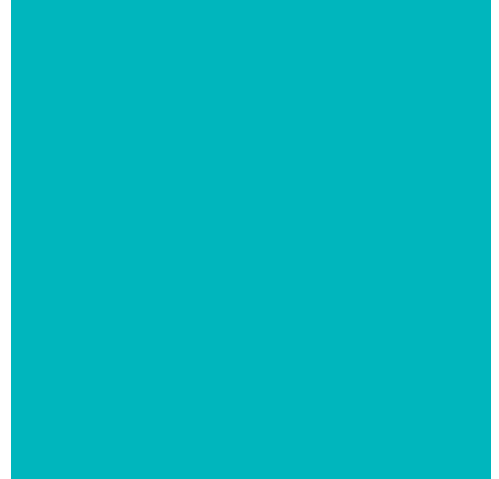
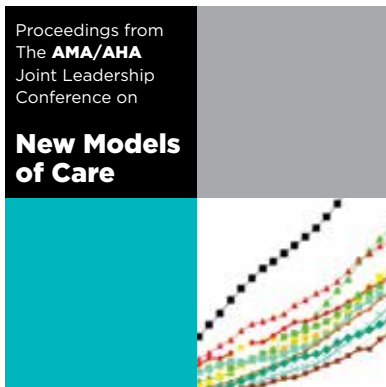




Proceedings from  
The **AMA/AHA**  
Joint Leadership Conference on  
**New Models of Care**





The American Hospital Association's and American Medical Association's *Joint Leadership Conference on New Models of Care* furthered the conversation among health care provider organizations, clinicians, and policymakers on the need for greater alignment to meet the goals of a more effective delivery system.

Participants included knowledge leaders successful in integrating the administrative and clinical aspects of health care delivery which is essential to providing the most efficient, effective, high quality, and seamless care delivery.

The following proceedings share the themes and key insights from the October 2013 meeting.

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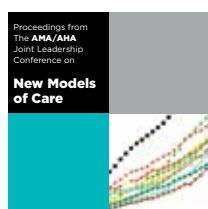
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# Introduction

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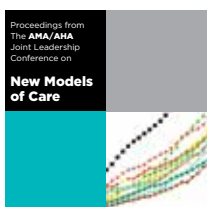
**WITH THE ONSET** of health care reform, provider organizations and clinicians need to work together to achieve the Triple Aim of better health, better health care and lower cost. To encourage efficiency and high-quality outcomes, providers need to align financial structures and incentives, foster a culture that respects both the perspective of the clinician and the economic realities of the organization, and develop an operational structure that encourages the judicious management of clinical resources to improve individual outcomes and the population's health.

These changes can only be achieved through true partnership and alignment of clinicians and provider organizations focused on the needs of the communities they serve. On October 9-10, 2013, the American Medical Association (AMA) and the American Hospital Association (AHA) held the *Joint Leadership Conference on New Models of Care* to expand the conversation between and among health care provider organizations, clinicians, and policymakers on how to create a more efficient and effective care delivery model.

The integration of the administrative and clinical aspects of health care delivery at all levels will be essential to reach the most efficient, effective, high-quality and seamless provision of care. The program began with panels addressing three fundamental aspects of physician-hospital integration: financial, cultural, and operational considerations. Each panel focused on how the specific area of integration could be addressed in both health policy and practical terms, including strategies to overcome internal and external obstacles to progress.

The second day included presentations by four health systems from different geographies, different marketplaces, and different patient populations, all of which have created a successful model of physician-hospital alignment and integration. In total, the program highlighted 10 health care delivery systems from across the country, with different models of physician involvement and engagement, all of which are proving to be successful.

The AMA and AHA hope sharing these proceedings will shine a light on best practices as well as increase the discussion and collaboration to move the health care field forward towards new models of care delivery.



# Welcome and Opening Comments

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## American Hospital Association

Benjamin K. Chu, MD, chairman, Board of Trustees  
Richard J. Umbdenstock, president & CEO

## American Medical Association

David O. Barbe, MD, MHA, chairman, Board of Trustees  
James L. Madara, MD, executive vice president & CEO



Chu



Umbdenstock



Barbe

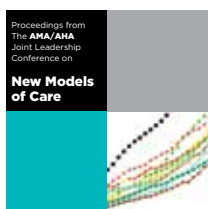


Madara

**TO SET THE STAGE**, the AHA and AMA leadership shared thoughts regarding the conference purpose and ways in which physicians and hospitals can work together to drive new models of care delivery.

Developing more efficient and effective care delivery systems is imperative as patients and providers look for greater collaboration in the continuum of care and fewer silos. Relationships between physicians and hospitals are improving at a faster rate than ever before, but it will take a full team approach to move to the next model of care delivery.

Teamwork is necessary to drive better outcomes. Current examples show what can happen when a whole team is on the same page for the right reasons. The models presented at the *Joint Leadership Conference on New Models of Care* offer insight and guidance in how to achieve the Triple Aim with strong physician-hospital relationships. There is not one model for the future of health care delivery, but many. Only by working together can solutions to meet each community's needs be determined.



Physician-hospital relationships in the past have often been rocky. There have been struggles to find the right model for that relationship in many communities. While there are exceptions and shining examples of robust relationships, as care delivery continues to move forward, there will be less natural physician interaction in the hospital setting, particularly for community-based primary care providers. Physicians must work in a strong and equal partnership with hospitals to drive real change and create the models that will address the care needs of the future.

It is important to understand how physicians and hospitals interact and the ways in which collaboration can be increased and improved. Health care delivery must focus on building social capital – developing relationships and bridges between physicians and hospitals – as a foundation for creating the successful models that are reaching across the divide.

In addition to convening the joint conference, both the AHA and AMA have taken steps to foster strong physician-hospital relations. The AHA established the Physician Leadership Forum, which seeks to advance excellence in patient care through these partnerships. The very morning the conference convened, the AMA in partnership with the RAND Corporation, released a research report, *Factors Affecting Physician Professional Satisfaction, and Their Implications for Patient Care, Health Systems, and Health Policy*. Understanding what drives physician satisfaction is a key element to bridging the silos in health care delivery.

# Keynote Address

**Geisinger Medical Center, Pennsylvania**  
Glenn D. Steele Jr., MD, PhD, president & CEO

Dr. Steele set the tone for the conference. Under his leadership, Geisinger has advanced the model of physician-led, jointly-managed, fully-integrated care delivery. Geisinger was an early innovator in the use of electronic health records that span and integrate physician office and inpatient care sites. In addition, Geisinger has advanced patient safety techniques across care settings and introduced new payment processes bringing together the interests of caregivers, payers, and patients. In his remarks, Dr. Steele explored the value of and obstacles to spreading these and other innovations nationwide.

Geisinger's philosophy and experience demonstrate that patients can be treated more efficiently and effectively where they are, even if it is a non-Geisinger hospital. Geisinger has found value in moving care to the most appropriate setting, often out of the hospital and close to patients' homes. The Geisinger model's preferred solution is for expertise to be available in the primary care office utilizing different technologies.

Geisinger's model, while efficient and effective in its geographic market, may or may not be scalable, and is absolutely not generalizable without fundamental change, but the underlying principles upon which it rests are those that will help drive health reform forward. For example, Geisinger credits the development and strong commitment of physician leaders as one of its elements for success, which can

be translated across markets and settings. Physician leadership has been a key driver for Geisinger as evidenced by their treatment protocol program, ProvenCare, and consensus building necessary to create and implement the program.

Dr. Steele highlighted the importance of incentives in driving change, but emphasized they are just one tool and cannot change behavior alone. At Geisinger, all change is measured by whether patients do well and the reengineering improves outcomes and decreases costs.



## KEY TAKEAWAYS

### Structure

Situated in rural Pennsylvania, Geisinger is structured to provide care across the continuum with primary care, acute and post-acute care, and a health plan covering more than 400,000 lives in a 43-county area. A significant amount of care is provided by non-employed physicians, and all Geisinger hospitals are open staff.

One of the ways Geisinger is able to improve outcomes while decreasing cost is through their owned health plan. By managing both the payer and provider sides of the equation, Geisinger has been able to redistribute financial gains from reengineering care delivery to the areas that drive the best care improvements. Savings often are from the hospital or the insurance company while the care delivery model

changes are happening at the clinic and physician office level. By managing the risk, Geisinger is able to distribute savings realized to those driving change, as well as with employers through premium reductions.



## Quality and Innovation

Physician leadership is critical to the Geisinger model of care delivery. Physicians are driving quality and innovation by leading other physicians through fostering ownership and buy-in. Establishing physician leadership has been intentional and structured. Geisinger provides training for current and future leaders, and pairs physicians and administrators who are expected to work together as a team, understanding the role each plays in managing the clinical enterprise.

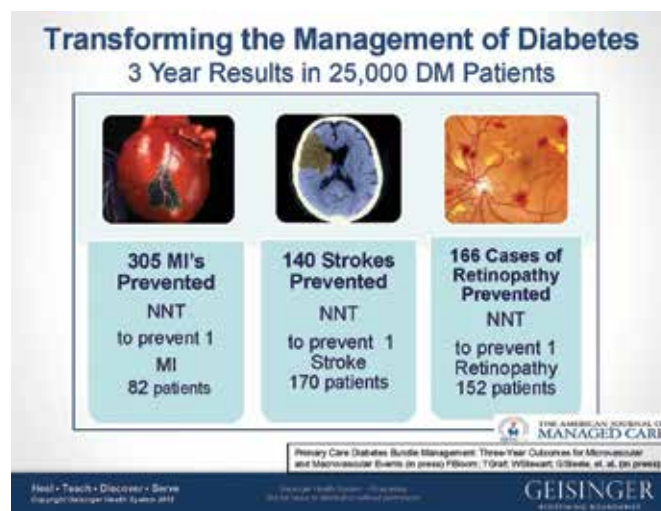
A culture of physician leadership taps into physicians' desires to see better outcomes for patients while at the same time extracting costs. With a common and shared vision, physicians are empowered to lead, to make changes and to practice medicine.

At Geisinger, reengineering care must create value. That which is not optimal care delivery is extracted and redeployed. Geisinger's reengineering efforts have resulted in several initiatives such as ProvenCare, an advanced medical home model. Geisinger started hospital-based reengineering with a successful practice, interventional cardiology, and

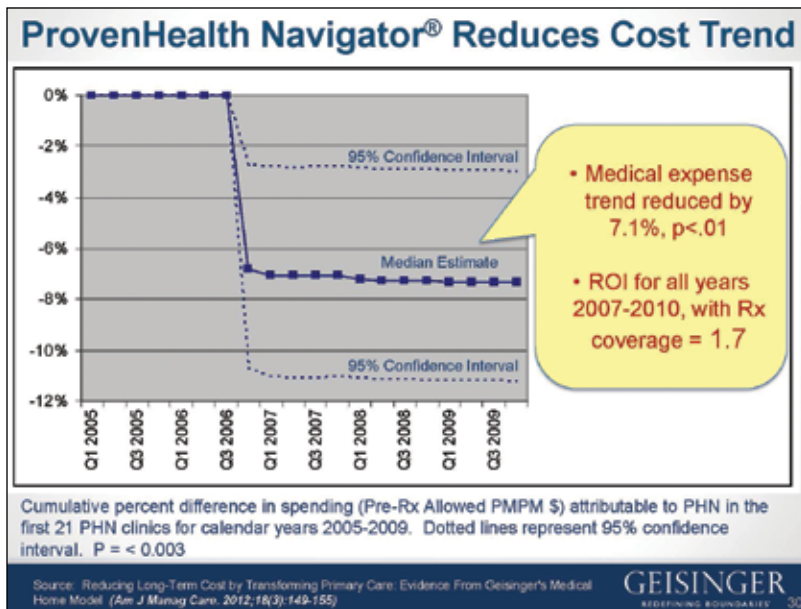
developed the ProvenCare model for acute episodic care. Through an 18-month consensus process, physicians and administrators developed protocols of best practices from diagnosis to rehabilitation. Next they gained unanimous support for complete adherence to the protocols with any variation documented in the medical record. The consensus process adapts to changes in medical science and allows for appropriate variability while maintaining evidence-based standards that drive efficient and effective care. Geisinger's results indicate that ProvenCare drives high reliability with 96.6 percent of patients receiving all best practice elements as well as realizing savings.

The success of the initial ProvenCare model has led to the development of similar programs for acute episodic care, chronic disease, an advanced medical home and a program to improve transitions of care. Additionally, ProvenCare has received market affirmation as exemplified by the "Centers of Excellence" program, providing care for Wal-Mart employees. Increasing market share in this way is revolutionary in health care, but possible because of the demonstrated efficiency of ProvenCare models.

Geisinger's patient-centered medical home, ProvenHealth Navigator, embeds nurses into practices armed with insurance information. The nurses provide triage services to the sickest patients – those with multiple chronic conditions. In addition, navigators work with the elderly to manage transitions of care and lengths of stay by working with local nursing homes. Both programs have reduced hospitalizations and re-hospitalizations, and decreased overall costs.







Geisinger's health plan has allowed for innovations to develop and grow and prove their value to the organization. Once successful, innovations that add value are rolled out throughout the system.

### Incentives

Incentives are aligned with the strategic aims of quality, patient-centeredness, expanding the model and reengineering care delivery. The strategic aims are set by the board and senior management

and communicated across the organization. Each service line, however, is responsible for developing innovations specific to their discipline-based division. Consensus building occurs at every level – from setting strategic aims to establishing innovations – to ensure all efforts coordinate with other choices in the organization. Twenty percent of compensation is available for incentives based on whether the quality metrics of specific innovations are achieved. Incentive compensation jumps to forty percent for leadership based on achieving the strategic aims. While incentives are important, professional leadership *with* incentives is the key to a successful model.

### Next steps

Geisinger is putting pieces in place to address the next opportunity - population health management. While Geisinger is working to extend its brand and tackle how to scale and generalize to other markets, there is a concern of becoming distracted from the core commitment. What is unknown is whether size increase will move Geisinger away from the core mission of treating patients. Dr. Steele shared that he is not worried about the chaos that is occurring writ large. He believes the industry will get through it, and looking back describes it as an amazing time of transformation.

Geisinger also has experimented with technology to bring specialty care to rural areas. Use of eICU technology, primary care e-visits and specialty consults via telehealth have increased care availability for more remote service areas, allowed patients to be treated closer to home, and reduced overall costs while maintaining high-quality, patient-centered care.

The use of technology also has helped spark patient activation through the Open Notes program, which allows patients to review and comment on notes in their electronic health record. Data thus far indicate 90 percent of patients review visit notes, 60 percent log in multiple times, and 25 percent correct errors in the record - showing the potential to fundamentally redefine the relationship between patients and providers.

Dr. Steele emphasized the key role that data plays in the ProvenCare initiatives, from the best practice bundles to providing practitioners with patient data as close to real-time as possible. He shared his vision of a future state beyond company-specific EHRs where data and analyses could be shared and delivered in real time. Clinicians need real-time, customizable and usable data from all aspects of care delivery to understand how to best treat the patient in front of them; a time lag is no longer acceptable. In addition, health delivery systems, insurance companies and population health managers need to understand the community health data to be able to best deploy scarce resources to do the most good for the overall health of the community.

# Financial Considerations in New Models of Care

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Safran



Lloyd



Lopez



West



Nielsen

*Presenters:* **Blue Cross Blue Shield of Massachusetts**  
Dana Gelb Safran, ScD, senior vice president, Performance Measurement and Improvement

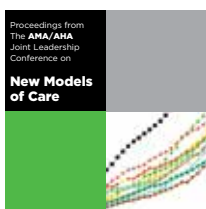
**MHMD Memorial Hermann Physician Network, Texas**  
Chris Lloyd, CEO

**PIH Health, California**  
Leo J. Lopez, MD, MBA, senior vice president & chief medical officer  
Jim West, president & CEO

**University at Buffalo School of Medicine, New York**  
Nancy Nielsen, MD, PhD, senior associate dean for health policy

## OVERVIEW

The integration of the administrative and clinical aspects of health care delivery at all levels will be essential to reach the most efficient, effective, high-quality and seamless provision of care. The panel discussed the future of population-based risk bearing by integrated systems, the advantages and disadvantages of different models of shared savings and how to manage associated regulatory issues.



## KEY TAKEAWAYS

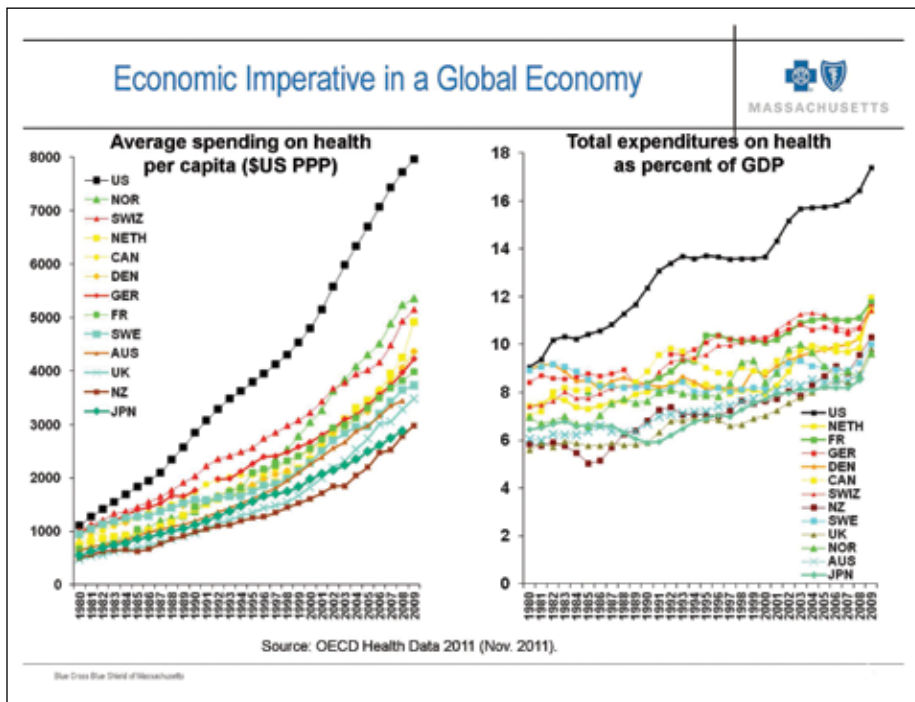
### The Problem

By any measure, whether per capita spending or percent of GDP, the U.S. spends more than every other developed country on health care, and the rate at which spending is growing is significantly faster than those other nations.

Care coordination is needed to both reduce variation and to deal with post-discharge costs which exceed hospital-related costs by more than 100 percent.

the sharing of broader data on patients and ways in which to best organize and administer their care.

The four panelists highlighted models that include shared financial risk across the continuum of care from hospitals to physicians to payers, to better coordinate and understand resource use across the continuum of care delivery. Each presented a unique approach to bringing the various stakeholders together into a more efficient and effective collaboration.



### Approach

Dr. Nielsen suggested that as a field, we study data on cost and utilization and design a payment model that supports change toward increased collaboration and coordination while reducing variation. Currently, there are tremendous variations in practice and costs which are not readily explained by patient need; while studies have shown an inverse relationship between quality and cost. To ensure we are providing the highest quality and most efficient care, work is underway through various campaigns to address variation. For example, the Choosing Wisely campaign, where each specialty can identify overused

According to Mr. Lloyd, problems inhibiting progress include the silos in which physicians, hospitals, and insurers work, a lack of data and data sharing, and unnecessary care in the system from inefficiencies, errors, and complications. Mr. Lloyd suggested the first order of business is to understand how to defragment the market so physicians and hospitals can come together and address global cost and quality measures.

Mr. West also spoke of a lack of integration, not just between physicians and the hospitals, but with health plans. This connection with insurers could provide significant advantage to care coordination through

services that should be discussed between a patient and physician before proceeding, is aimed at a more appropriate use of finite care resources. Electronic medical records, checklists, guidelines, registries and performance measures also offer opportunities to decrease variability, improve outcomes and manage costs. These new models of care must also become more patient-centered. Dr. Nielsen emphasized the importance of all participants in the health care arena working together to bring about these changes. All providers will need to practice at the top of their license and provide care as part of a team. This team-based care delivery, a change in the payment system to move toward

population-based pay, and greater integration will all be key factors in the new models of care.

Dr. Safran presented the BlueCross BlueShield of Massachusetts payment model, known as the Alternative Quality Contract (AQC), created in the early days of implementing state coverage reform with the twin goals of significantly reducing medical spending growth while significantly improving quality and outcomes. The AQC model is distinct from traditional provider contracts in that it requires provider organizations to accept accountability for their patient population across the full continuum of care, from prenatal to end-of-life and everything in between, regardless of where care is delivered. Provider organizations accept accountability for cost, quality, and outcomes. Payment is based on a global budget, which is set at baseline according to historic spending for each provider's unique patient population and risk-adjusted throughout the five-year contracts to account for changes in the population mix. Inflation on the budget is established in advance for each year of the contract to allow providers to plan for managing total resources over time. The AQC model includes two-sided risk, so providers share in savings achieved in a budget year, but also sharing in deficits when those occur. A unique feature of the AQC model is its emphasis on quality and outcomes measurement and rewards. The contract includes a robust set of 64 quality measures that encompass ambulatory and hospital care, including measures of clinical process, outcomes, and patient care experience. In the initial two rounds of 5-year contracts (2009, 2010), providers could earn up to an additional 10 percent on the global budget for performance on these measures. Starting with 2011 contracts, these incentive offerings were moderated, though they remain significantly greater than traditional pay-for-performance incentives, and the quality score is now also used as a gate that defines the extent of shared savings or deficit payment for an AQC group each year. To support success on both cost and quality goals, AQC participants also receive a wide range of ongoing data sharing, analytic reporting, consultative support and best practice sharing from BlueCross BlueShield of Massachusetts.

Mr. Lloyd described the Memorial Hermann path

towards increased integration and the creation of the Memorial Hermann Physicians Network (MHMD), which includes 3,900 physicians. In a marketplace where the average physician practice has fewer than two people, there is low physician employment, and there are multiple large health systems, the first order of business was to understand how to defragment the market so hospitals and physicians could come together to address global cost and quality measures.

Rather than an employment model, MHMD includes 2,000 physicians participating in a clinically integrated network, 650 affiliated with the University of Texas Health Science Center and about 200 employed physicians. In order to come together as a physician and hospital organization and effectively reduce variation, Mr. Lloyd shared the work of Memorial Hermann Physician Network's clinical programs committee. The committee involves more than 800 physicians meeting in specialty-based groups, tasked with the responsibility of writing order sets and setting standards for the health care system. There are structures that support this effort capable of developing order sets through a rapid cycle consensus process that are then "hard wired" into the care system. This type of system has large financial implications, but the reduction in variation and improvements across the system paid dividends once it gained traction among the medical staff. Mr. Lloyd credited the delegation of responsibility to the independent physician association for all order set development, outcome measures, standards, and clinical pathways as key to the organization's ability to move towards accountable care and use data to improve care delivery.

Mr. West and Dr. Lopez set a goal to create a model of care that integrated with a health plan, which aligned incentives but didn't pose a significant downside risk to the health system. They approached an insurance company, CareMore, to move from Medicare fee-for-service to Medicare Advantage. They wanted to align the three "legs of the stool" but not own all three. The model is a shared financial partnership with joint management and variable risk over a 10-year period. PIH provides the physician and hospital services while CareMore provides the Medicare Advantage plan. They work together to create order sets and processes to focus on two goals, first get members enrolled in the CareMore plan and second, keep them in their homes for care delivery as much as possible. Key

## Delivery System Innovation: Four Themes



There are four domains in which we see AQC Groups innovating to improve quality and outcomes while reducing overall spending



providers now have access to data allowing them to manage their population more effectively. Finally, the accountability model of the AQC has created some new types of referral relationships that are helping to drive increased integration across care settings, again to support better outcomes and more efficient care.

Driven by the strong belief that there is unnecessary care in the system from inefficiencies, errors, and complica-

tions, MDHD made it their mission is to have 100 percent of services add value to the care delivered. However, the system is not currently set up to for this. From the silos in which physicians, hospitals, and insurers work to the lack of data and data sharing, there are numerous areas for improvements. To address these challenges, MHMD focused on de-fragmenting not only the physician community and the hospital community, but also on employing data and technology to bridge gaps and ensure a common vision. Mr. Lloyd credited three key factors in their move toward more integrated and efficient care:

to their success was keeping the providers in the community engaged and involved in the process with a strict focus on the patient as the center of care coordination. From enrollment onward, patients receive a comprehensive assessment to understand their needs and goals and to design a care plan to best address those needs with the ultimate goal of avoiding or reducing admissions where possible. The model focuses significant resources and efforts to address potential issues before patients require hospitalization to control costs and improve outcomes.

### Innovations

In order to improve quality and outcomes while reducing overall spending, Blue Cross Blue Shield of Massachusetts AQC participants have demonstrated innovation in four domains: new staffing models, new approaches to patient engagement, data systems, and changes in referral relationships. Staffing changes at providers participating in the AQC include the addition of social workers, case managers and other clinicians as well as instituting home visits for those particularly at risk for hospital admission or readmission. The AQC participants also have had to increase their focus on patient engagement and the factors that affect health in the community. Held accountable for outcomes, the AQC providers needed to create innovative ways in which to engage their patients as partners in improving their health. Through the AQC,

- An organizational structure that provides physician leadership, as well as administrative leadership, to drive change;
- Reliance on evidence-based medicine to drive clinical protocols; and
- Dedication to sharing information across the continuum and creating unconventional partnerships with uncharacteristic partners to achieve goals.

**Health Reform Distilled** 

**What is needed to drive the Quality & Cost Equation?**

- Organizational Structure
- Commitment to Evidence Based Medicine
- Dedication
- Information
- Partnership in uncharacteristic ways with uncharacteristic partners

For PIH and CareMore, risk sharing has driven more efficient use of resources and treatment of patients in the most appropriate setting, anticipating needs to avoid more costly admissions. Through their partnership with the community providers, a strong help line for patients and robust care coordination, their model is focusing care where it belongs, on the patient at the earliest point of intervention to provide the best outcome.

**KEYS TO SUCCESS**

The panelists agreed that physician leadership and true partnerships are keys to financial success in new models of care. In Massachusetts, each AQC group has put in place a leadership structure makes available data “real” for physicians on the front lines to improve quality and reduce cost.

When discussing partnerships, the presenters emphasized the importance of developing relationships with unlikely, unconventional, and uncharacteristic partners beyond physicians and hospitals. One such collaboration may be with insurance companies, to design products that drive lower premiums, share risk between providers and payers and begin to emphasize an understanding and treatment approach for chronic disease within a population. For example, after a year and a half of negotiations, PIH entered a 10-year contract with insurance company CareMore. Both partners share risk and endeavor to address patient concerns at the earliest possible opportunity to improve outcomes, avoid costly admissions, and improve satisfaction. Mr. West and Dr. Lopez both felt that the fee-for-service system presented too many potential obstacles to good patient care and felt that sharing risk through the Medicare Advantage plan provided incentive alignment towards a more efficient and effective system.

Access to and understanding data, including cost of care, is vital. Concerns have been raised about

compromising ethical principles when considering cost of care, but those can be addressed through a thorough understanding of the studies and data about resource use and how physicians can begin to work outside a fee-for-service model. All providers need to understand costs and be good stewards of limited health care resources. For example, every AQC provider receives a full claims data set every month on their patient population, with a 360 degree view of the care received, and the associated costs. In addition to access to data, the panelists highlighted the need for robust information systems that would harness the available data into effective metrics and guidelines to move the system forward. Mr. Lloyd shared that for actualizing a new care delivery model, MHMD required a sophisticated information system focused on population management and risk stratification, as well as systems for patient interaction. They also have worked to deploy an electronic medical record across the continuum and extract data from the system to drive improvement.

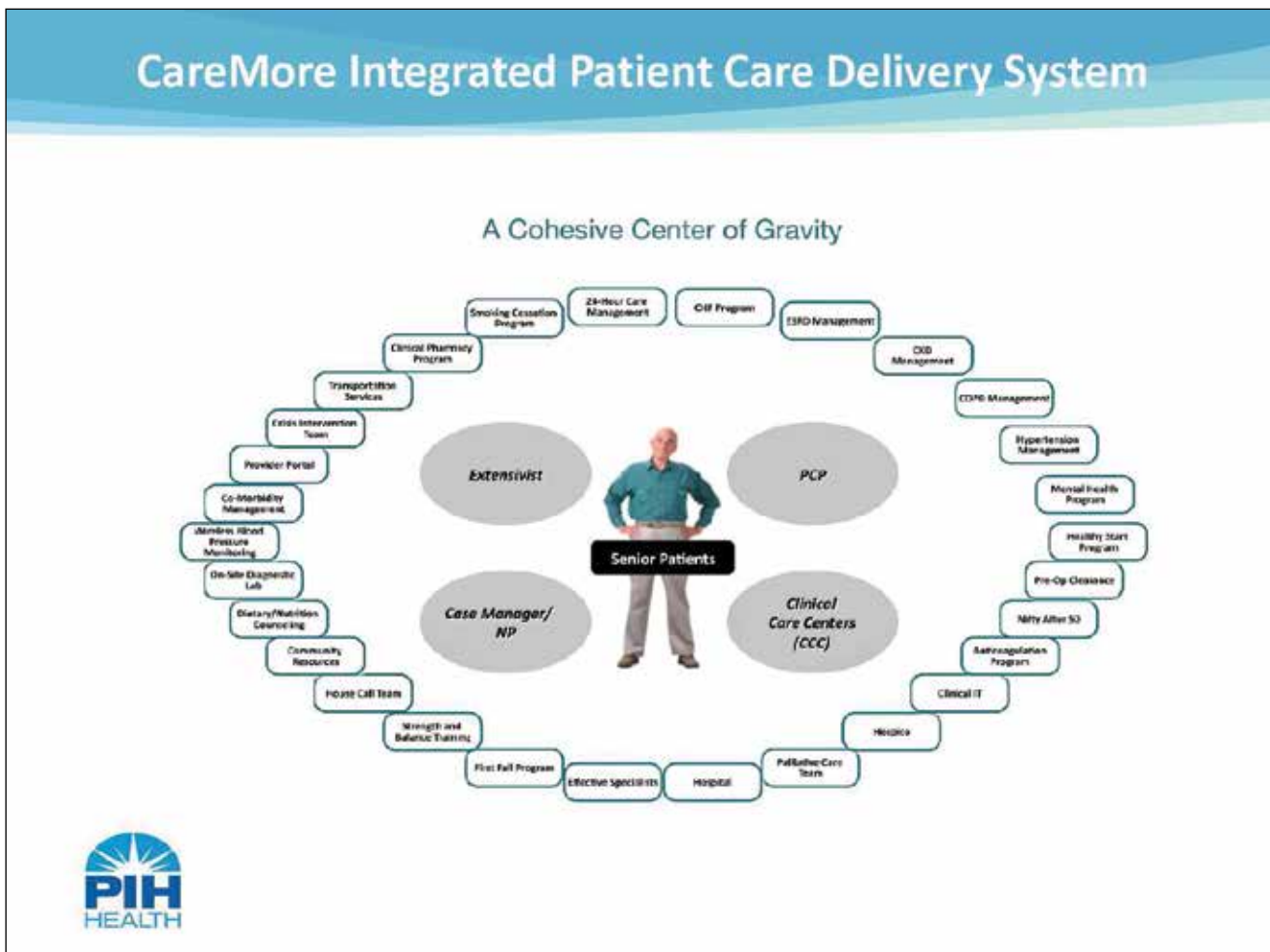
Several panelists echoed the theme of physician leadership from Geisinger’s model. They felt that with strong physician leadership to drive the partnerships between physicians and hospitals, protocols and models could be developed that would drive more efficient care. The panelists agreed that the drive toward evidence-based protocols and care guidelines are key to reducing care variation. The AQC credits, as one of the keys to success, support

for the program quality measures as meaningful and clinically appropriate.

The panelists agreed that incentives were a key ingredient in driving change, but keeping with the Geisinger model, felt that they were only an effective tool when used in conjunction with strong leadership, data and partnership. Mr. Lloyd suggested incentives should focus on system goals over time and migrate to an enterprise-wide compensation system that allows focus on utilization compression and cost management rather than looking at incremental volume. According to Dr. Safran, the use of incentives in the AQC has succeeded due to having significant money at stake as well as the structure of the targets on a continuum of improvement, to allow providers to be rewarded for both attainment and improvement. While these financial incentives are

important drivers, Dr. Safran emphasized that the AQC providers, through increased access to data, are driven to improve care to their patients.

Dr. Nielsen described medicine as facing a Kodak moment. Kodak was the dominant player in the camera industry, invented digital technology, but then sold it because its business model was based on selling film. Kodak is just now emerging from bankruptcy. This is a hopeful time in health care delivery; there now exist many opportunities and incentives to redesign care for the good of patients.



# Cultural Considerations in New Models of Care

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*Samitt*



*McGlynn*



*Levine*



*Casalino*

*Presenters:* **Health Care Partners, California**  
Craig E. Samitt, MD, MBA, executive vice president

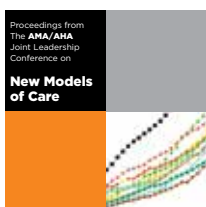
**Kaiser Permanente Center for Effectiveness and Safety Research, California**  
Elizabeth A. McGlynn, PhD, director

**The Permanente Medical Group, California**  
Sharon Levine, MD, associate executive medical director

**Weill Cornell Medical College, New York**  
Lawrence P. Casalino, MD, PhD, chief, Division of Outcomes and Effectiveness Research, Department of Public Health

## OVERVIEW

As new models of care develop, cultural considerations emerge. These considerations must be taken into account in order to ensure the success of any new care model. Some of these considerations include building consensus among health system managers and clinicians on a common patient-centered model of mutual success, bridging longstanding biases between practicing physicians and health system executives, attracting and training physician





leaders and managers who can lead other physicians and be full partners with system managers, and creating a working physician organization out of independent practices sufficient to enable physician engagement in informed and consistent health system cooperative efforts. Keys to success include mutual respect, collaboration, and partnership.

## KEY TAKEAWAYS

### The Problem

Dr. Casalino began the discussion reflecting on the growing trend of physician employment. He highlighted that with so many physicians now working for hospitals a social experiment is occurring, and it isn't clear if physicians would rather be employed by hospitals or are not finding group practices to join. Dr. Casalino raised several concerns regarding the trend of hospitals purchasing physician groups and cautioned the audience to avoid the cultural pitfalls in changing group practice dynamics. He cited several cultural barriers that may be encountered as a physician practice is acquired by a hospital including: lack of trust of unknown hospital-appointed physician leaders, imposition of measures and procedures without consensus, changes in profitability, shifts in staff loyalty, loss of relationships with team members in a more matrixed system, loss of referral networks, lack of connections

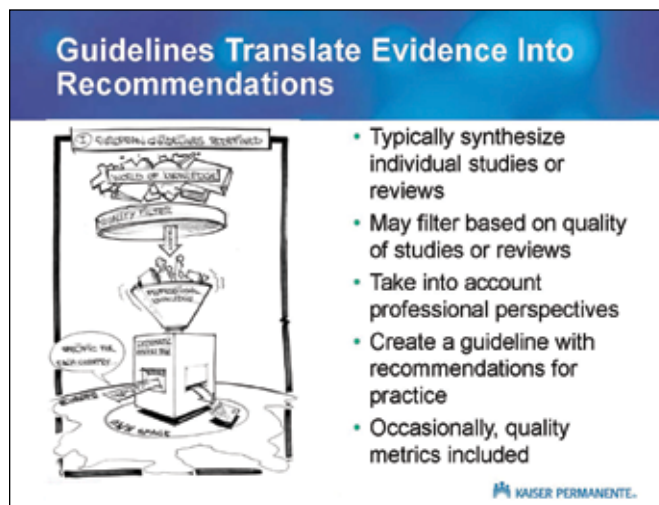
**“If an employee is expected to devote time and effort to some activity for which performance cannot be measured at all, then incentive pay cannot be effectively used for other activities.”**

— P. Milgrom  
*Economics, Organization, and Management*

and collegiality with specialists, and concern that the hospital is not providing help in improving quality in ways important to the practice.

Dr. Casalino also raised a concern regarding the use of incentives and the potential for misuse through measurement of factors not viewed as clinically relevant or sufficiently impactful. Certainly small financial and larger non-financial incentives can improve care, however; focusing too much on financial incentives and not enough on non-financial incentives will decrease professionalism.

Making sure quality measures and incentive targets are meaningful and relevant to improve care is not as easy as it sounds. As Dr. McGlynn explained, many recommendations form the basis of quality measures, but generalizing from evidence to practice can be challenging and the standards for doing so vary. In addition, not all quality measures capture data that can be directly translated into improvement efforts.



## From Silos to Teams

Engaging Physicians as Partners in Care Transformation

Even when evidence matches the population, data collection and scoring can be very difficult with claims data often missing nuances. Even more clinically-sophisticated electronic medical record documentation varies enough to present barriers.

In addition to the difficulty in developing meaningful quality measures that would form the basis of shared goals for an organization, measures focused on population outcomes add to the cultural divide between physicians and hospitals as most physicians focus their efforts on what is best for the particular patient in front of them, not the larger community.

Dr. Samitt highlighted that few organizations have mastered the art of engaging, persuading, inspiring, and aligning physicians as equal partners in the transformation of care, a key factor in building a strong culture of trust between hospitals and physicians.

Culture by definition isn't something you can create in a day or a week or a year. It takes time to create. The best leaders and the best physicians couldn't make a new culture in a short amount of time.

### Approach

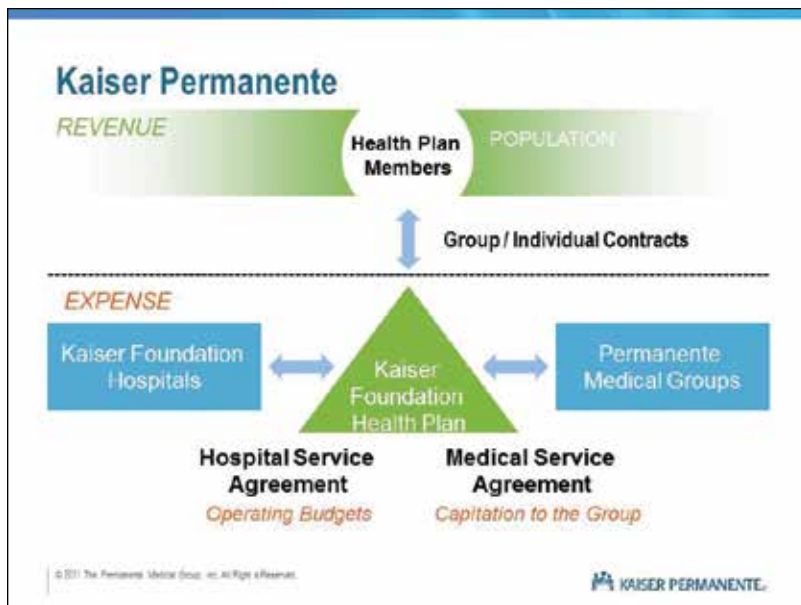
To address the problems of cultural divide, Dr. Casalino suggests fostering a feeling of "being all in this together." It is essential that groups function coherently if they are going to succeed and have hospitals and physicians feel like equal partners. One of the ways to foster this equality is through physician involvement in decision making. Dr. Samitt, too, argues for aligning physicians as equal partners in the transformation of care. Physicians should be involved in the vision and jointly establishing strategic plans. Physicians, hospitals, and health plans all have key assets and talents that should come together around a common vision of better quality at lower cost and a clear understanding that each participant has a unique perspective to bring to the partnership.

At the Dean Clinic, nearly 40 percent of physicians are involved in some way, whether in management, governance, process improvement or designing care solutions. Dr. Samitt believes it's better to ask for

permission than forgiveness. If hospitals treat physicians as employees, if a health plan focuses only on finances, and if physicians seek to treat hospitals or payers as commodities, it's not going to be a true team of equals. When hospitals partner with doctors and health plans as a team of equals, transformation of the health care industry will occur. It is necessary to bring physicians in to a room with hospital administrators and front line staff as equals and ask them to participate in designing a solution. Dr. Samitt indicated that at Dean Clinic, this approach turned "physician terrorists" into "missionaries for change."

To support this partnership, the use of evidence-based guidelines, protocols and measures is essential. Clinical judgment occurs on a continuum of inputs from personal experience, through science and reasoning, to expert opinion. This integration between personal experience and reasoning to incorporating evidence-based medicine leads to predictable improvement in outcomes. An explicit evidence-based medicine approach is necessary, beginning with guidelines, best practices, and clinical pathways, and then translating them into a set of recommendations. It won't work to just "let doctors be doctors." However, the other extreme of allowing quality measures to exclusively drive clinical practice won't work either. What needs to happen is an explicit conversation about how clinicians and hospitals are going to work together to determine the best guidelines. This conversation requires trusting relationships and the understanding that both an individual and a population view are needed to address full improvement.

Kaiser Permanente is the largest private integrated delivery system in the U.S., comprised of a not-for-profit health plan and community hospitals organization and seven independent self-governed, self-managed medical groups in seven states and the District of Columbia. The hospitals and hospital services are cost centers, not revenue centers, and the organization operates with a global budget and prospective payment, which together eliminate the



environmental and structural obstacles to resource stewardship, a relentless and uncompromising focus on both the appropriateness and quality of care delivered, and collaboration to achieve a shared set of goals which are present and often problematic in a fee-for-service environment. What makes it work, however, is not the structure itself but rather the substantial and sustained effort expended to build a culture of commitment, performance, and shared accountability for the success of the enterprise. The health plan, hospitals, and each of the independent, self-governed and self-managed medical groups are connected by mutually exclusive partnership and contractual relationships with

one another, and share a common vision, and social mission.

## KEYS TO SUCCESS

### *Physician leadership*

Physician leadership is an essential element in the success of the enterprise, and in enabling the medical groups to partner as full equals with the health plan and hospital leadership in delivering performance. Physician leaders' primary responsibility can be described as building and maintaining a culture - a culture of accountability, a culture of commitment to excellence in care and service delivery and resource stewardship, and a culture of continued performance improvement. Dr. Levine explained that at the Permanente Medical Groups, recruitment of physicians includes assessing aptitude for and interest in taking on a leadership role. Management training and leadership development opportunities are provided for physicians to equip them to assume leadership roles and responsibilities, and to work side-by-side as equal partners with hospital and health plan leadership.

### *Trust, transparency and honest communication*

Every panelist cited trust as a key to success. Models of care need leaders who can be trusted - in fact are

trustworthy - and actionable, timely and trustworthy data. Relationships of trust are essential. Alignment of goals and incentives, shared values and purpose, and mutual respect are the necessary components in establishing the environment of trust essential to achieving success.

Physicians need to trust the ability of their leadership to work on behalf of their patients and to represent the profession in partnership with the leadership of the hospitals and plans. If physicians do not trust the governance and management processes, the ability of their leadership to harness physician commitment to shared goals and enterprise success is very tenuous.

Finally, there was general agreement among the panelists on the need for better data which more accurately reflects and captures the complexity involved in providing high quality, appropriate care in an efficient and effective manner. Currently much of what is being measured is used because it is easily captured from claims and payment systems. Some of what can be measured does not matter, and much of what matters most cannot easily be measured at this time.

### *Incentives/Accountability*

Dr. Samitt has found timely and actionable data work even better than incentives. A key to success is sharing and utilizing data which motivates and enables physicians to change their behavior. Dr. Samitt discussed the effectiveness of peer accountability based on transparent sharing of unblinded data among physicians, which influences how engaged physicians are in the change process. At HealthCare Partners, physicians have publicly shared profiles based on quality and efficiency, which are used for incentive payments.

Dr. Samitt suggests using money not just to influence physician behavior, but as a means of aligning partners. Dr. Levine, too, spoke of aligning incentives for more than just the individual, but at the group and enterprise level as well. At Kaiser Permanente, the leaders of the health plan, the hospitals and the medical group share a common dashboard for performance, and the domains of performance used for determining incentives are common across the enterprise. Health plan and hospital leadership is held accountable for quality performance and the medical group held accountable for efficiency and affordability. Incentive payment is viewed and used as a reward for excellence, rather than a lever to pull to get people to do specific things.

Dr. Levine shared elements contributing to Kaiser Permanente's success which includes a common vision across all entities and continual reinforcement of the sense of purpose, sense of belonging to and committing to something larger than oneself and an uncompromising attitude toward quality of care. Harnessing professionalism to do the right thing, and the social mission of a not-for-profit health plan and hospital organization with a commitment to community benefit are integral to cultural cohesiveness. Accountability also means effective management both within and across entities, joint manager and physician responsibility across the organization for quality, safety and resource stewardship. The leaders of each clinical specialty have responsibility

for identifying optimal clinical practices, guidelines, and measuring and monitoring adherence. There is an understanding across the organization that the organization is a substantial part of the community and every action has an impact not only to their members but the communities in which they live.

Lastly, what helps keep the separate entities which comprise Kaiser Permanente committed to the partnership is a "shared fate arrangement:" the deep understanding that any behavior by one part of the enterprise which could undermine the success of another would ultimately damage the entire organization.

# Operational Considerations in New Models of Care

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*Penso*



*Afable*



*Hamory*



*Selberg*

*Presenters:* **American Medical Group Association**  
Jerry Penso, MD, MBA, chief medical and quality officer

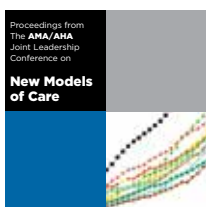
**Covenant Health Network and St. Joseph Health, California**  
Rick Afable, MD, MPH, president & CEO, Covenant Health Network and executive vice president, St. Joseph Health, Southern California

**Geisinger Medical Center, Pennsylvania**  
Bruce H. Hamory, MD, Geisinger Health System CMO Emeritus

**Institute for Healthcare Improvement**  
Jeffery D. Selberg, executive vice president & COO

## OVERVIEW

Operational considerations in designing new models of care include creating opportunities for clinicians and management to jointly decide on appropriate health system strategies such as resource use. The panel provided examples describing gains in quality, patient safety, and operational efficiency resulting from properly constructed clinical integration efforts. Presenters also shared observations about how to adapt integration efforts to different marketplace conditions.



## KEY TAKEAWAYS

### The Problem

One of the biggest obstacles to integration for hospitals and providers is breaking down the silo mentality. Mr. Selberg illustrated how integration fosters success describing Apple's ability to beat Sony to market with the iPod music player. Apple didn't have all the pieces needed to create a music player while Sony did. However, Apple was integrated, while Sony was not. Apple had the ability to create an integrated vision, and then find the technology while Sony couldn't coordinate different divisions to design a product. Fostering cooperation across an

more difficult than originally anticipated. With governance and operations designed to be successful in managing hospitals and medical groups there is little incentive to alter the structure.

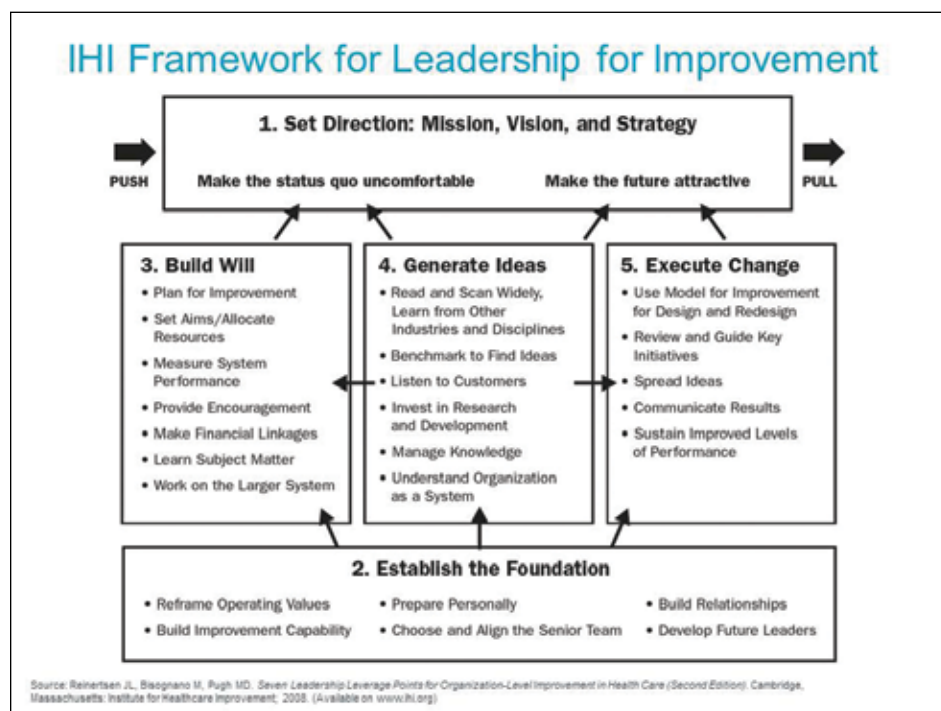
### Approach

The panelists detailed several approaches to operationalizing new models of care and ways to accelerate the velocity of improvement. In order to improve, the organizational leadership needs to define a structure through the setting of a mission, vision, and strategy. Aims should be set to reach

strategies as specifically as possible and as well as define the infrastructure. Once designed, leadership must build will among staff and maintain a clear direction of the organization in order to generate ideas and move toward realizing the vision.

Dr. Penso's task, when developing a Pioneer ACO at Sharp HealthCare, was to leverage the assets Sharp had developed for managed care, and build a sustainable business model that improved outcomes and increased value to beneficiaries. Planning and coordination across the system was vital to the process as well as understanding which successful practices from

managed care would add value to a fee-for-service environment. Data was essential in designing the new model, as the population the Pioneer ACO would serve was vastly different from Sharp's managed care experiences. In operationalizing best practices, Dr. Penso stressed metrics that matter and the need for specificity. He also highlighted the success of their care management program in coordinating across multiple sites and creating a seamless system.



enterprise is the key driver to creating operational integration.

At the time of the meeting, Covenant Health Network was six months into the journey to create a new model of care following the merger of independent health systems in Orange County. Even though the merger brought together systems made up of successful elements and practices, operationalizing these systems into a new model of care was proving



**Key Themes & Expectations**

- Health System expectations/goals for physician practice
- Physician practice goals and strategies
- Physician:Administrator partnership
- Franchise concept for accountable units
- Alignment strategies
- Importance of metrics
- Sample reports/tools

GEISINGER  
HOSPITALS

Dr. Hamory described how Geisinger operationally redesigned their care model, noting it is an on-going process. He outlined the several stages starting with creating leadership and governance structures to drive change followed by enhancing infrastructure to support the new care model. He stressed that centralized support systems, such as information technology and finance, are instrumental to transformation. Next is the organizational redesign and implementation of the new framework, which in Geisinger’s case was developed jointly with physicians. The model calls for common standards, common signage, common policies, but allows for allowance for certain decision rights akin to a franchise model. Each service line team is responsible for budget, patient satisfaction and quality numbers, and staffing decisions. Service lines are managed through physician-administration partnerships with shared expectations, matched incentive compensation; goals aligned with metrics, and shared responsibility for targets. These partnerships, which lead at every level, are accountable for each other and can speak on behalf of and commit for one another. In order for this team to work, there must be a shared vision, shared alignment to goals, and very clear communication.

Dr. Afable addressed the difficulty in creating change. While Covenant Health Network was formed with the vision of operationalizing a new care model, the structural changes needed to move from governing hospitals and medical groups to the communal leadership and operating model necessary has been difficult. While the shared vision was the driving force, the details of changing fundamentally successful systems to a new model has proved a cultural challenge in addition to a structural one. While it will be challenging, structural and cultural changes are necessary and can occur. Every system is perfectly designed to get the results it gets and if it isn’t disrupted, it will continue to produce the same results.

## KEYS TO SUCCESS

The panelists agreed that successful models all shared strong physician leadership, robust infrastructure support, including access to data, and patient engagement across the care continuum.

### *Physician Leadership*

Several panelists emphasized the need for physician leadership in driving clinical integration. Historically, physician leadership positions have either involved leading the medical staff or a physician group. To drive clinical integration, physicians are instrumental to directing population health for a system. Panelists were concerned that without sufficient physician leaders trained and interested in these roles driving change will be difficult.

Dr. Hamory explained that Geisinger changed 75 percent of physician leaders and a third of administrators in the first two years of operationalizing the new care model. In his experience, the challenge was not training for leadership skills but finding those who want to lead.

### *Data*

Data can drive closer alignment between physicians and hospitals, but must be structured. Collecting unnecessary information and receiving unorganized output is unproductive. At Geisinger, for example, patients can enter data directly into the medical record in an ordered, retrievable way which can be displayed for the physician along with other parameters such as lab work. This process enhances physician functionality, reduces work load, and improves care, both in terms of outcomes and engagement of patients. Building analytics and business intelligence is difficult and costly. However, a good system can yield results to start predictive modeling to address gaps in care.

Ideally, quality data can be utilized to support translational research. It is important to know what works, what's the most cost effective treatment that produces the best outcomes, and how to get there as quick as possible.

### *Patient Engagement*

Historically, the patient's voice has been missing in the discourse of transforming care delivery and population health. It is important to get the patient's perspective, and that voice must matter. Patient engagement and activation is critical to a successful care model. When patients are not engaged, costs increase and care coordination decreases.



# New Models of Care

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*Sacks*



*Wolter*



*Hinton*



*McGough*

*Presenters:* **Advocate Health Care, Illinois**  
Lee B. Sacks, MD, executive vice president, chief medical officer,  
Advocate Health Care and CEO, Advocate Physician Partners

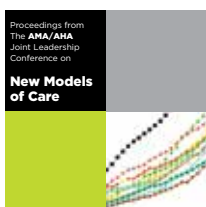
**Billings Clinic, Montana**  
Nicholas Wolter, MD, CEO

**Presbyterian Healthcare Services, New Mexico**  
James H. Hinton, president & CEO (2014 AHA chairman)

**University of Washington Medicine, Washington**  
Peter McGough, MD, medical director, UW Medicine  
Neighborhood Clinics and clinical professor, Department of  
Family Medicine

## OVERVIEW

The panel on new care models featured leaders of an additional four mature integrated delivery systems, each of who have led innovative system integration, but in very different geographies, characterized by different marketplace and operational realities. By sharing their models, the presenters expanded the vision of what is possible and transferable to different settings across the country, including inner city, rural and safety net environments.



Advocate Health Care primarily serves the metropolitan Chicago area with recent expansions to Bloomington-Normal, a community 150 miles southwest of Chicago, as well as rural Eureka, Illinois. Advocate consists of hospitals ranging from major teaching to critical access, physicians, and home health services. 6,000 physicians serve on medical staff, about 20 percent of whom have privileges at more than one hospital. Advocate Physician Partners, representing those physicians partnered closely with the hospital, includes 4,000 physicians.



Advocate Health Care was formed with the merger of two hospital systems in 1995, but the evolution of a strong physician-led, coordinated care model had been in development for years and continues to grow and evolve. Advocate continues to look toward the future and define their strategies on safety, quality and service, access and affordability and coordinating care across the system; understanding they cannot be successful without strong physician engagement.

Dr. Sacks' defined culture as the usual order of business for an organization, a predictable pattern. In order to create a culture of physician engagement, Dr. Sacks cited five key factors: strong governance, supporting infrastructure, aligned incentives, transparency of results, and continuous feedback loops.

### *Governance*

Shared governance requires open, honest dialogue, transparency, maintaining a focus on facts and

always the best interest of patients and the community at the fore. To ensure strong physician groups Advocate maintains local PHO boards that while having no financial accountability, keep health care decision-making local. More than 100 physicians are involved in the governance process throughout Advocate Health Care.

### *Infrastructure*

Advocate's infrastructure helps small practices perform like large multi-specialty groups. In addition to the EHR, Advocate provides training for office staff to help stabilize the workforce. Care managers are embedded in practices to manage chronic disease and help those with multiple conditions navigate the system. Practices also have access to group purchasing for supplies and pharmaceuticals as well as insurance. Just recently, Advocate created a risk purchasing group for liability insurance which has resulted in physicians reducing their premiums by fifteen percent due to demonstrated safety and outcomes metrics.

Through the clinical integration program, each practice collects metrics tied to pay-for-performance. Advocate uses registries and in January 2014 is implementing a customized product co-developed with an electronic health record company, which will provide real-time registry data at each patient visit. Education is provided throughout the organization for all levels of staff, including Institute for Healthcare Improvement-style learning collaboratives for disease management.

### *Incentives*

As others described throughout the program, financial incentives are a catalyst to begin to drive behavior change, but sustaining change has been the result of physician engagement. Demonstrated improvement motivates the team to continue functioning at a high level, with quality performance becoming ingrained in the culture.

### *Transparency of results*

Dr. Sacks shared an example of a monthly physician practice report card which compares performance to network benchmarks. To assist physicians having difficulty with the benchmarks, Advocate hired ten practice performance coaches to analyze data with each practice or physician and suggest changes to drive continuous quality improvement.



Billings Clinic serves a large geographic area in Montana and Northern Wyoming, more than 147,000 square miles with a population in that area of about 600,000 residents. To cover this expanse, Billings Clinic holds over 100 outreach clinics a month, relies on telemedicine in 30 specialties, and an electronic health record in all rural clinics and 13 affiliate critical access hospitals. Billings Clinic is the sole sponsor of the largest Medicare Advantage program in the state of Montana, with about 20,000 beneficiaries, which provides a great opportunity to refine how to actively manage and coordinate care over a large area. In addition, Billings Clinic started the first internal medicine residency in the state. Given the vast distances, Billings Clinic required a proactive strategy to ensure care delivery across the state at different sites. To help organizations in the region perform, Billings Clinic provides infrastructure support through an integrated financial and clinical information system, strategic planning, budgeting, clinical integration including quality and safety tactics and patient flow coordination. Training in LEAN and Six Sigma is also supported to ensure operations are efficient as possible.

Dr. Wolter shared several key characteristics contributing to the success of Billings Clinic in providing care in a very large, rural geography including his strong belief in multispecialty group culture which fosters teamwork and partnership, being obsessive about quality and safety, and maintaining a mission-driven focus. Additional elements include:

**Physician leadership** – Billings Clinic is committed to physician involvement across all governance leadership levels. Professionalism and putting patients first are critical as they drive the culture.

**Collegiality** – A multispecialty group practice culture, where all physicians agree on how they will function as a group and understand the importance of agreeing on standards and coordination of what is best for patients, is essential.

**Infrastructure** – Geography is a big influence on how Billings Clinic developed and how they look at integrating care delivery. All sites are on the same financial and clinical information system, driving virtual integration.

Dr. Wolter briefly described his views on changes in payment policy to drive new models of care, indicating while payment policy will drive change, there are also other important factors to consider. Ideally, professionalism drives behavior regardless of payment policy. Some of the current payment models are complex, layered on top of outdated fee-for-service systems. Improving the fee-for-service system would create more rational incentives for how and where energy is spent. There is intense focus on unit price reductions, but the wide variation in the number of units of care that are provided needs to be looked at as strongly as the unit price of those units.

In his work at Billings Clinic, Dr. Wolter has spent time considering complexity theory, or how to drive change within the organization. Complexity theory is the study of how organizations function, how individuals can be effective, and very importantly how relationships across silos can be critical to improvement. For example, through changes in relationships and new collaborations, staff was able to reduce MRSA infection rates by 35 percent. Other techniques, which some refer to as liberating structures, also can strongly and positively influence group dynamics and foster emergence of positive change.

Finally, Dr. Wolter cautioned that the path to new models of care will require physician and executive leadership focusing coordination of care across a broad continuum of patient care needs including acute care, post-acute care, home care, and more successful population health approaches. Professionalism, partnerships, and the skill sets for the science of health care delivery are all critical. Dr. Wolter concluded with a quote from Charles Mayo MD, who said in 1913, “the past 50 years have been marked by advances in the science of medicine. The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered.” Dr. Wolter opined that Dr. Mayo might be disappointed in where we are now, but perhaps more optimistic about current and future initiatives.

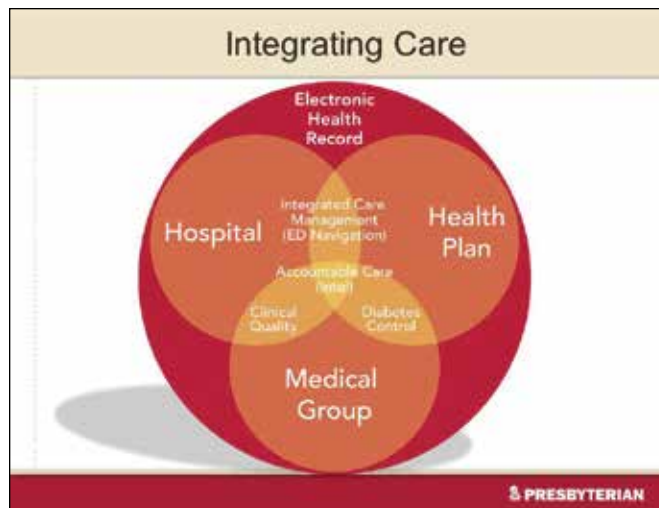
For 75 of the 105 years it has been providing care, Presbyterian has been a hospital organization. About 30 years ago the leadership team and board set out a vision to become an integrated financial and delivery system. Today, Presbyterian has a large health plan in the state of New Mexico with 420,000 members. Presbyterian Medical Group includes more than 600 providers practicing in 36 multispecialty clinics in 10 communities. There are eight hospitals in seven communities. While the integration of systems has transformed how care is delivered, the real change, to some extent, has been a de-emphasis of the hospital. Presbyterian balances between capitated and fee-for-service health care with about half of their revenue coming from pre-paid arrangements. In addition, New Mexico is a unique environment with the lowest rate in the U.S. of employer-sponsored insurance, second highest level of poverty, and high rates of diabetes and tobacco use.

Mr. Hinton described integration as a journey, where they put pieces in place, set targets, measure the results, make adjustments, and continue forward. The system explicitly adopted the Triple Aim as a strategy. Through the overlap of the hospital, health plan and medical group, Presbyterian is able to produce results that couldn't be achieved independently.

Presbyterian has an EHR that connects outpatient and inpatient records and is available to independent physicians throughout the network. It serves as the backbone for organizing care delivery and coordination. Mr. Hinton shared two programs demonstrating Presbyterian's ability to integrate and produce better results.

### *Emergency Department Navigation*

Emergency department (ED) use was chronically used as a primary care service by many in Presbyterian's service area. Through a new screening program, about ten percent of patients are screened and referred to other services prior to a typical ED workup. Screened patients are guaranteed an appointment with a primary care physician within 24 hours, and if needed, transportation is arranged. Following the screening exam, a patient can choose to pay-out-of-pocket at the time of service and continue treatment



within the ED. However, few if any choose to do so, instead accepting the referral. While ED rates are continuing to increase nationally, Presbyterian has been able to decrease ED demand, creating more capacity for life-threatening emergencies. The ED navigation works with Medicaid patients as well and they have found a low rate of repeat navigations. As yet, only Presbyterian's own health plan realizes and reimburses for the value of this service. Mr. Hinton clarified for the audience that the program is in compliance with the Emergency Medical Treatment & Labor Act. Before initiating the program, Presbyterian sought approval from the Centers for Medicare and Medicaid Services and shared the model with other community hospitals, agreeing to monitor for any diversion issues. While currently only operational at Presbyterian's hospitals, several hospitals around the state are interested in adopting the program. Presbyterian has provided the protocols, but with only the Presbyterian health plan recognizing the new model, broad adoption may be difficult.

### *Hospital at Home*

Hospital at Home is not home care; it is hospitalizing patients in their own homes for a limited set of diagnoses, typically chronic care exacerbations. A hospital bed is provided, monitoring set up, and patients are admitted to their own home. Physicians complete rounds twice a day to these homes and tele-monitoring is established. Results thus far indicate a 20 percent savings, and clinical outcomes are equal or higher to hospital care, without the added risks of infections and falls. While there has been interest in participation by payers, thus far, only Presbyterian's own health plan is participating.

Dr. McGough shared the work of UW Medicine, which includes a 2,000-physician practice and a regional hospital system with teaching and research responsibilities. The teaching program is a collaborative across five states with a big emphasis on primary care. The model of care created is based on a common platform for assessing performance across the enterprise in areas such as service, satisfaction, access, and quality measures. Aligning priorities and operations was a challenge, as the field tends to work not only in silos within hospitals, but within service lines as well.

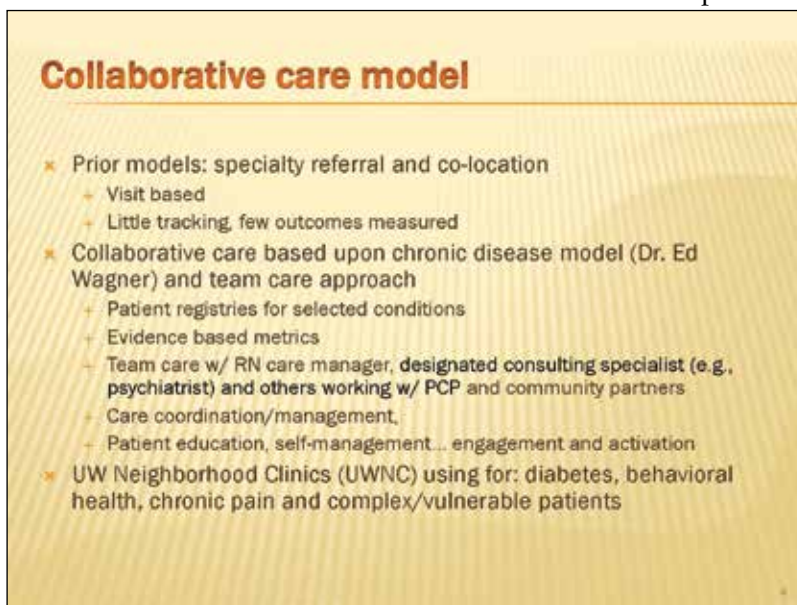
After some initial difficulties, UW Medicine built a new primary care model based on the chronic disease mode which includes three key factors: patient registries, evidence-based metrics, and patient involvement. Patient registries are vital to the operation of the program to provide opportunities for outreach to those not coming to the clinics. Quality metrics are also key to managing the care delivery, but need to be evidence-based and tailored to the different parameters for chronic conditions. Finally, patient involvement is not only patient education, but patient engagement, self-management, and activation. Dr. McGough presented two programs based on the chronic disease model.

### *Behavioral Health Integration*

While the first attempt to increase access to mental health was co-location of psychiatrists and psychologists within primary care clinics, there was not a unified model. They also tried relocating specialty services to the clinics, but found that without proper support systems, the services were under-utilized. By using a chronic disease approach to depression and anxiety, the new program utilizes team-based care and has substantially improved outcomes for depression and quality of life. The program has improved patient and provider satisfaction in addition to reducing costs. With the use of registries, patients with significant anxiety and depression are identified and introduced to the care management team. Primary care physicians work with licensed clinical social workers. Patients are contacted on a regular basis by phone in addition to office visits.

### *Chronic Pain*

The primary care network realigned clinical protocols in order to meet the requirements of new state regulations related to pain management. Physicians must consider diagnosis, risk factors, alcoholism, and comorbid behavioral health issues in assessing new patients for pain medication. The protocols require that pain medications not be prescribed on the first visit. Patients are entered into a registry, palliative care is provided and then pain and mental health scores are tracked. Patients sign informed consent, ensuring they are aware and understand the risks of opioid therapy. Drug screens are used as literature shows a significant number of patients who are on opioid therapy are not taking medication as prescribed. Identifying people who were struggling with addiction or diversion is an important part of program. Finally, a key component is prescription monitoring. Staff checks to see if patients have been getting prescriptions elsewhere.



**Collaborative care model**

- ✦ Prior models: specialty referral and co-location
  - Visit based
  - Little tracking, few outcomes measured
- ✦ Collaborative care based upon chronic disease model (Dr. Ed Wagner) and team care approach
  - Patient registries for selected conditions
  - Evidence based metrics
  - Team care w/ RN care manager, designated consulting specialist (e.g., psychiatrist) and others working w/ PCP and community partners
  - Care coordination/management
  - Patient education, self-management... engagement and activation
- ✦ UW Neighborhood Clinics (UWNC) using for: diabetes, behavioral health, chronic pain and complex/vulnerable patients

Physicians throughout the network are asked to identify chronic pain patients for assignment to the new protocol. A care manager is assigned to work with the patient and provide navigation to needed services and monitoring of pain medication use. UW Medicine is seeing good results when mental health issues are addressed in tandem with chronic pain. Most improvement is seen with the fully engaged patients.

As with depression or other chronic conditions, patient engagement and activation is essential. Just setting up registries and care teams will not achieve the results that could be obtained by engaging patients in their own care.

# Conclusion

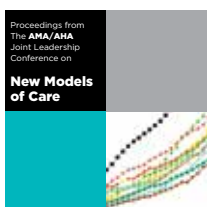
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**ONE MESSAGE** of the Joint Leadership Conference on New Models of Care is heard often, “culture eats strategy for breakfast.” All of the participants agreed, driving significant behavior change to create new care models requires fundamental shifts in culture supported by changes in financial arrangements and operational infrastructure. What culture means and how it is implemented will differ for each organization.

Physician leadership and true partnership between physicians and hospitals are critical elements for success. Each of the 10 models presented were unique, but common elements, such as physicians in leadership roles, supporting infrastructure, a common vision, and incentives to encourage change, were repeated throughout. Each model will need to be adapted to the geography, market, and culture of each organization, but the core elements remain the same.

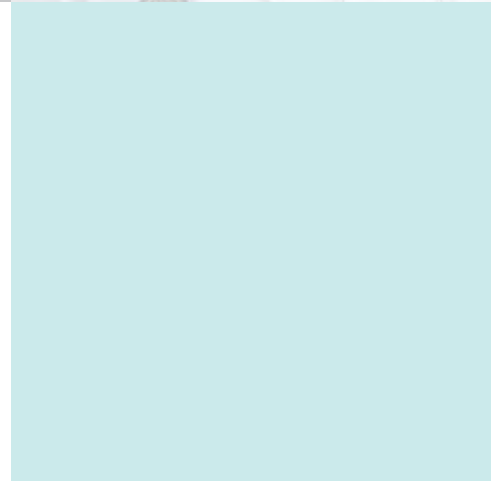
Program participants encouraged the AMA and AHA to continue to advocate for a variety of changes to foster more development of these successful models and to continue to share best practices across the country to encourage all care providers to move toward the Triple Aim. Among the needed changes:

- More rapid development of physician organizations capable of self-governance, collective management of quality and cost, and the ability to create integrated leadership structures.
- More focus on the development of physicians as capable leaders and managers. The knowledge and skills needed to create and maintain the success of organizations such as seen at the conference are not taught in medical school or residency programs. “On-the-job training,” which is the current norm, is slow and inadequate.
- More codification of the specific internal structures and processes that lead to successful integration of leadership and management functions between physicians and hospital administrators. Attention should then be paid to laws and regulations that inhibit well-meaning organizations from creating such functions.
- More evolution by payers away from payment for volume of services toward payment for value. The availability of such payment models will encourage delivery system integration similar to the models presented at this conference.





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