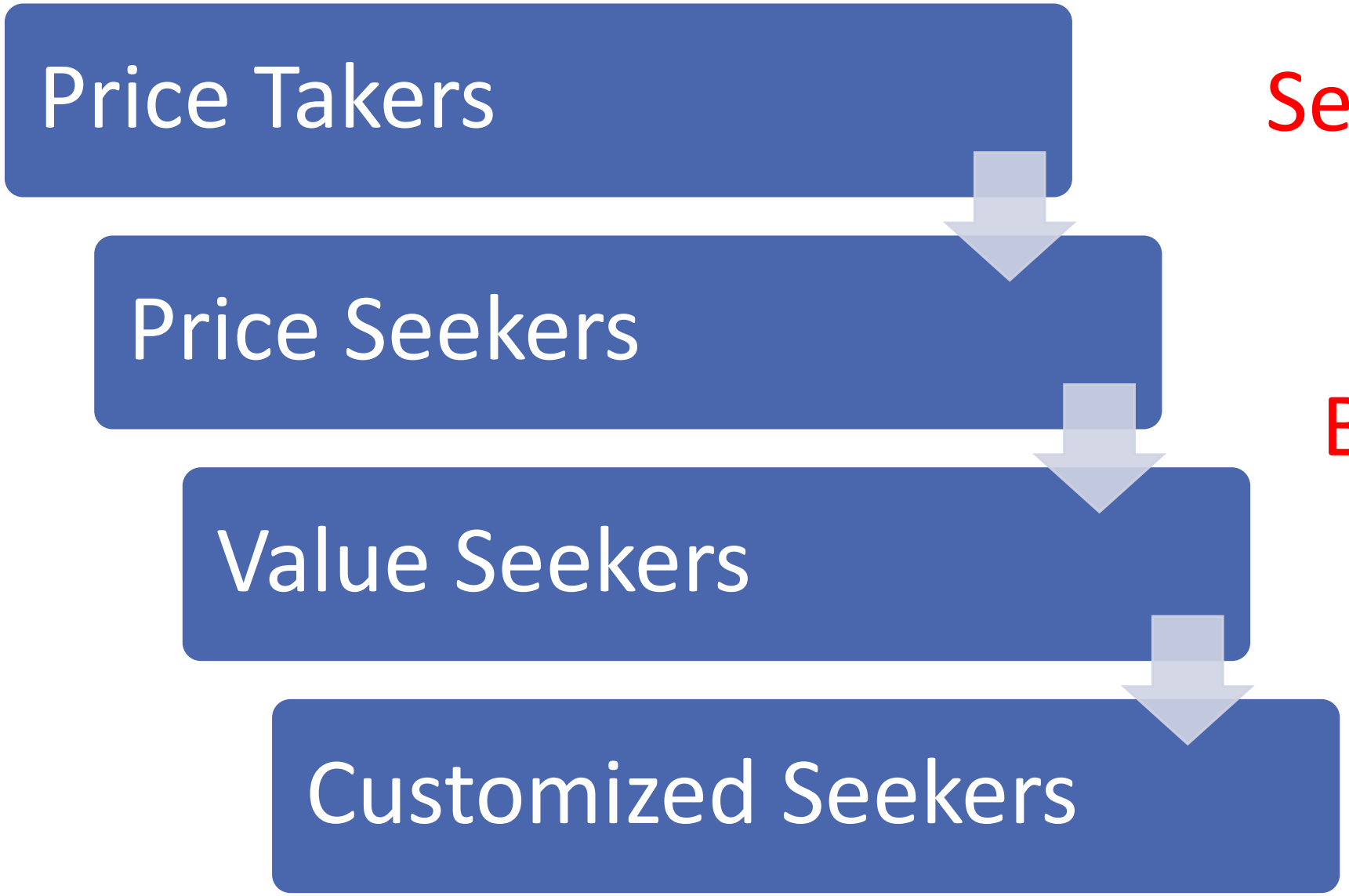
- HIE may be an important but ultimately transitional state

Price,

Value, and

Outcomes

Transparent consumer markets will shift the basis of competition from reputation and referrals to:



Sellers Market

Buyers Market

Personalized Market


I'M A
DOCTOR
TO SAVE TIME, LET'S JUST
ASSUME I'M ALWAYS RIGHT

Culture of Change

Only two physician cultures will survive

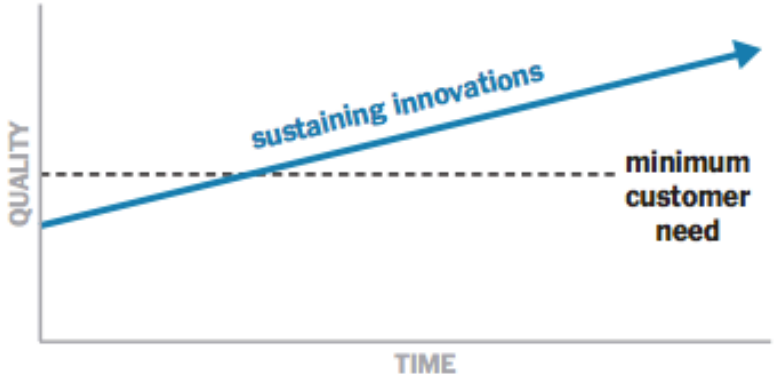
- The forward leaning, learning, adaptive physician culture
- The authoritarian and compliant culture

From the health system perspective, only 3 choices:

- Invest in physician leaders, build a learning and adaptive culture
- Beat all physicians into acceptance
- Opt Out - Don’t employ physicians, or those specialties or physicians that won’t adapt – just contract with groups that do

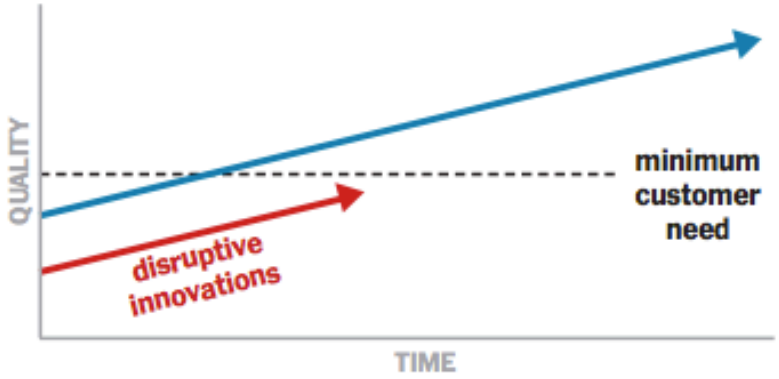
1. Incumbents treat innovation as a series of incremental improvements. They focus on improving the quality of their premium products to sustain their current business model.

For The Times, a sustaining innovation might be "Snowfall."



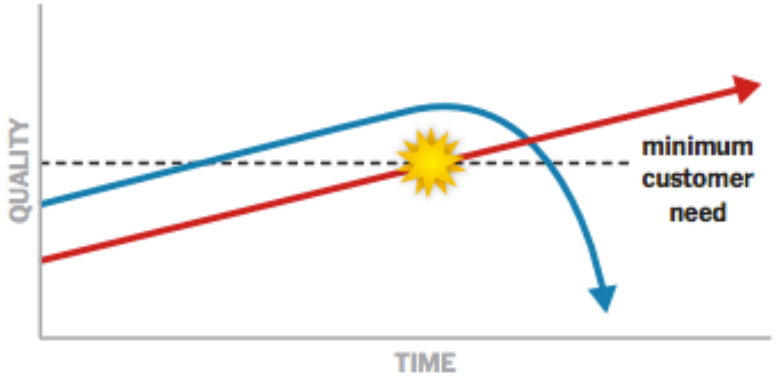
2. Disruptors introduce new products that, at first, do not seem like a threat. Their products are cheaper, with poor quality — to begin with.

For BuzzFeed, a disruptive innovation might be social media distribution.



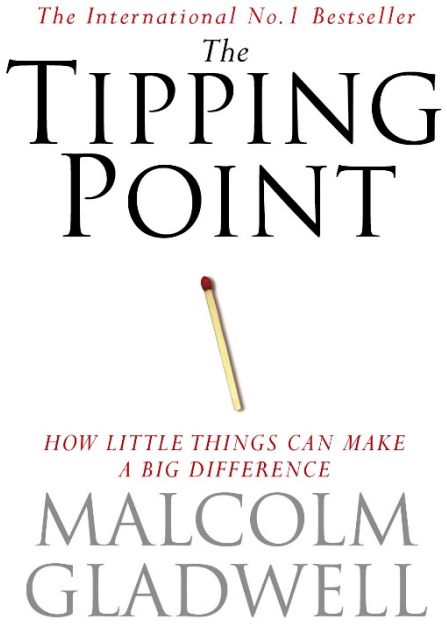
3. Over time, disruptors improve their product, usually by adapting a new technology. The flashpoint comes when their products become "good enough" for most customers.

They are now poised to grow by taking market share from incumbents.

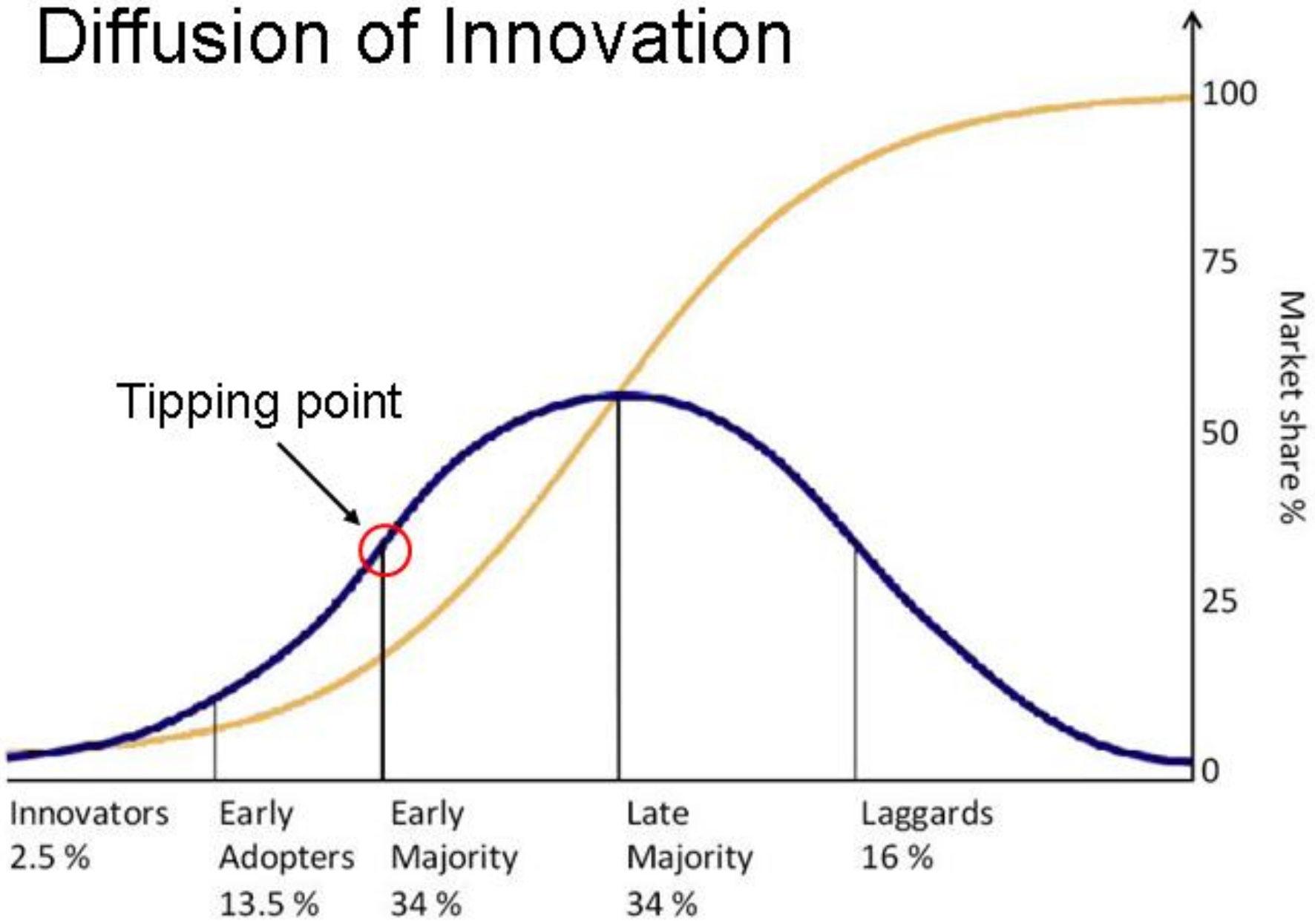


Healthcare Disruption

- Opening primary care centers in rural stores.
- Acute and chronic disease management.
- Not the first mover – focused on disruptive efficiency and cost efficiency management.



Diffusion of Innovation



Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn't be more serious.

Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as problems with medication management and provide continuing support after discharge.

It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

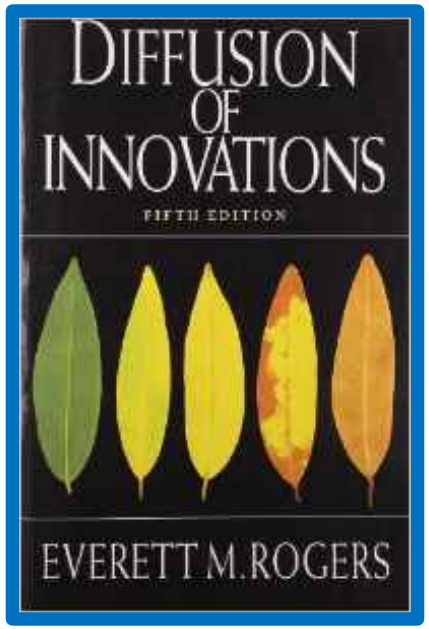
1-800-MD-SINAI
mountsinaihealth.org

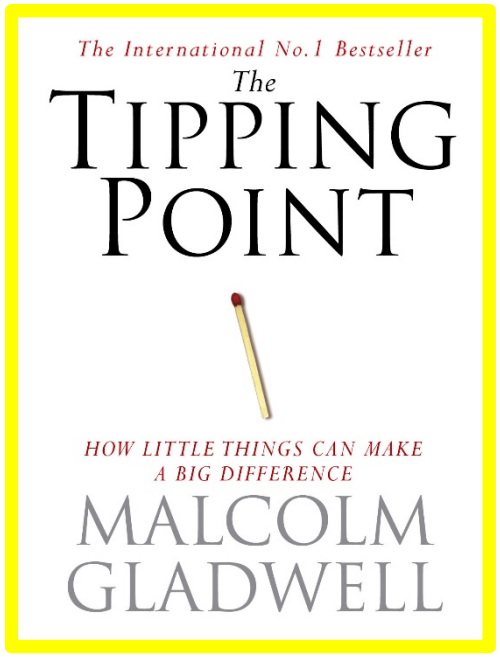
Mount Sinai

IF OUR BEDS

ARE FILLED,

IT MEANS WE'VE FAILED.





Gartner Hype Cycle

Acute Care Hospitals

"Hospitals are driven by increasing volume and pricing; every expense is someone else's revenue. I think that game is up." - former Vanguard CEO, Charlie Martin

Positioned as one stop shopping, offering wide range of services and world-class repair-care will continue to play an indispensable role in our broader healthcare system, but only the true value leaders are likely to thrive

Many advantages: starter set of the new competencies required for population health; financial resources, adaptable, and huge pool of talent

Focus on one or more different patient-centered population health businesses:

- Frail elder medical homes,
- Complex disease Extensivists
- "Focused factory" for ambulatory surgery and diagnostic services
- Diversified health/wellness program and smart teams

Our Challenges As Incumbent

Change bandwidth in our healthcare systems is a HUGE issue

Takes fundamental realignment AND being very precise with which problem we're working on

These are World Hunger, "Moon Shot" scale problems

- Solution to innovation, strategy, transformation is not A GUY, or even a DEPARTMENT
- "We need a population health solution", "we need an ACO solution"

Is it Clinical integration, governance, physician engagement, consumerism, analytics, money flow, finance, clinical delivery

- Must be crisp in defining the goal
- IT is ALL of these, at the same time!

Clayton Christensen - it is very hard, if not impossible, for incumbents to succeed or survive when an industry is being disrupted.

- Move to Contemplative and Action Phases: Timing is EVERYTHING
- Ruthlessly improve delivery of value based product, and communicate on that
  - Systematize, Simplify, Streamline
- Align the self interests of health system, physicians, and patients
  - What services to build & what to partner
  - Physician compensation
  - Transparent cost to consumers
- Define and understand expense - drive out all no-value services


THANK
YOU

Digital Transformation of Whole Industries

15 years ago Travel Agents would claim that you cannot book vacations online – “it needs a personal touch and experience”

10 years ago you would not dream of banking online – “it’s not safe”

5 years ago few people would buy groceries online

NCMJ
NORTH CAROLINA MEDICAL JOURNAL
a journal of health policy analysis and debate

Roadmap to Value Driven Health Care

Gary Salamido, MS

Address correspondence to Gary Salamido, 700 Corporate Center Dr, Suite 400, Raleigh, NC 27607 (kpayne@ncchamber.net).

+ Author Affiliations

Abstract

Uncertainty over future health care costs is a major concern to business and acts as a throttle, limiting new investment. This article discusses how the North Carolina Chamber is committed to making North Carolina a top-10 state for health care value, thus creating a robust business environment across the state.

In his book *The Coming Jobs War*, Jim Clifton dedicates an entire chapter to examining the need to fix health care if our country is to be competitive for global job creation. He goes as far as to say, “fix health care or destroy job creation” [1]. The data he presents is compelling, even startling, and served as the basis for the North Carolina Chamber

HealthAffairs

TOPICS JOURNAL BLOG

HEALTH AFFAIRS BLOG

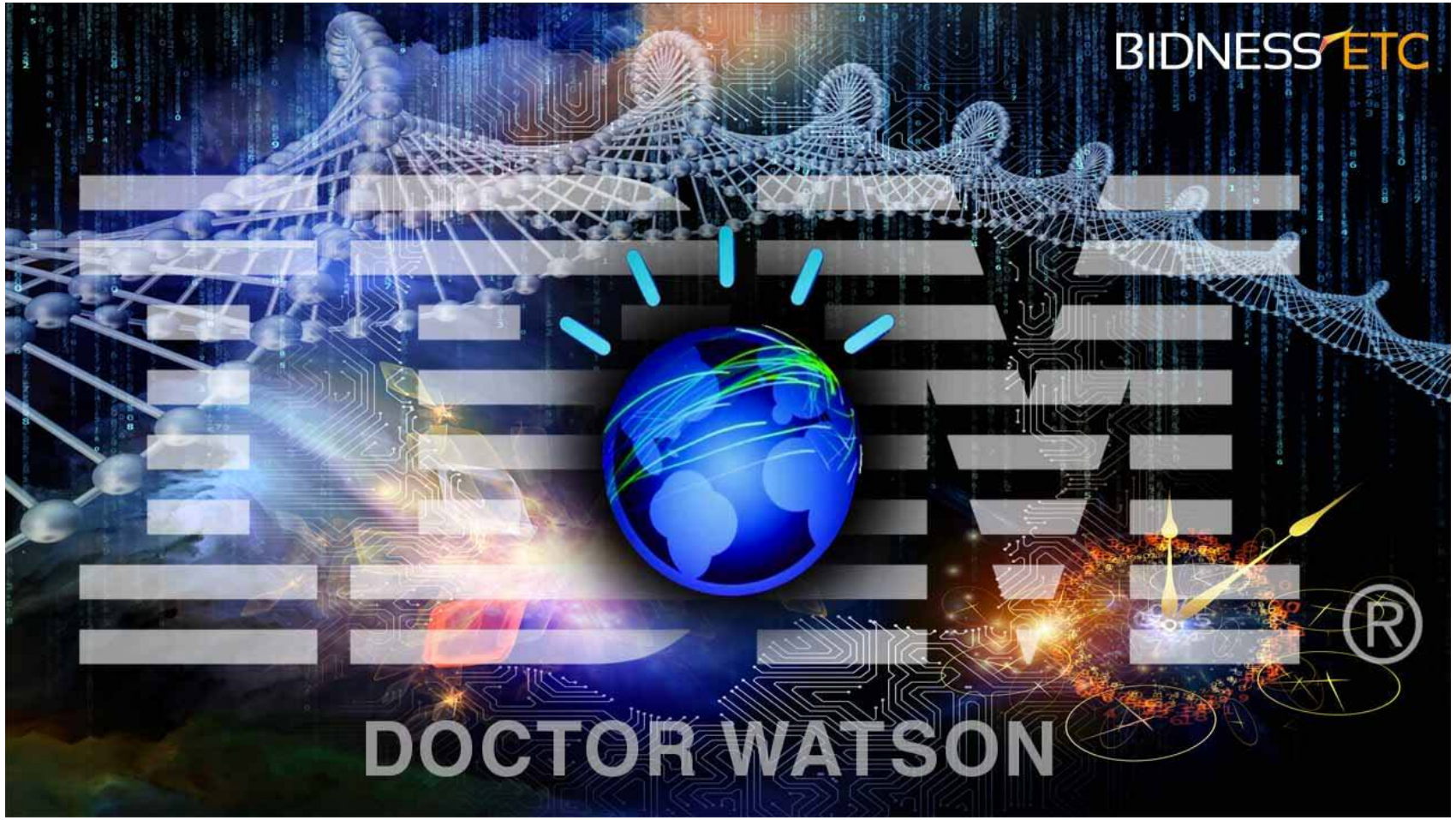
RELATED TOPICS:
PAYMENT | COSTS AND SPENDING | PAYMENT MODELS | ACCOUNTABLE CARE ORGANIZATIONS | POPULATION HEALTH | ACCESS TO CARE

North Carolina: The New Frontier For Health Care Transformation

Mark B. McClellan, Mathew Alexander, Mark Japinga, Robert S. Saunders

FEBRUARY 7, 2019 10.1377/hblog20190206.576299

The Digital Transformation



Telehealth ENT Consultation, 1962 version

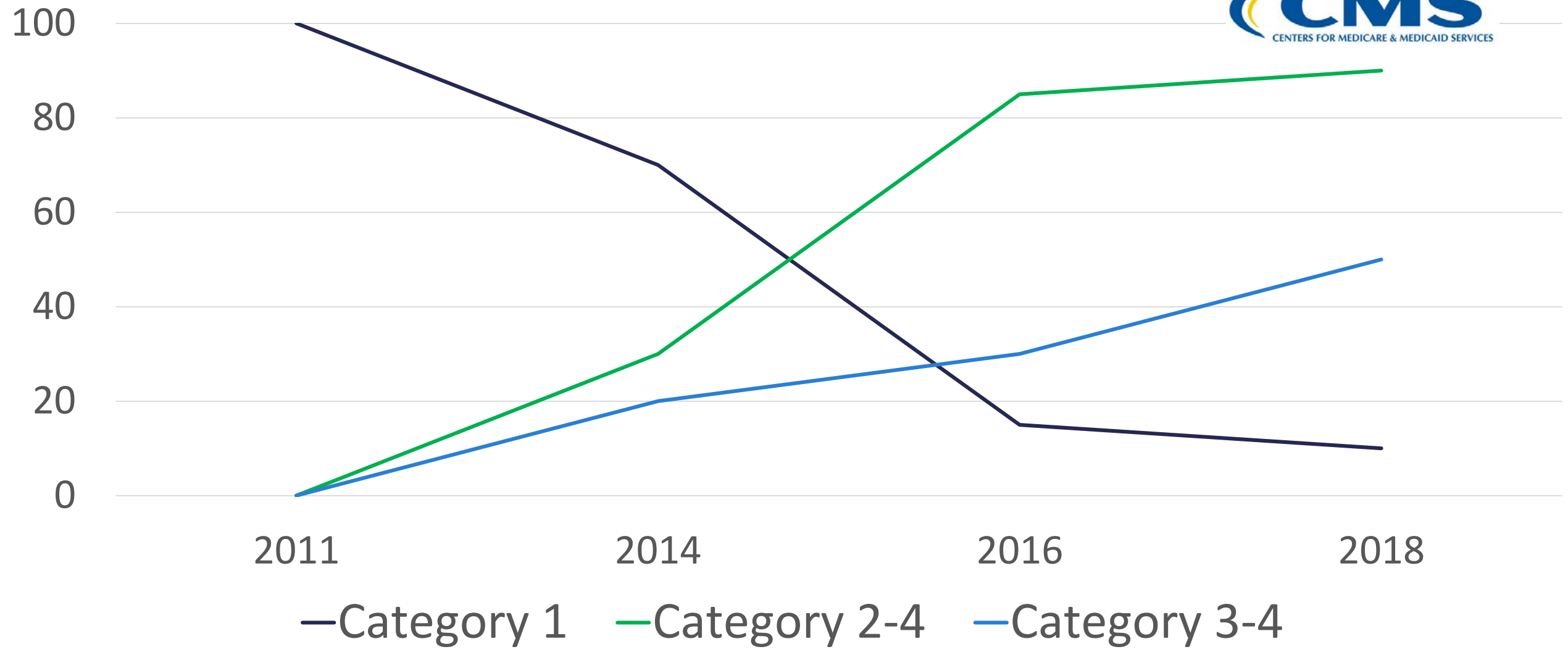
What is Disruption?

The world's largest taxi company owns no cars.

The world's most valuable accommodation provider owns no real estate.

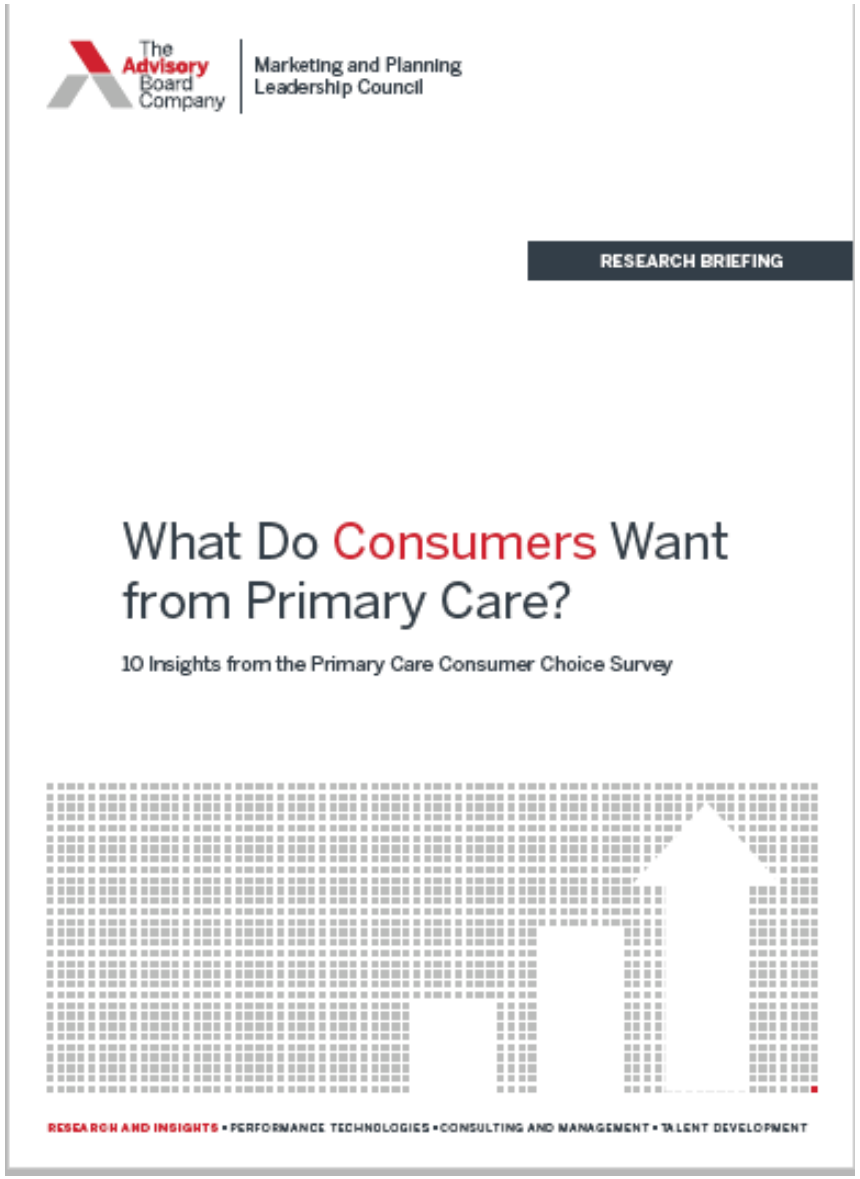
The world's most popular media source creates no content.

“Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume”



In Healthcare

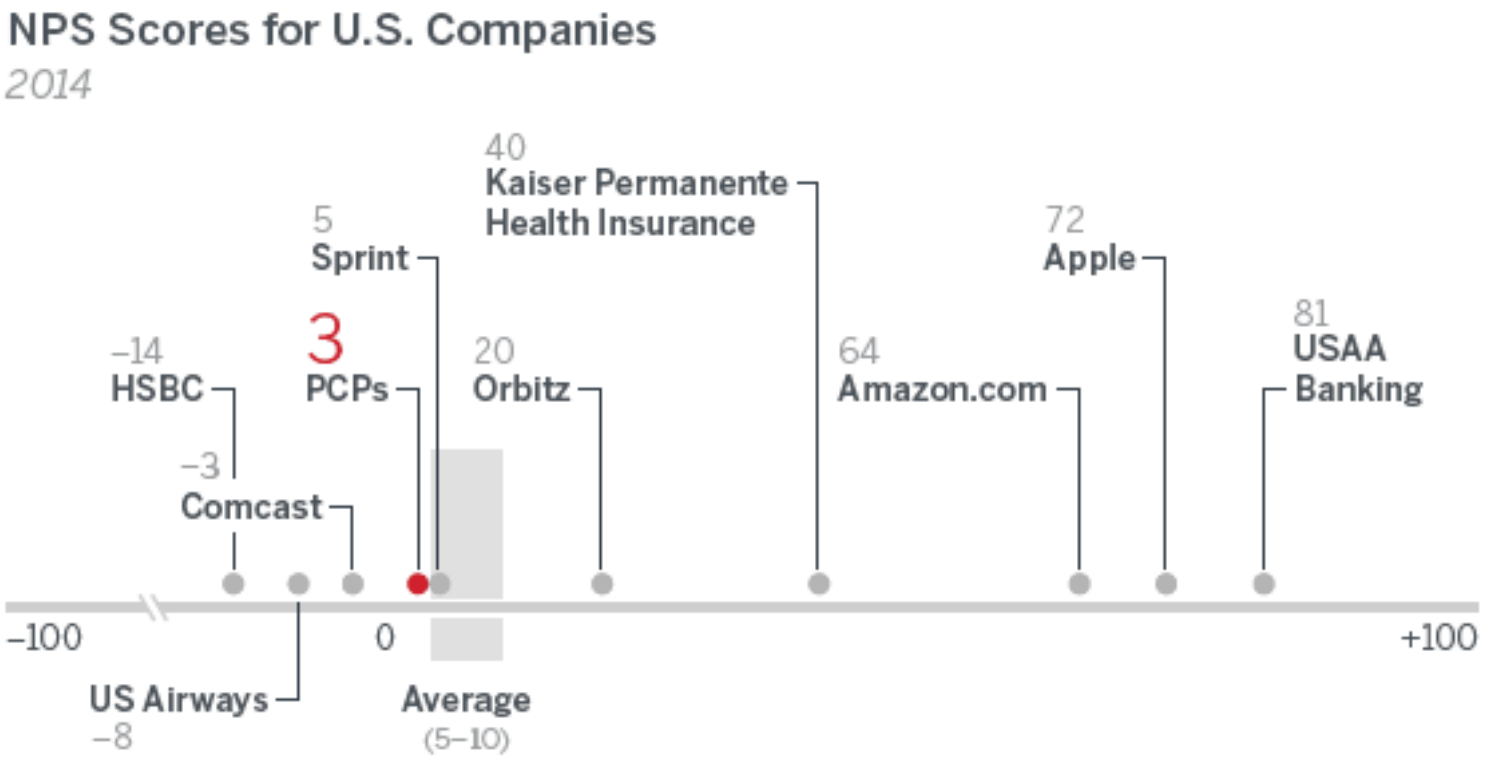
Slide Credit: Paul Grundy, MD

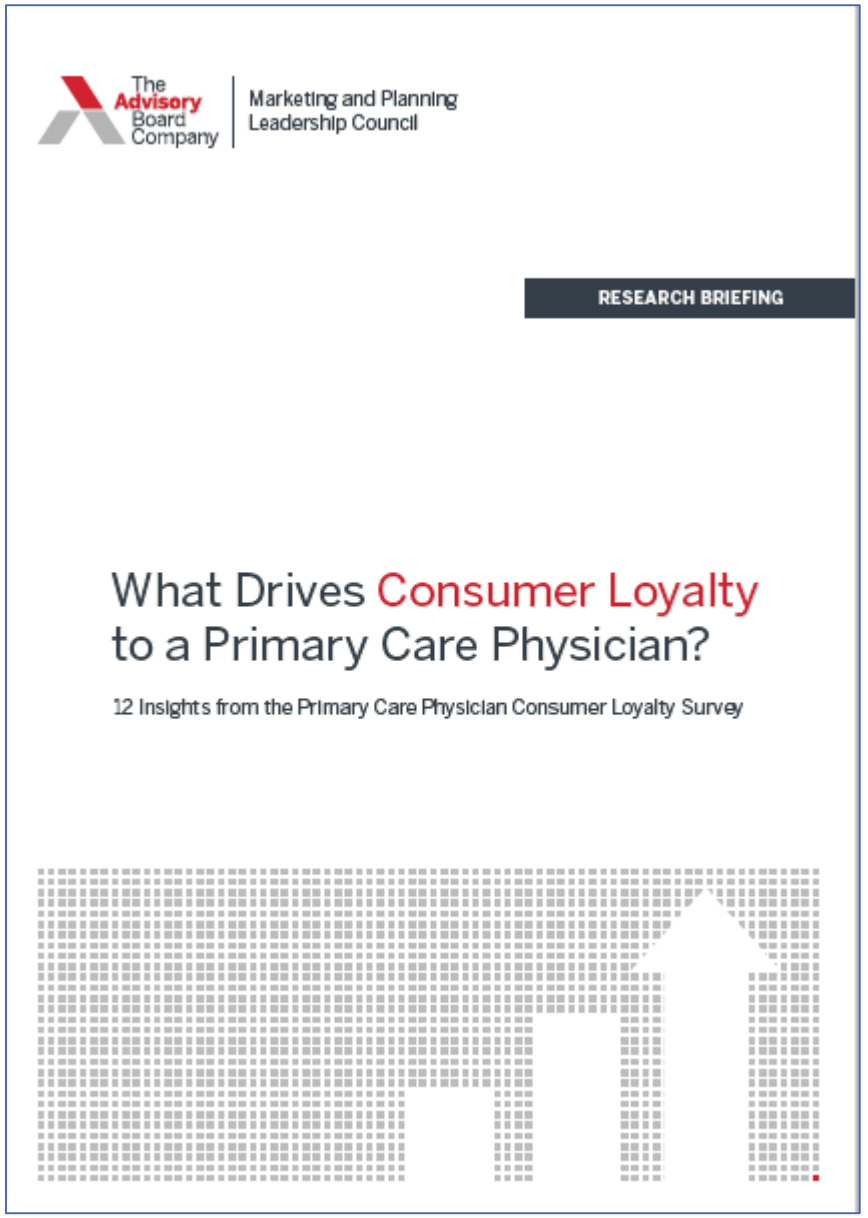


Rebuilt on-demand care

1. Convenience is King – 6 of 10 top attributes related to convenience
   - Walk In and seen w/in 30 min
   - Same Day appointments
   - 24/7 care available
2. Near home – location, location, location
3. Online and asynchronous
4. Convenience > Credentials and Continuity
5. Little value to reputation or brand (under age 65)
6. Virtually every other surveyed attribute ranked above non-transparency of cost; transparency outweighed actual cost

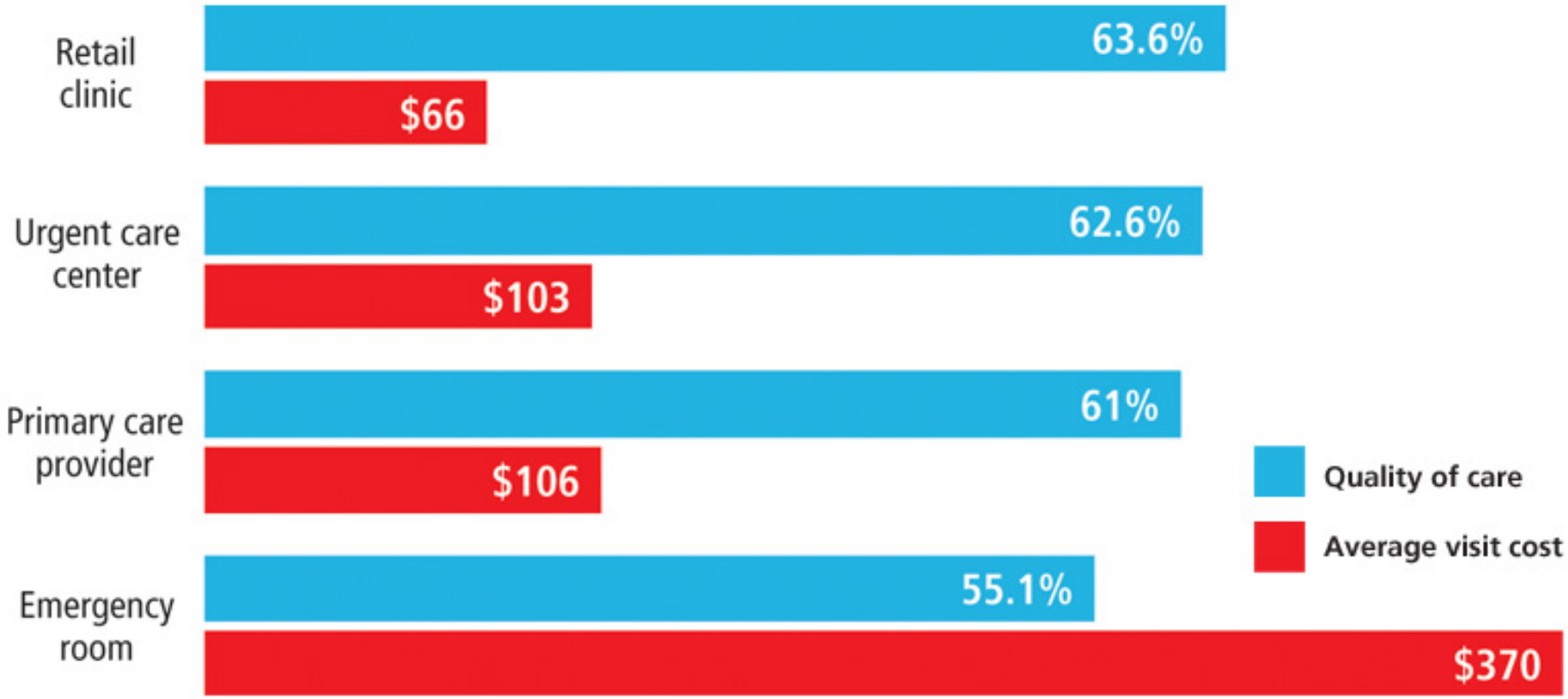
Loyalty


NPS Scores for U.S. Companies
2014
40
Kaiser Permanente
Health Insurance
5
Sprint
3
PCPs
20
Orbitz
72
Apple
81
USAA
Banking
−14
HSBC
−3
Comcast
64
Amazon.com
−100
0
+100
US Airways
−8
Average
(5–10)


The Advisory Board Company
Marketing and Planning Leadership Council
RESEARCH BRIEFING
What Drives Consumer Loyalty to a Primary Care Physician?
12 Insights from the Primary Care Physician Consumer Loyalty Survey

Quality at the right price

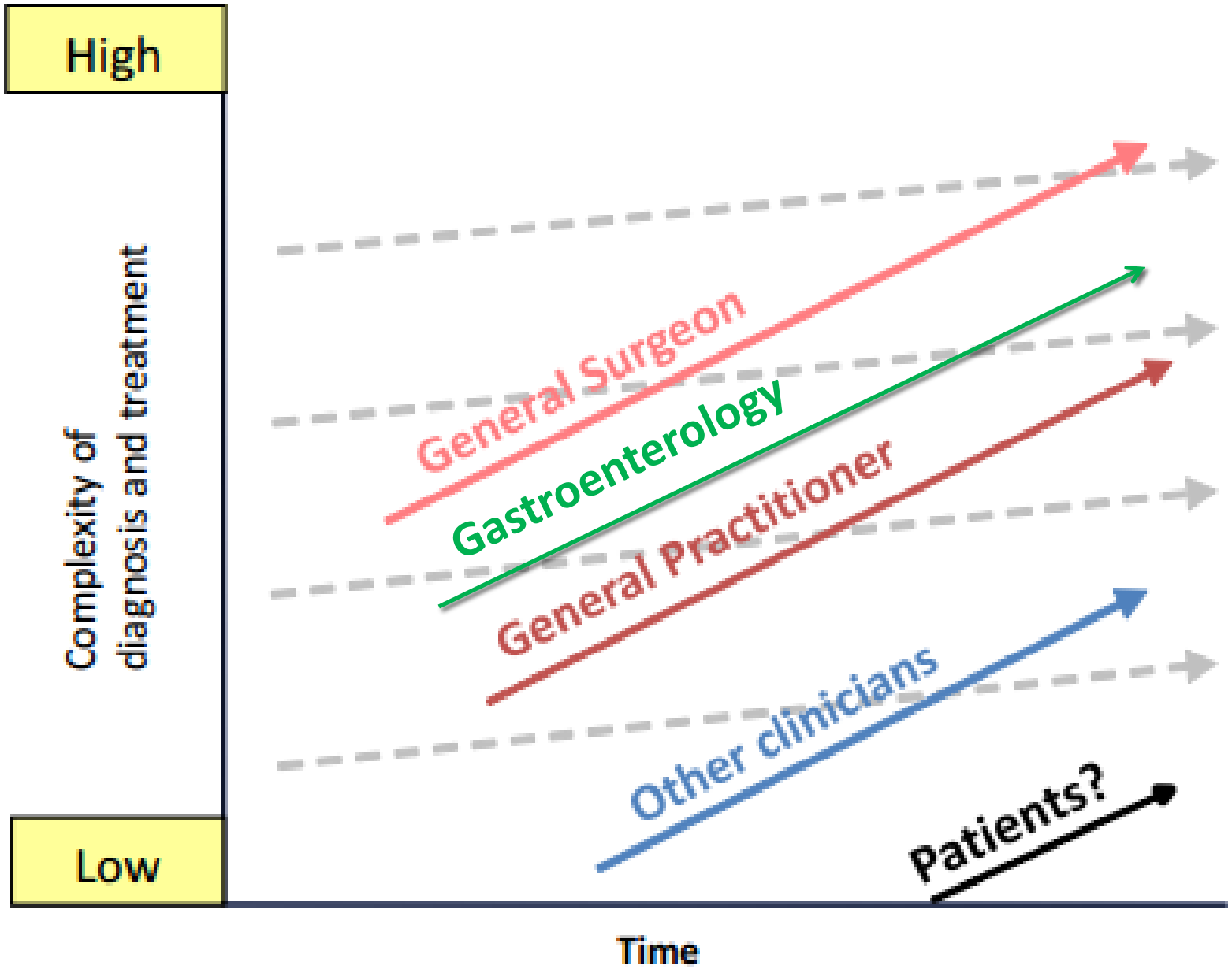
The RAND study found that retail clinics provided quality care at a lower cost than urgent care centers, doctors' offices or emergency rooms. Researchers measured 14 quality indicators expressed as percentages.



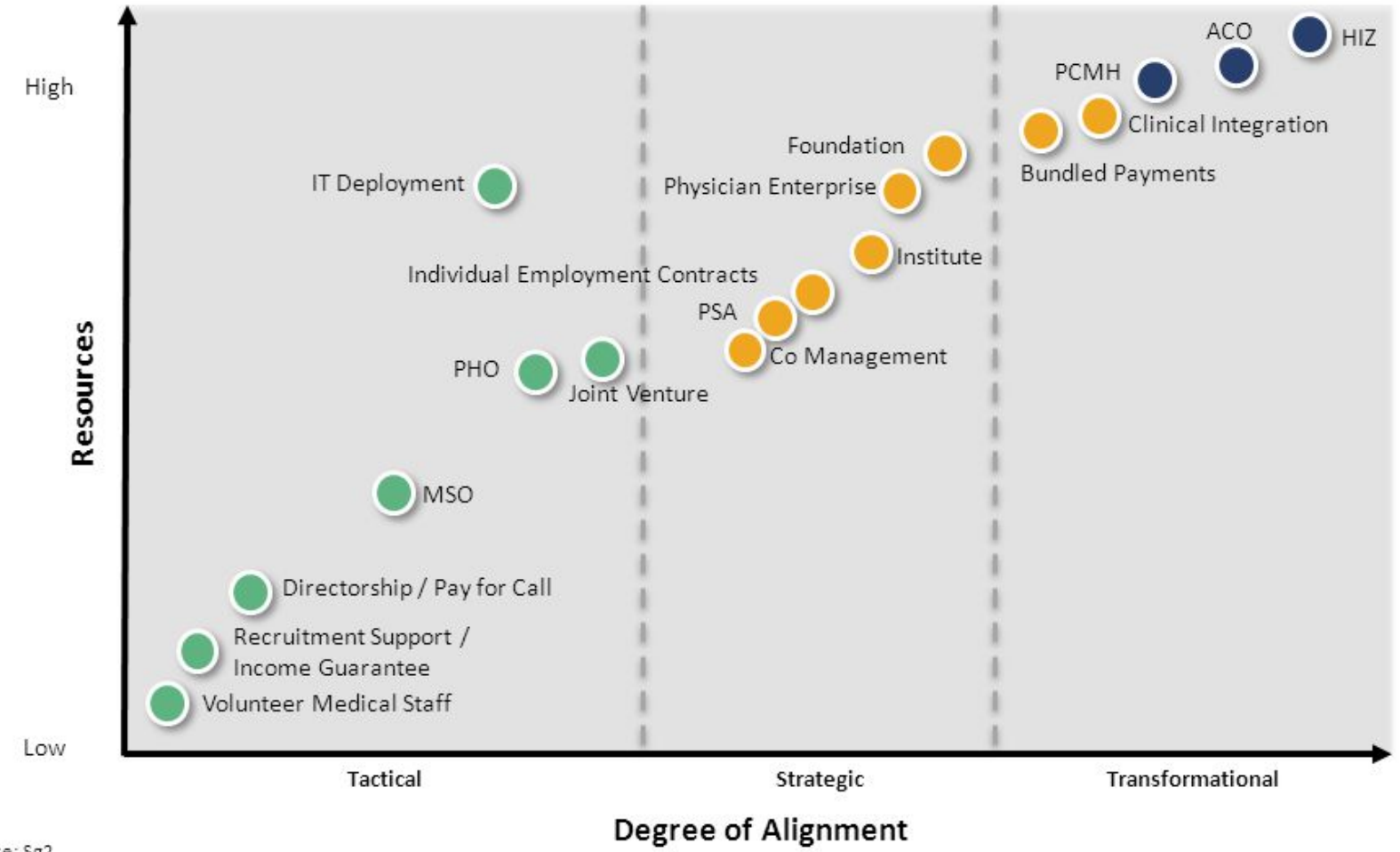
Example: Disruption in Specialty Care: Peptic Ulcer Disease

Jason Hwang, M.D., M.B.A.

http://www.pdsit.net/wp-content/uploads/2013/10/Jason-Hwang_-ppwt_FINAL.pdf

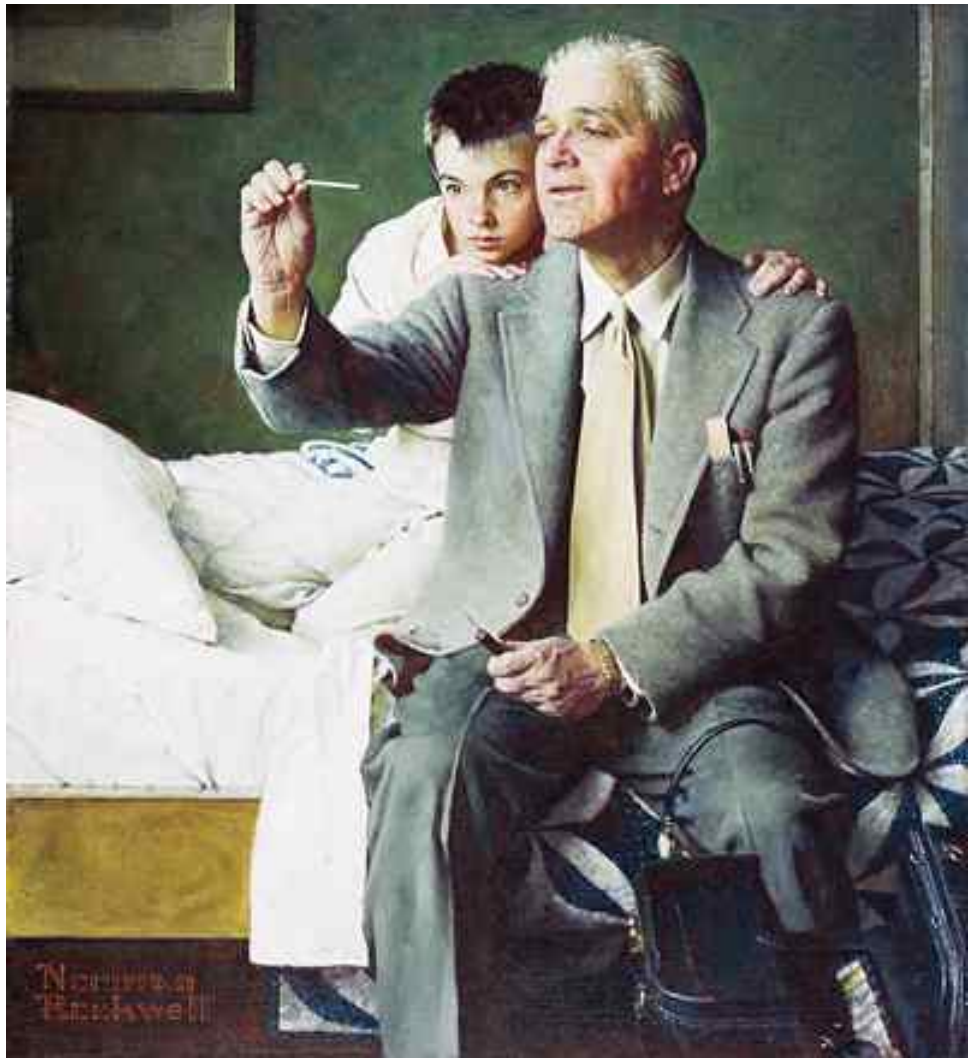


Physician Alignment Models



Source: Sg2

Less House…



More Rockwell

Surgery Center of Oklahoma

REQUEST A SPECIALIST

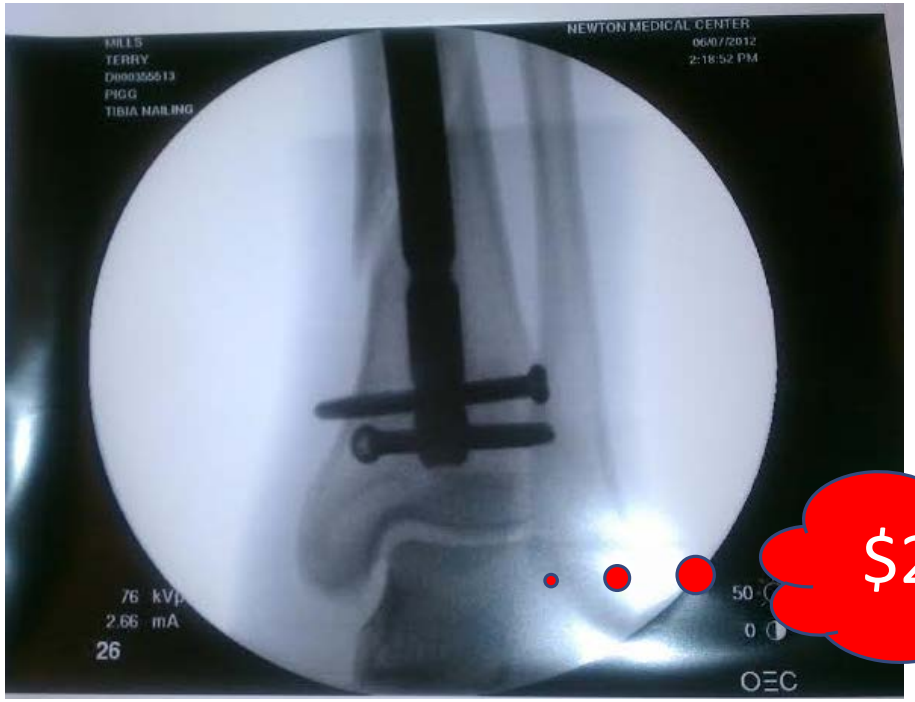
HOME ABOUT PRICING SPECIALISTS FAQS DR. SMITH'S BLOG MEDIA CONTACT

Complex Fracture (Includes Rodding Humerus / Tibia / Femur)

by Surgery Center of Oklahoma | May 30, 2013 | |

PRICE: $6,375.00

CPT Code: 23615

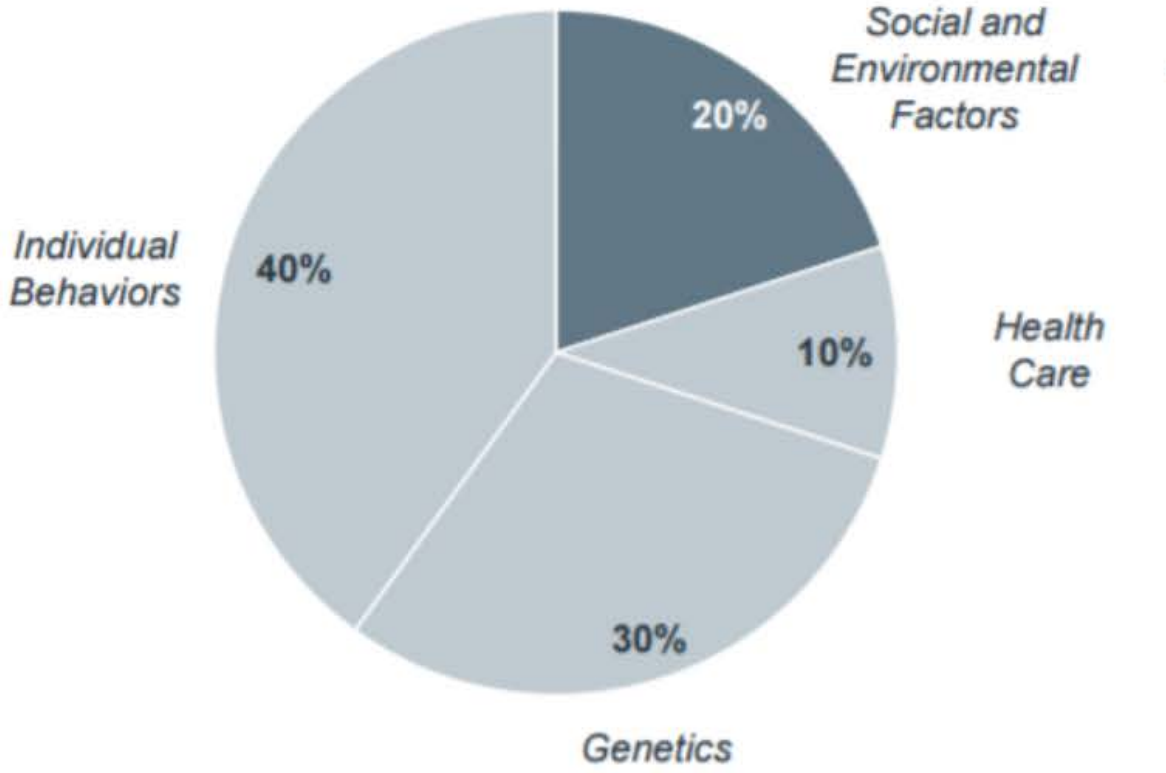


$22,000

Search

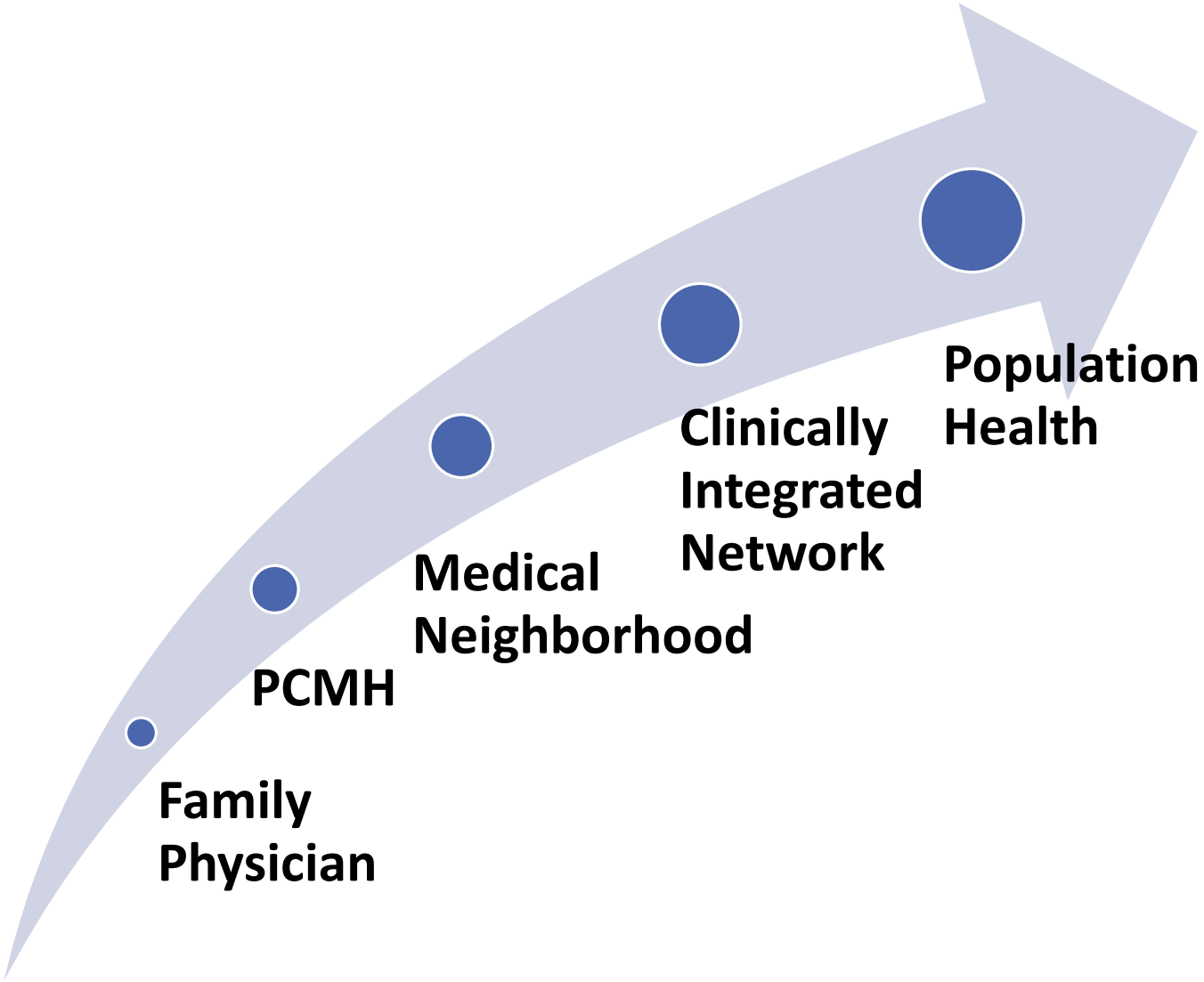
Free market-loving, price-displaying, state-of-the-art, AAAHC accredited, doctor owned, multispecialty surgical facility in central OK.

Impact of Different Factors on Risk of Premature Death



Examples of Social and Environmental Factors Influencing Health:

- *Income and employment status*
- *Housing and transportation*
- *Literacy and language*
- *Hunger and access to healthy food options*
- *Social integration and support*
- *Safety*



- All Patients All The Time
- Whole Health Ecology
- Usual Specialists
- Team Care + HIT
- Individual

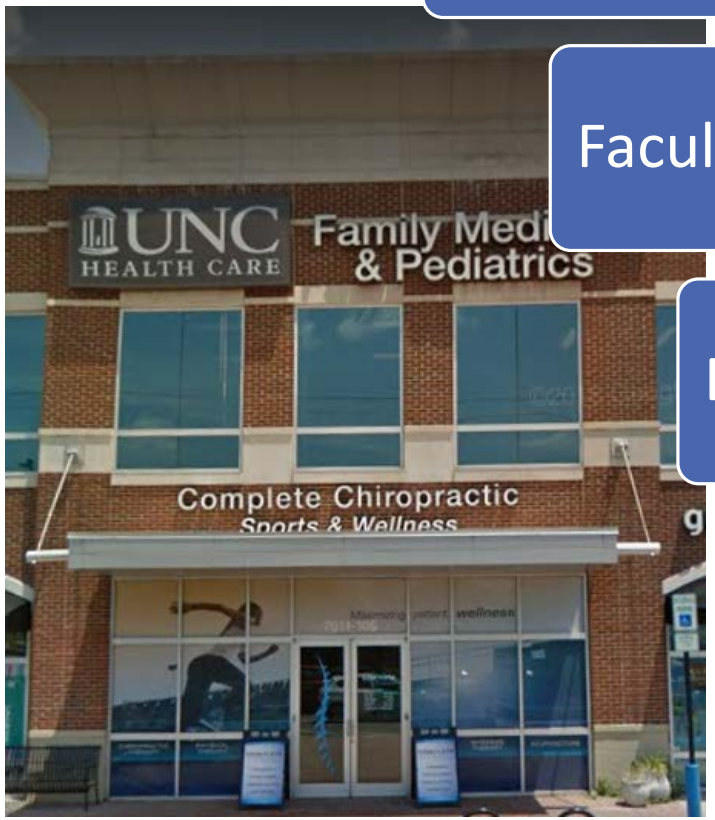
Purchasers: flat premium

Payers: FFS

Faculty Practice: FFS revenue + 5% Capitation

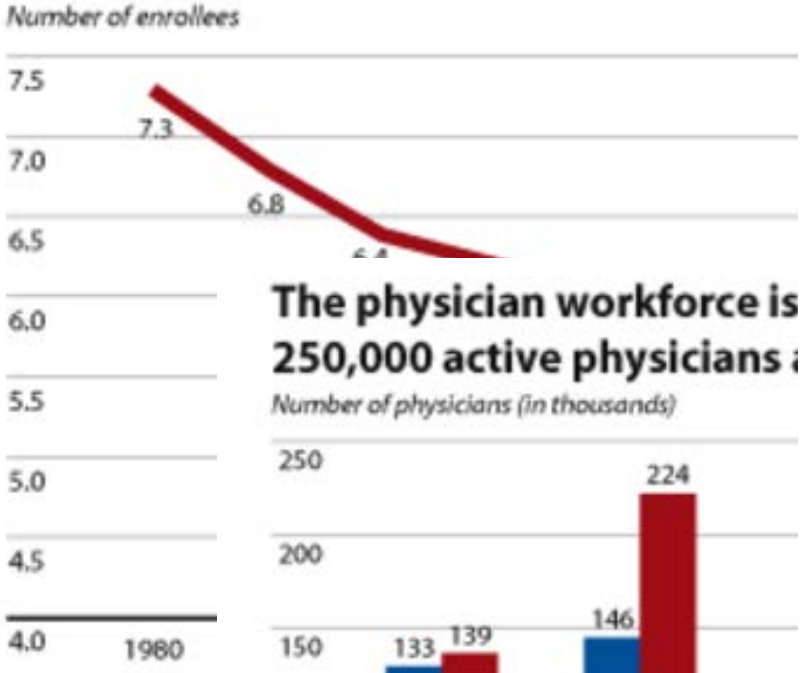
Department: 100% pmpm

Physicians: salary + supplemental + 15% variable (wRVU tier based)



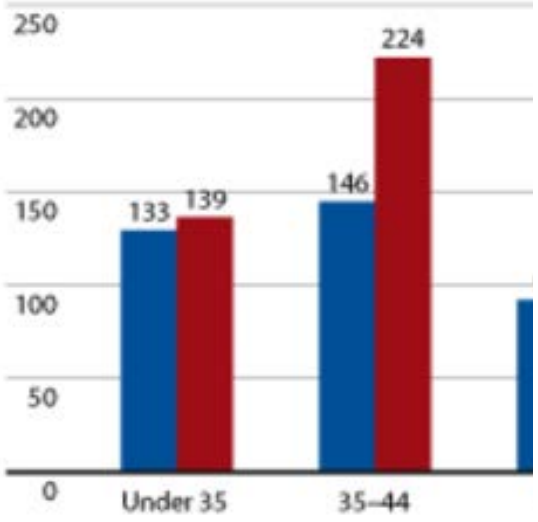
Metrics 60:40 mix of individual and practice

First-year MD enrollment per 100,000 population has declined since 1980



Source: AAMC; U.
Prepared by Cent

The physician workforce is 250,000 active physicians

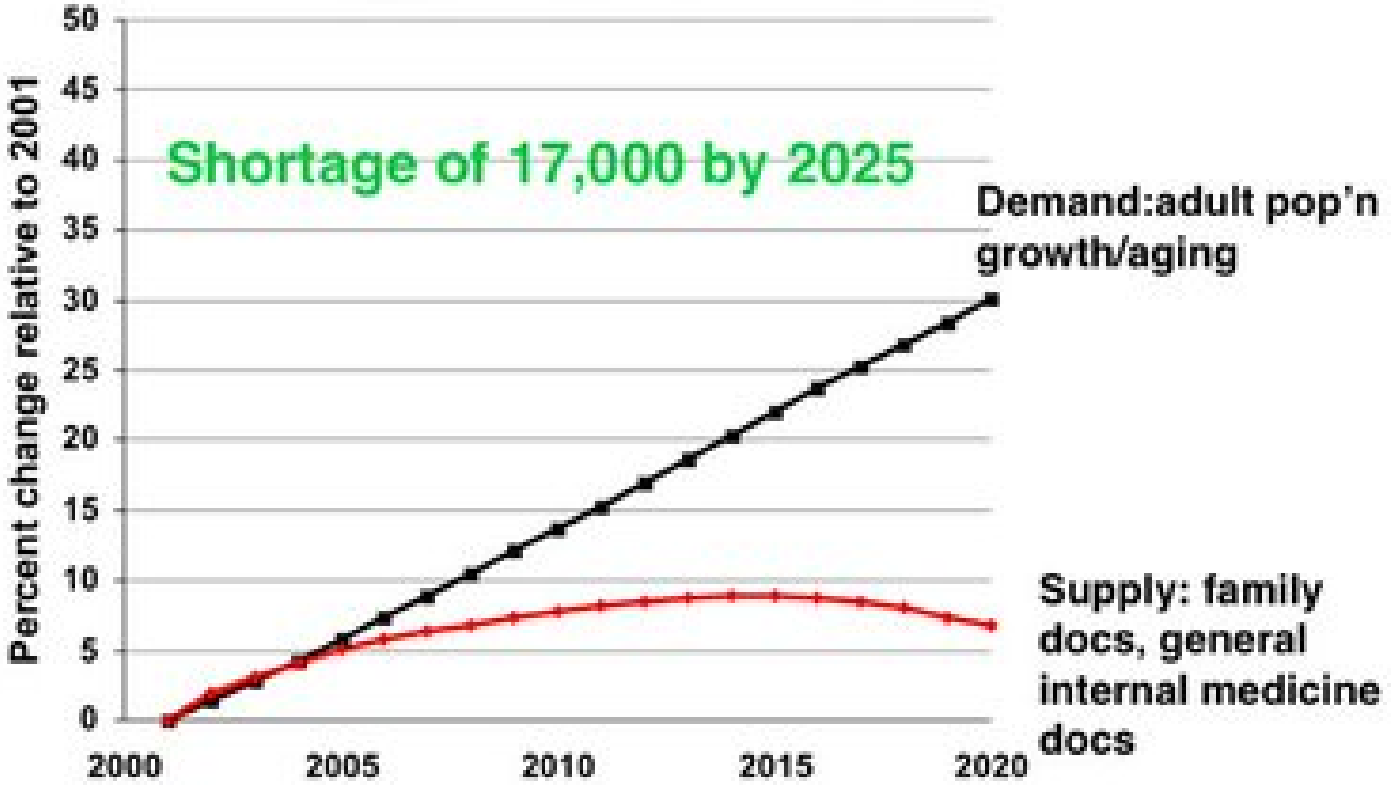


Source: American Medical Association (AMA)
for 1985 data; AMA Masterfile for 2005 data
Active physicians include residents/fellows
NOTE: 1985 data excludes 24,000 DOs
Prepared by AAMC Center for Workforce Stud

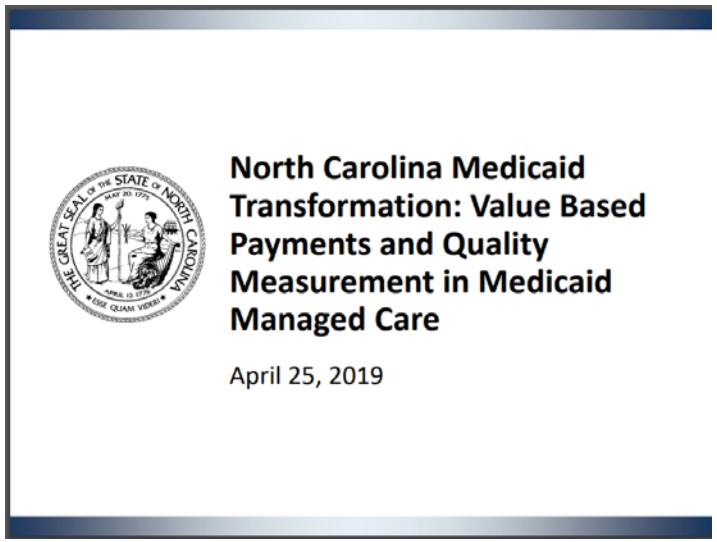
Family Medicine in the NRMP Match 1999-2019

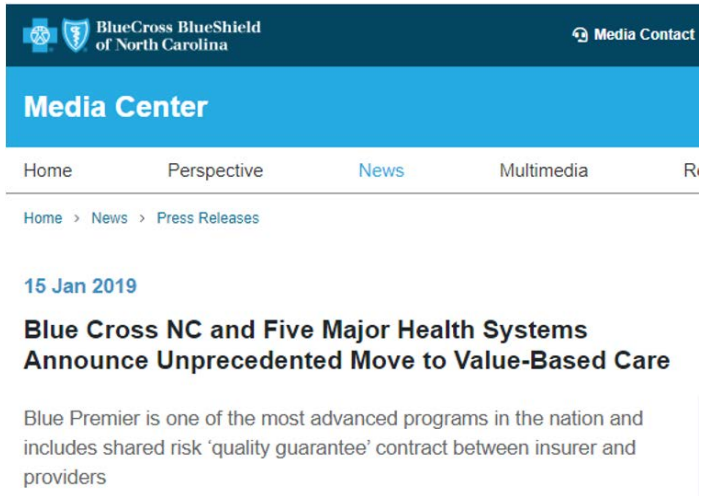
PGY-1 Residency Positions Offered, Filled, and Filled with U.S. MD Seniors

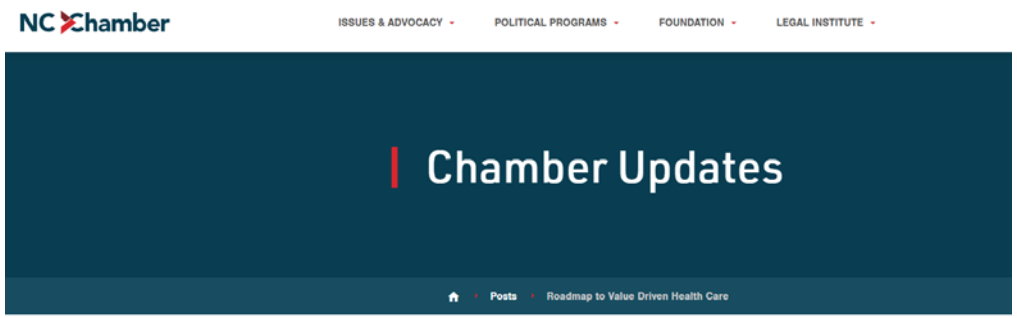
Projected generalist physician supply vs. demand for US adults



Colwill et al., Health Affairs, 2008:w232
Petterson et al, Ann Fam Med 2015;13:107







UNC SENIOR ALLIANCE
UNC HEALTH CARE

UNC HEALTH ALLIANCE
UNC HEALTH CARE

PCP Attribution List Updates

Read the two key reasons why the PCP attribution updates are important.

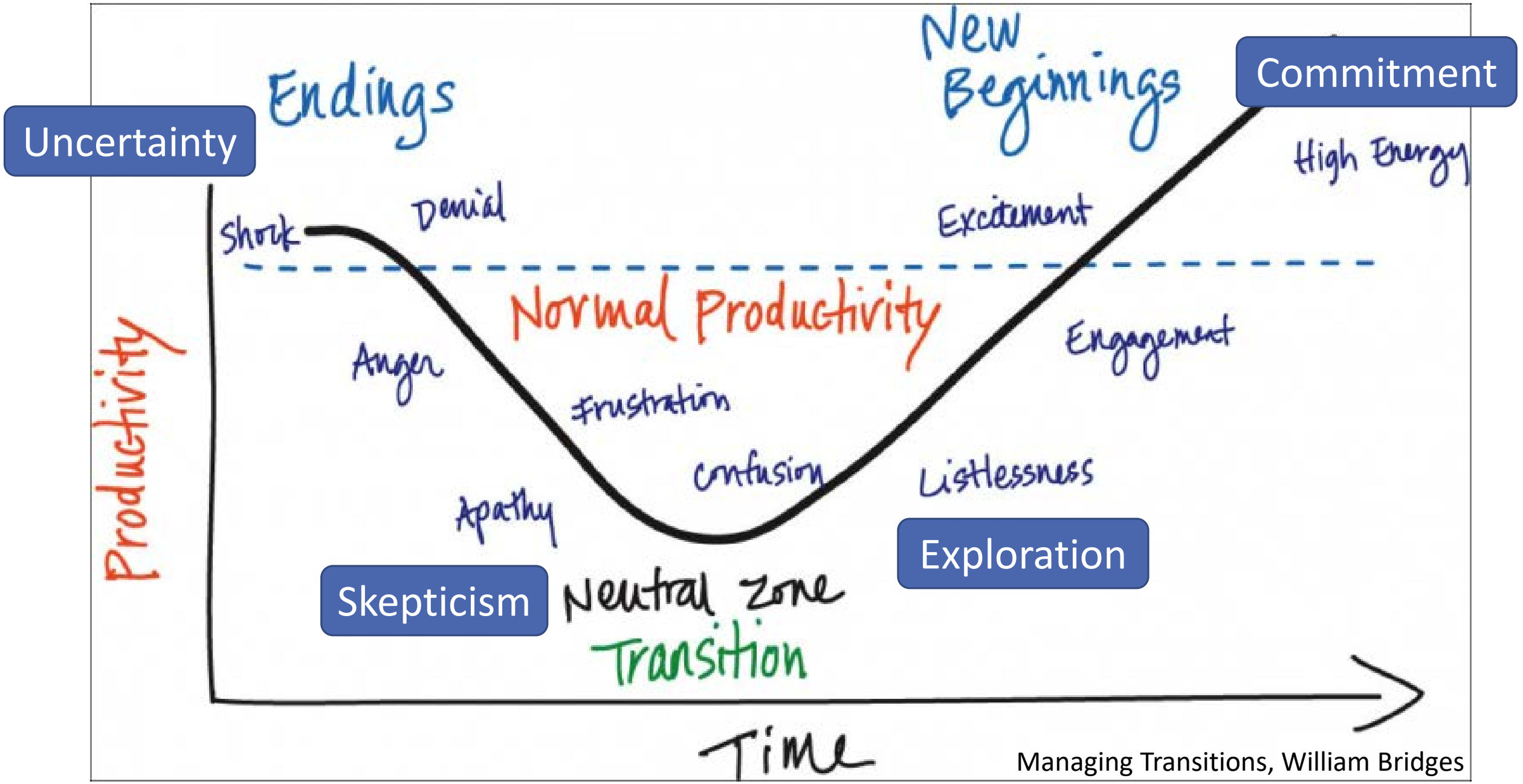
Updated attribution lists are now available in EPIC for primary care providers. As a reminder, updates to attribution lists will occur during the first week of each month. Please note that these attribution lists are for primary care provider types only (Internal Medicine, Family Medicine, Geriatrics, GYN).

Two key reasons for EPIC PCP attribution updates:

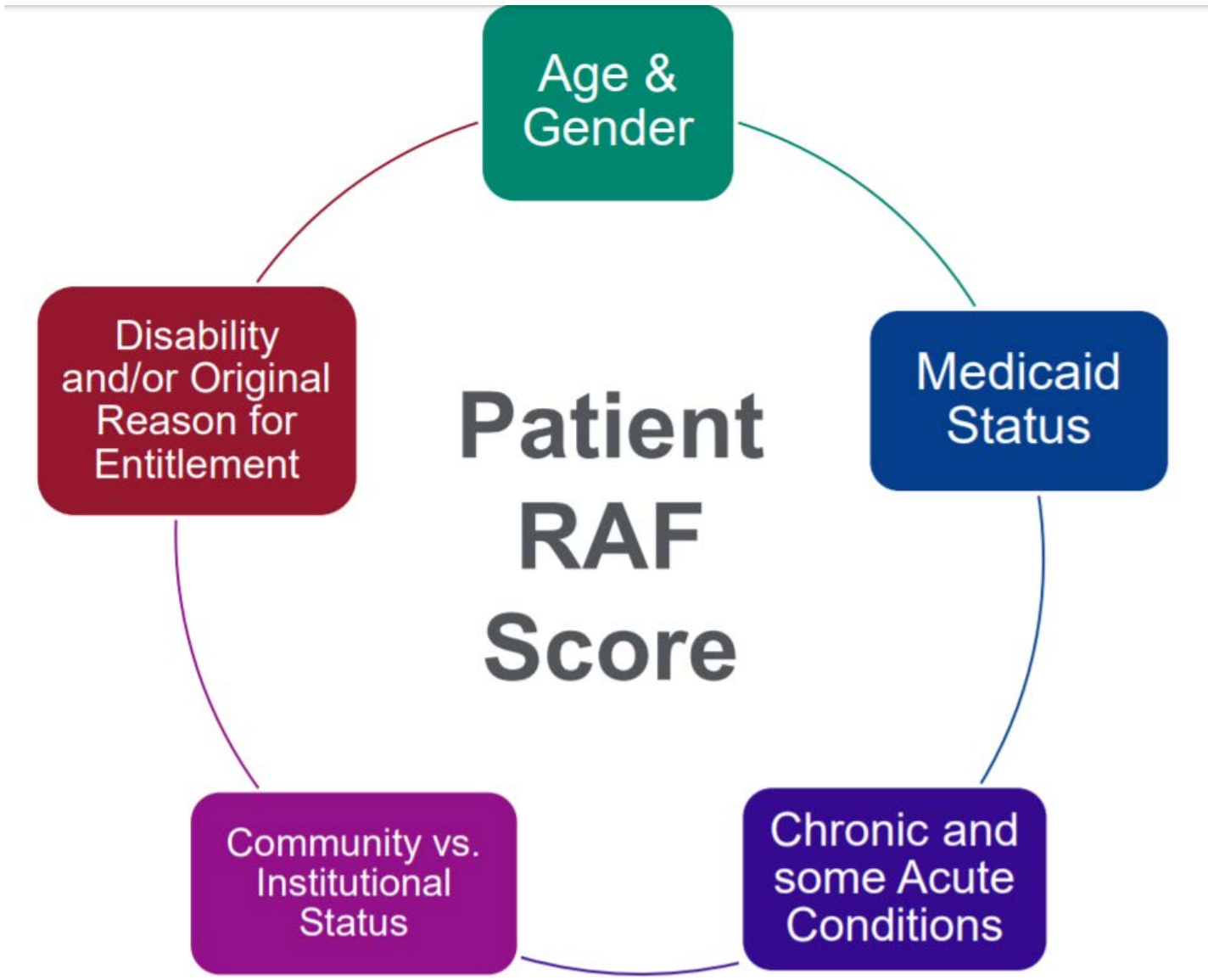
1. To ensure all patients are assigned to a PCP in EPIC.
2. To ensure patients are assigned to the PCP providing the majority of their care. Since patient encounters drive quality scores, it is important to make sure that these quality scores are accurate.

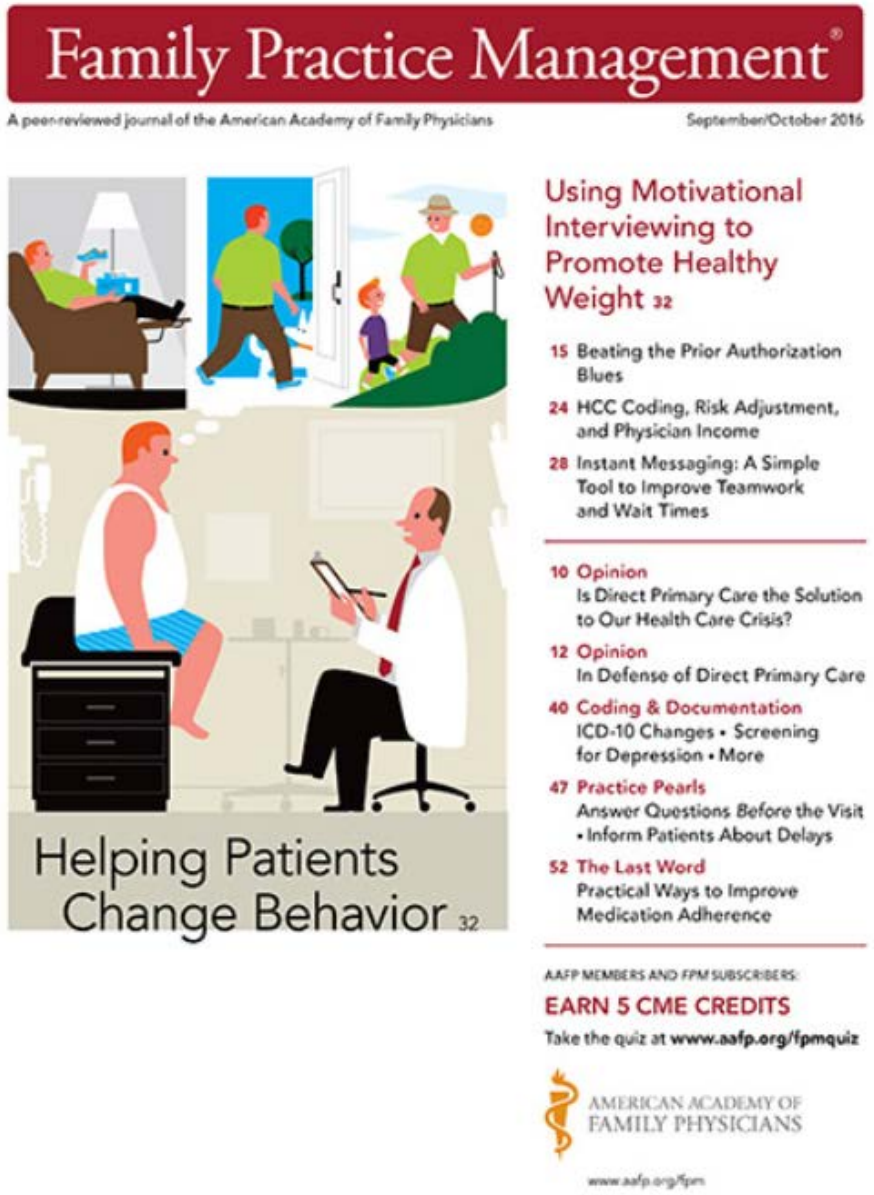
Click here to review a clarification document distributed by the PQI analytics team.

Click here to review a tip sheet for running your attribution report.



Managing Transitions, William Bridges


Age & Gender
Medicaid Status
Chronic and some Acute Conditions
Community vs. Institutional Status
Disability and/or Original Reason for Entitlement
Patient RAF Score

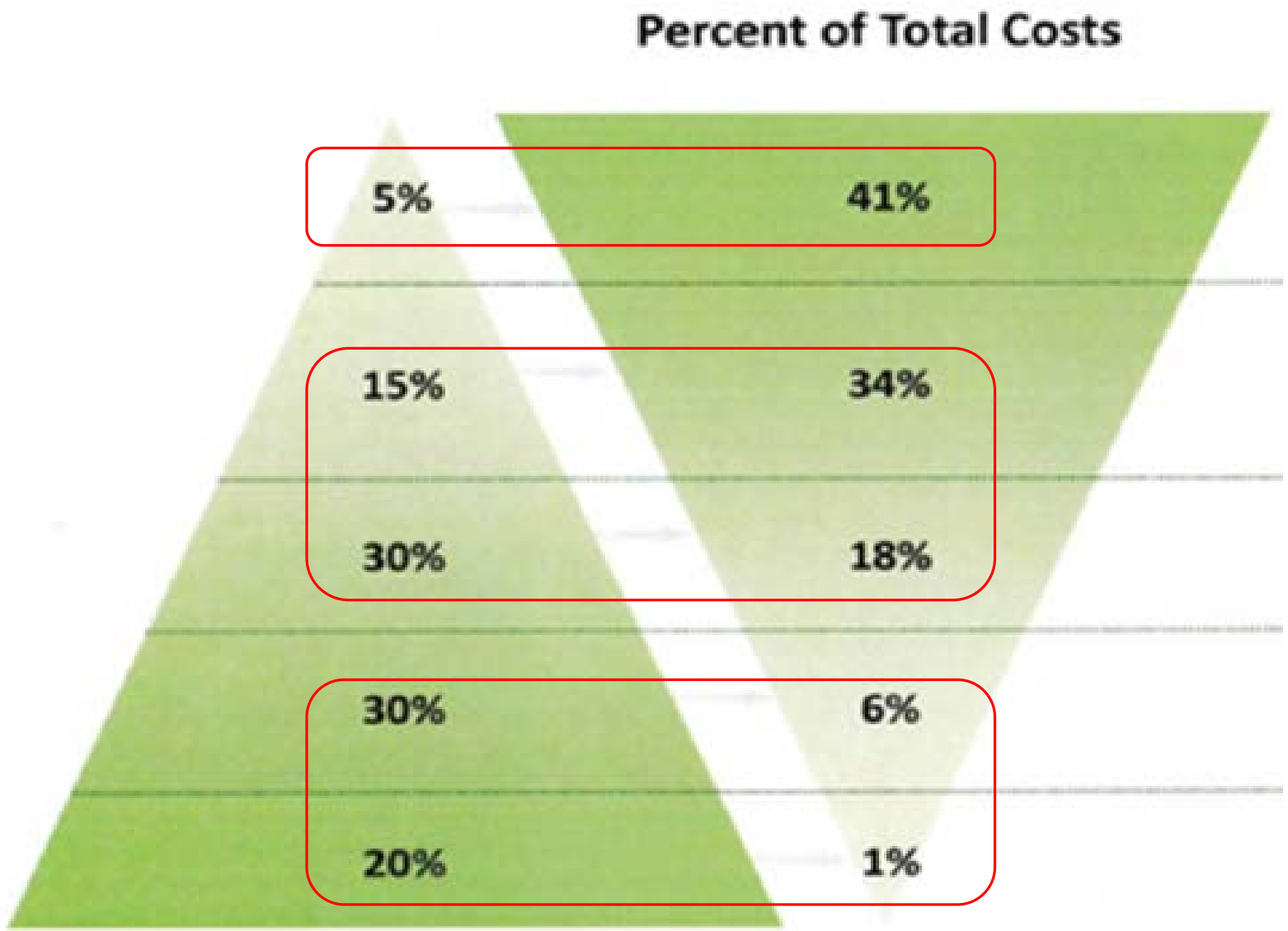


CDPS – Chronic Illness and Disability Payment System (Medicaid)
CMS-HCC – Hierarchical Condition Classifications (Medicare)
HHC-HCC – HHS HCC Model (ACA)
DRG – Diagnosis Related Groups (Inpatient)
ACG – Johns Hopkins Adjusted Clinical Groups (Outpatient)
MARA – Milliman (Outpatient/Ambulatory)

Beyond Our Capacity

THE TRANSFORMATION OF THE PHYSICIAN CULTURE

Stratified Population



Observation #8

Prepare for a Bumpy Ride

At times regulations conflict with what policy makers and CMS expressly desire – better coordination, more communication, better integration, and linking pay to outcomes.

Example 1: Clinical Quality Metrics

42 CFR § 411.357 - Exceptions to the referral prohibition related to compensation arrangements

For purposes of § 411.353, the following compensation arrangements do not constitute a financial relationship:

- Stark Law: Compensation of physician that has any construed connection to the volume or value of referrals is expressly forbidden, unless a specific exception is granted.
- A strict liability statute, meaning that proof of specific intent to violate the law is not required.
- Exception list of out of date

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Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services

MLN Matters Number: MM10181 Revised | Related Change Request (CR) Number: 10181
Related CR Release Date: August 18, 2017 | Effective Date: January 1, 2018
Related CR Transmittal Number: R3844CP | Implementation Date: January 2, 2018

Note: This article was revised on February 9, 2018, to reposition text under different headers on page 2. All other information is unchanged

BACKGROUND

Replacement of Mammography HCPCS Codes

Effective for claims with dates of service on or after January 1, 2018, the following HCPCS codes are being replaced:

- G0202 - "screening mammography, bilateral (2-view study of each breast), including computer-aided detection Computer-Aided Detection (CAD) when performed"

- G0204 - "diagnostic mammography, including when performed; bilateral" and
- G0206 - "diagnostic mammography, including CAD when performed; unilateral"

These codes are being replaced by the following CPT codes:

- 77067 - "screening mammography, bilateral (2-view study of each breast), including CAD when performed"
- 77066 - "diagnostic mammography, including (CAD) when performed; bilateral" and
- 77065 - "diagnostic mammography, including CAD when performed; unilateral".

As part of the January 2017 HCPCS code update, code G0389 was replaced by CPT code 76706. Type of Service (TOS) "5" was assigned to 76706, and the coinsurance and deductible were waived.

Effective January 1, 2018, the TOS for 76706 will be changed to "4" as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Summary of Changes: For claims with dates of service January 1, 2017, through December 31, 2017, report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018, report CPT codes 77067, 77066, and 77065 respectively.

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Home > Medicare > Physician Self Referral > Code List for Certain Designated Health Services (DHS)

Physician Self Referral

- Spotlight
- Advisory Opinions (AOs)
- Call Center
- Code List for Certain Designated Health Services (DHS)
- CPI-U Updates
- Current Law and Regulations

Code List for Certain Designated Health Services (DHS)

We maintain and annually update a List of Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes (Code List), which identifies all the items and services included within certain DH categories. We update the Code List to conform the list to the most recent publications of CPT and HCPCS and account for changes in Medicare coverage and payment policies. The updated Code List is published in the F Register as an addendum to the annual Physician Fee Schedule final rule. That rule is usually published in and generally becomes effective January 1 of the following year. In addition, we may publish other rules notices that may change the Code List. We post any changes to the Code List on this webpage as soo after publication in the Federal Register.

File Window Help

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Find CPT

77067 Find

CPT CODE	DUP	SHORT DESCRIPTO
77061		BREAST TOMOSYNTHESIS UNI
77062		BREAST TOMOSYNTHESIS BI
77063		BREAST TOMOSYNTHESIS BI
77065		DX MAMMO INCL CAD UNI
77066		DX MAMMO INCL CAD BI

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

The following tests,if performed for screening purposes, are eligible for use with th

77063	Breast tomosynthesis bi
77067	Scr mammo bi incl cad
80061	Lipid panel [only when billed with ICD-10-CM code Z13.6]
81528	Oncology colorectal scr
82270	Occult blood feces
82465	Assay bld/serum cholesterol [only when billed with ICD-10-CM code Z13.6]
82947	Assay glucose blood quant [only when billed with ICD-10-CM code Z13.1]
82950	Glucose test [only when billed with ICD-10-CM code Z13.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-10-CM code Z13.1]
83718	Assay of lipoprotein [only when billed with ICD-10-CM code Z13.6]
84478	Assay of triglycerides [only when billed with ICD-10-CM code Z13.6]
G0103	PSA screening
G0106	Colon CA screen;barium enema
G0118	Glaucoma scrn hgh risk direc
G0120	Colon ca scrn; barium enema
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0328	Fecal blood scrn immunoassay
G0432	EIA HIV-1/HIV-2 screen
G0433	ELISA HIV-1/HIV-2 screen
G0435	Oral HIV-1/HIV-2 screen
G0475	HIV combination assay
G0476	HPV combo assay CA screen
G0499	HepB screen high risk indiv
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys

Example 2: Fair market value

42 CFR § 411.357 - Exceptions to the referral prohibition related to compensation arrangements

(c) *Bona fide employment relationships* - Any amount paid by an employer to a physician (or immediate family member) who has a *bona fide* employment relationship with the employer for the provision of services if the following conditions are met:

- **(1)** The employment is for identifiable services.
- **(2)** The amount of the remuneration under the employment is
  - **(i) Consistent with the fair market value of the services**; and
  - **(ii)** Except as provided in paragraph (c)(4) of this section, is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.
- **(3)** The remuneration is provided under an arrangement that would be commercially reasonable even if no referrals were made to the employer.
- **(4)**Paragraph (c)(2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician).

Fair Market Value

- as determined by legal or consulting actuarial service
- tied to best data sources available – examples:
  - MGMA
  - AMGA
  - Merritt Hawkins
- Value Based Care leading to quality bonuses, Shared Savings, or higher cap rates related directly to Physician performance may not be able to be included in physician compensation!