MEDICAL GROUP LEADERSHIP COUNCIL

Providence St. Joseph Health

January 15th, 2020
8:00am-4:00pm
Seattle, WA | Swedish Education Conference Center – Meeting Rooms A & B

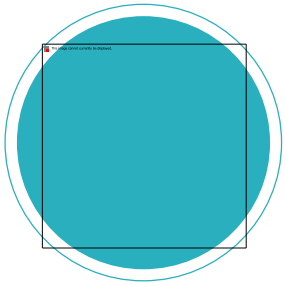
Kevin Manemann
EVP, Chief Executive, Physician Enterprise

Physician Enterprise

2019 IN REVIEW

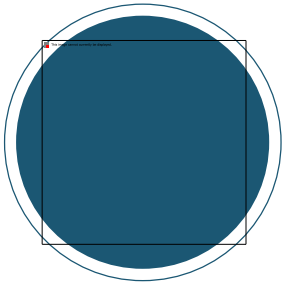
Physician Enterprise: Year in Review

Providence St. Joseph Health



Caregiver Engagement

HSE 56%
Outstanding Performance

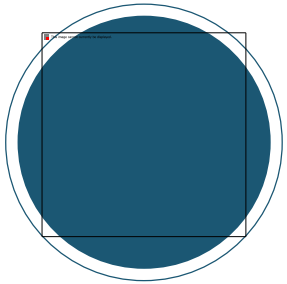


Patient Experience

Pat Sat 86.02%
Outstanding Performance

Quality

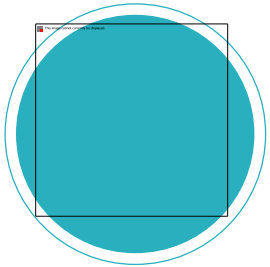
8 of 8 Achieved
Outstanding Performance



Provider Engagement

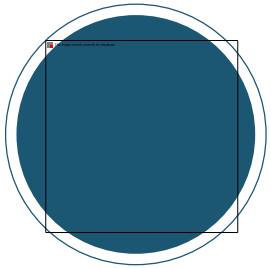
Engagement 4.14 (54th)
Alignment 3.72 (49th)

Physician Enterprise: Year in Review



Financial

$30 Million
Ahead of Budget
Outstanding Performance



First Year Turnover

27.5 %
Outstanding Performance

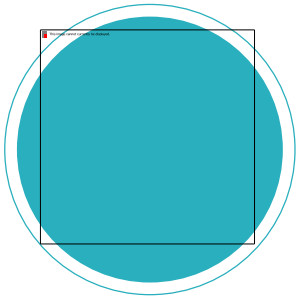
Digital Reg Users

2,876,069
Outstanding Performance

Digitally Enabled Transactions

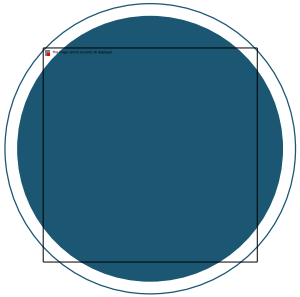
Outstanding Performance

Physician Enterprise: Year in Review



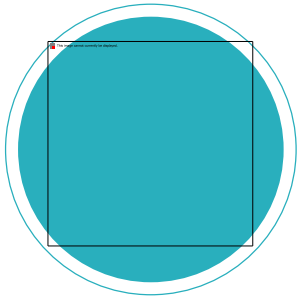
Recruitment (PS&D)

9.1M (NOI)
Outstanding Performance



Access

New Metrics Established



Panel Size*

1676
Under Performance

Productivity

PCP – 90%
SPC—87%
Under Performance

*Data integrity needs to reviewed to ensure accuracy

DESTINATION 2020

GROUNDED IN OUR GUIDING PRINCIPLES


GUIDING PRINCIPLE
Restore the joy
in practicing medicine.


GUIDING PRINCIPLE
Simplify the
care experience.
To ease the way of our providers,
caregivers and patients


GUIDING PRINCIPLE
Create a unified
Providence provider voice.

DESTINATION 2020

A LOOK AHEAD

Multi-Specialty Medical Group

DESTINATION 2020

- We're a multi-specialty medical group that knows where it's going, has **optimized operations** and **tight clinical integration** across primary care, specialty, our lines of business and our hospital partners.
- Operating with a multi-specialty mindset means **greater collegiality**. The more we function this way, the more we support each other, mitigate burnout and differentiate ourselves in the market.
- Together, we can achieve our vision of delivering the **best health outcomes**, with incredible **compassion and empathy**.

Value-Based Care

DESTINATION 2020

- We are on a journey toward **value-based revenue** and contracts.
- Markets (and the government - CMS) moving this way **across the country**.
- PMPM and premium revenue funds teams members and roles that FFS doesn't – that "team" provides professional satisfaction and resilience (**joy**), enables work to be offloaded and work at top of license to other roles, could ease documentation, enable virtual care, all of which will **simplify**.

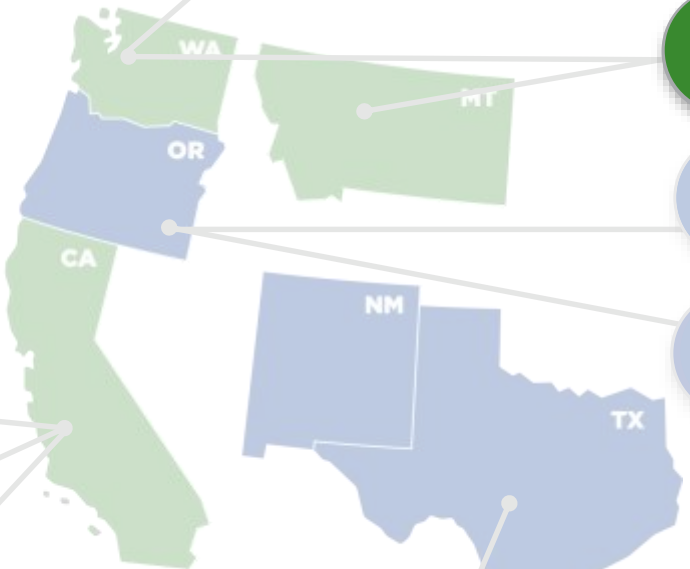
Unified Physician Voice

DESTINATION 2020

- A unified physician voice enables us to **drive performance**
- Launch of a new **system board** and regional governance structures
- Provides the Physician Enterprise a **seat at the table**, to better drive decision-making
- Allows us to be both **big and small**

DESTINATION 2020

OUR TEAM



Tom Yetman, MD
Chief Executive,
Alaska

Jatin Motiwal
Chief Executive,
Puget Sound

Mike Marshall, MD
Chief Executive,
Washington/Montana

Ben Leblanc, MD
Chief Executive, Oregon

Kevin Olson, MD
Chief Executive,
Clinical Programs & Services,
Oregon

David Kim, MD
Chief Executive,
Orange County/High Desert

Dave Mast
Chief Executive,
Los Angeles

Bob Just
Chief Executive,
Northern California

Kristen Kothmann
Chief Executive,
Texas/New Mexico

Physician Enterprise | Support Structure

DESTINATION 2020

COMMON VOICE AND CULTURE

GUIDING PRINCIPLE

Restore the joy
in practicing medicine.

GUIDING PRINCIPLE

Create a unified
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GUIDING PRINCIPLE

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To ease the way of our providers,
caregivers and patients

Own It

- Reground our purpose in health care
- Culture of compassion, empathy, and accountability
- Reconnect with our Mission, vision, values and promise statement
- Create a common language

Own It

5 declarations and actions

I own how I greet and welcome you

- ***Introduce yourself by name/role and address the person by preferred name***
- Greet others in a manner best appropriate to the situation
- Eye contact, facial expressions/smile, and speech should be welcoming, friendly, and match the circumstances

I own how I show you respect

- ***Say "Please", "Thank you", and "You're Welcome"***
- Turn and face the other person. This is speaking heart to heart
- Respect the diversity, guard safety and confidentiality in all situations
- Work efficiently and effectively in an ethical manner, aligned with our Values

I own how I engage you and discover your needs

- ***Provide opportunities for questions and discovery - "How can I help you?"***
- Actively and attentively listen with empathy and intent to understand
- Validate their needs

I own how I assist you and personalize my actions for you

- ***Explain what you are doing, why you are doing it and your positive intent***
- Collaborate and work in partnership with the patients and others to fulfill needs
- Include others in decisions, explain what needs to be done, and seek the patients permission before acting

I own how I assist you in transitioning your continuum of care and service

- ***Ask, "Is there anything else I can do for you?"***
- Explain what will be happening next and make introductions as appropriate
- When fitting, escort the person so they are not alone, confused or lost
- Provide an appropriate, authentic departing remark

Own It

DESTINATION 2020

THE WORK AHEAD

- Clinical Laddering Initiatives
- Provider Onboarding
- Top of License Workflows
- Team Based Care Models
- Own It Scaling & Sustainment

- Medical Group Governance – Physician Enterprise Board
- Value-Based Care Contracting & Performance
- Branding & Creating Experience
- Residency & GME Development

- Epic Optimization
- Access & Navigation
- Integrated Shared Services with the LOB
- Scaling Digital Technologies, Aligned with Workflow

Physician Enterprise Leadership Updates – Volume to Value Transition

Doug Koekkoek, MD
Chief Medical Officer, Physician Enterprise

GUIDING PRINCIPLE

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“The math doesn’t work anymore.”

Venkat Bhamidipati

FFS reimbursements are **declining** while the cost of delivering care is **going up**

- ***Moving to Value Based Care*** *revenue, where we get paid to:*
  - Better manage and coordinate complex care
  - Prevent expensive complications
  - Diagnose earlier
  - Move care to lower cost sites of serves
  - Eliminate unnecessary and redundant care
- ***Is a key strategy*** *in solving our fiscal problem*

The Business Imperative for an aligned medical group that functions as part of an **Integrated Delivery System** in a **Value Based Revenue** model is…..

To **Grow** and to **Reduce Utilization**

Panel Growth will be critical to our success

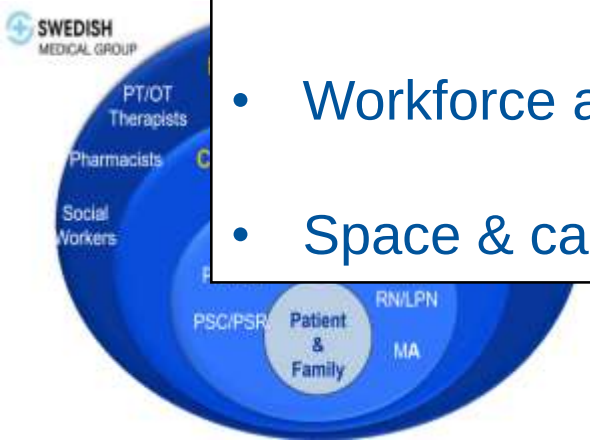
Maintaining “open” practices is the lifeblood in the Managed Care world

- Team-based care models
  - Increased use of APCs
  - RN visits
  - Clinical Pharmacist visits
  - BHP visits
- Use of the Ambulatory Care Network
- Clinical algorithms and automated care
- Optimal Return Visit frequency

Many team-based care models today

Why the variation?

- Patient demographics & panel acuity differences
- Payor Contracting – Revenue differences
- Workforce availability variation
- Space & capital availability variation



Value-Based Revenue ≠ Low Productivity Providers

Smart Productivity Improvement

- Are they working their contracted hours?
- Is there demand in that location?
- Does the practice need marketing?
- Does their schedule template reflect appointments that can achieve 60th percentile productivity?
- Are there too many appointment type restrictions?
- Do they have a high ‘no show’ or cancellation rate?
- Is there a coding concern?
- Is there an adequate number of exam rooms to manage patient flow?

Utilization Improvement

- Provider-Governance
- Measure & Monitor PMPM
- Rowdmap and efficient network
- Full scope PC & Specialty referral guidelines

Don’t forget HCC coding – Education coming soon

Connecting the Dots

AQC → ***Quality P4P***

Primary Care → ***Set the Utilization Trajectory***

Hospitalist Care

GME → ***Source of PCPs and Hospitalists***

The Medical Neighborhood

Physician Enterprise Leadership Updates – Operations Update

Jennifer Schaab, MBA, MPH
COO, Physician Enterprise

Physician Enterprise

Strengthen the Core: Strategies

Providence St. Joseph Health

=Medical Group Focus

We will deliver outstanding, affordable health care, housing, education and other essential services to our patients and communities. We seek to create a place where caregivers are fulfilled and inspired to carry on the Mission.

GOALS	2020-2022 STRATEGIES	PE 2020 Tactics
1. Create a work experience where caregivers are developed, fulfilled and inspired to carry on the Mission	Improve Experience x3: • Caregiver Experience • Provider Engagement/Alignment • Patient Experience/Satisfaction	Improve caregiver first year turnover and highly sustainably engaged percentage via: • Caregiver Own It rollout & sustainability • Rollout physician Own It • equity assessment and alignment • enablement improvement opportunity • rollout Lead position in the medical group structures
	▪ Practice at **Top of Licensure**	Create clinical ladders which enable practicing at top of licensure for MAs, APCs, Coders: standardize panel size definition; partner with Compliance, Legal, IS and Operations to develop workflows supporting top of license within EMR build
2. Deliver safe, compassionate, high-value health care	▪ Improve Patient Experience / Satisfaction	Implement system-wide elements of Providence Promise framework, develop standardized service cycle for in-office and shared services across PE via scenography
	▪ Improve Clinical Quality & Value	Improve overall quality measure performance across Physician Enterprise, and in government programs [MACRA/ MIPS/MSSP/CPC+]; align provider compensation to incentivize toward quality performance; develop and implement Medicaid Improvement plan [FQHC Alignment]; align with Value-Based Care strategy & team; develop and deploy analytics platform to drive improvement; automate, optimize and scale clinical outreach
	▪ Hospitalist Program Optimization	Standardize best practices around FTE & staffing models, develop and deploy analytics platform to drive improvement
3. Make PSJH the provider partner of choice in all our communities	▪ Improve Provider Engagement / Alignment	Develop physician leadership and development program for medical directors leading clinics
	▪ Standardize Onboarding for Physicians & Providers	Develop and implement standardized high touch physician onboarding experience: unified physician enterprise caregiver orientation experience, unified provider handbook
4. Steward our resources to improve operational earnings	▪ Steward our Resources to Improve Performance	Create labor standards for caregivers across PE, define and standardize leader leveling criteria, partner with system shared services teams on resource allocation, align and unify vendor contracts
5. Foster community commitment to our Mission via philanthropy	• N/A	

Physician Enterprise

Be Our Communities' Health Partner: Strategies

Providence St. Joseph Health

=Medical Group Focus

We will be our communities' health partner, aiming for physical, spiritual and emotional well-being. We seek to ease the way of our neighbors in their journey to good life.

GOALS	2020-2022 STRATEGIES	PE 2020 Tactics
1. Transform care and improve population health outcomes, especially for the poor and vulnerable	▪ Ambulatory Care Composite (ISFP Metric)	Improve ambulatory care for all populations (8 components): diabetes management bundle, cardiovascular patient statin use, depression assessment, breast cancer screening, colon cancer screening, cervical cancer screening, pediatric immunizations, hypertension management
	▪ **Access & Navigation** – Right Care, Right Time, Right Place (ISFP Metric)	Increase use of consumer/patient engagement platforms (Circle, Xealth), create scheduling optimization using tools from Epic and DIG, partner with patient engagement center (PEC) to determine best areas to scale services
	▪ Align Care Model with New Payment Methodologies	• Implement alternative care models (i.e. team-based care) • utilization of APCs • virtual care
	▪ Build a High-Performing Network	• Deploy Cotiviti (Rowdmap) in markets moving towards value-based care, develop change behavior structure and tools helping groups better prepare for value-based care • develop and scale referral management program simplifying patient hand-offs • focus on Medicare Advantage improvement performance
	▪ Clinical Program Partnership	Implement key clinical programs in partnership with CPG, etc.: examples: whole person care, Mental Health & Wellness, age-friendly health system, genomics, healthy weight initiative, opioid management, breast cancer screening decision-making, Patient Reported Outcomes
2. Lead the way in improving our nation's mental and emotional well-being	▪ N/A	
3. Extend our commitment to whole person care for people at every age and stage of life	▪ N/A	
4. Engage with partners in addressing the social determinants of health, with a focus on education, housing and the environment	▪ N/A	
5. Be the preferred health partner for those we serve	▪ **Real Estate & Growth**	Deploy clinic space efficiency formulas and methodologies including real estate, PCP, and specialty needs; develop

Physician Enterprise
Transform Our Future: Strategies

Providence St. Joseph Health

=Medical Group Focus

We will respond to the signs of the times, pursuing new opportunities that transform our services. We seek to expand and sustain our Mission.

GOALS	2020-2022 STRATEGIES	PE 2020 Tactics
1. Diversify sources of earnings to ensure sustainability of the ministry	▪ Continue Partnership Opportunities to Enhance Future Earnings	• Expand and scale MediRevv and MSM model in markets • Improve Physician Billing Office performance in the following areas: increase payer yield through reductions in controllable write offs and denials, capture missing charges through technology adoption and training • Partner in markets and develop MSM model where independent physicians can be in a "foundation light" structure • PS&D achieving revenue
	▪ Physician & APC Pipeline	Develop and implement system-wide GME program and APC fellowship program, to support provider pipeline into PE; refine and standardize Locum program
2. Digitally enable, simplify, and personalize the health experience	▪ Enhance Patient **Access, Navigation and** Experience through Innovation	Deploy and scale DIG technology solutions to improve operations and consumer experience, including: MyChart scheduling, Mpulse, DexCare, InQuicker, QueueDr, UpFront, IRIS eye exams
3. Create an integrated scientific wellness, clinical research and genomics program that is nationally recognized for breakthrough advances	▪ N/A	
4. Utilize insights and value from data to drive strategic transformation	▪ Epic, **Technology** Optimization, and Analytics	Partner with system teams to optimize Epic and other technologies, via: Healthy Planet, Tapestry Implementation, Epic eco-process, Bluetree engagement to simplify workflows. Build analytics platforms and capabilities to use data driven strategies to improve operational, clinical, and financial performance.
5. Activate the voice and presence of PSJH nationally to improve health	▪ Create a Medical Group Governance Structure	• Establish a system-wide medical group governance structure and launch a system board • Partner with regions to develop medical group governance to enhance multispecialty group culture and performance • launch regional medical group governing boards

Investing in our People

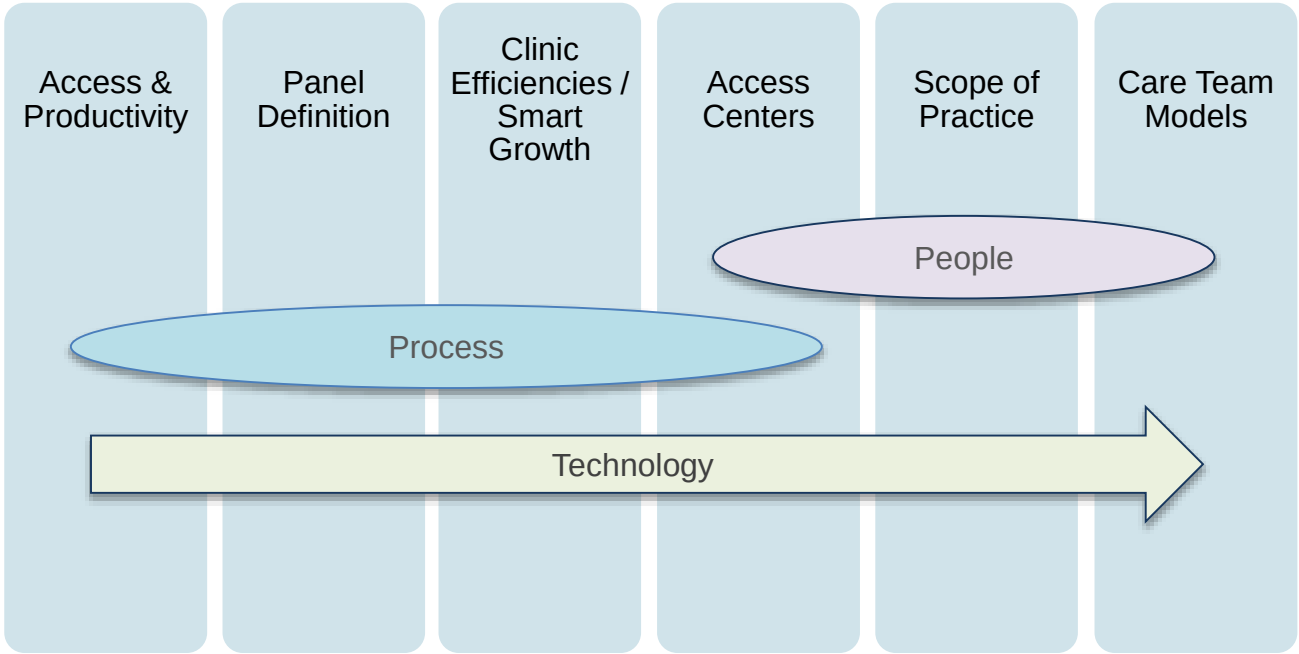
MA Laddering

- Investing in retaining our workforce to ensure growth & competency
- Up Next: LVN & RN

Own It

- Ensuring our caregivers and providers get back to the joy of working in healthcare

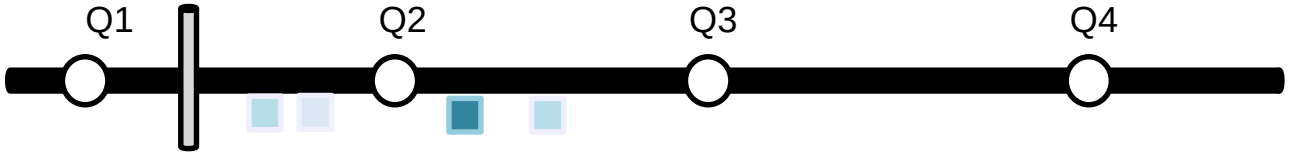
Advancing the Work



Advancing the Work: Access

- Standardize definition and measurement for **CAPACITY**
- Establish **CARE MODELS** for optimal performance (use of APCs and other ancillary services)
- Standardize **visit types** for optimal technologic integration.
- Establish toolkit for optimal **scheduling templates**
- Create alternative visit modalities for patient centered care
- Educate patients on expected capacity and proper channels of care

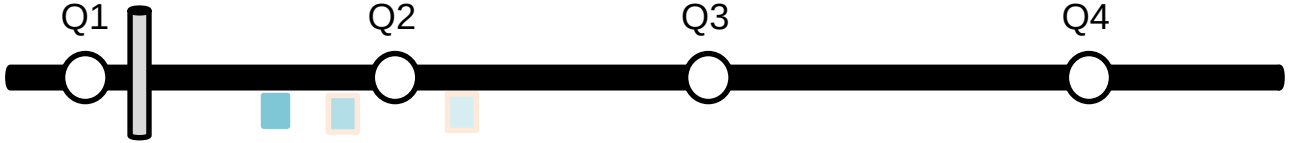
Panel Size Definition	• Redefine **Adjusted** panel size • Impact analysis & Rollout Plan • Contracting Impacts • Update reports with new definition
Standardized Schedules	• **Two** preferred template models defined • Identify low performing provider/clinic • Engage clinical leaders • Regional implementation with PE support • Track improvement
Standard Visit types	• Align visit types across system • Standard usage of a visit type • Submittal and approval process • Subcommittee reviews and provides recommendation to COOC
Innovative Access Tactics	**Building capacity through provider schedules and digitally enabled patient interactions**: • Fast Pass • mPulse • Expand No Show Tool



Advancing the Work: Navigation

- Define and educate patients on the multiple channels to navigate their care (online, apps, patient portal, etc.)
- Partner with Digital Innovation Group (DIG) and other IT committees and sub-committees to bring solutions to ease navigation

Access Points	• **"HOT"** handoff • Partnering with PCEC and Nursing leaders to align recommendation for right care/right location • Same Day appointment priority (ex: PCP vs EC)
Patient Education	Create toolkit and confirm regions are educating patients appropriately • Patient handouts, electronic communication • Caregiver training • PAUSE document
Online Scheduling	• Identify clinics and physicians to implement online scheduling • Each region to submit one specialty clinic to implement MyChart scheduling in 2020 • Partnership with DIG to explore additional self services
Innovative Access Tactics	**Digital Interaction Avenues**: • ODHP • MyChart • Clockwise MD • Dex Care



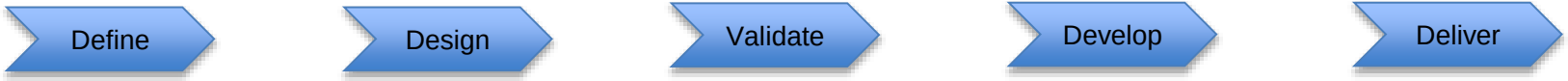
Proposed Future Panel Size Metrics

Unadjusted Panel Size:

- The total number of patients assigned to a specific provider (both established primary care patients seen for a billable service and those assigned or attributed patients from an at-risk contract

Current adjusted panel definition:

- Known predictors of visit utilization and acuity: age, gender, payer type



Proposed adjusted panel definition:

- Additional social determinants and severity of conditions to further risk adjust to accurately represent the panel.
- Goal is to obtain the optimal count to effectivity care for a population by a provider and/or care team.
- The panel size metric should also consider how to adjust for APP's, team based cared, clinical FTE, and specialty.

Test Methodology for Panel

Define → Design

- Leveraged the CPCI “At-Risk” and “High-Needs” patient logic
- Additional Criteria
  - 17 diagnoses; active on Problem List
  - 8 Medications
  - ED Visits
  - Hospital stays
  - Active Tobacco User
  - Substance abuse

- Each criteria is weighted as very intense, intense, moderate, low risk and exclude

Analysis for Panel

Validate → Develop

Comparing prior : new adjusted panel

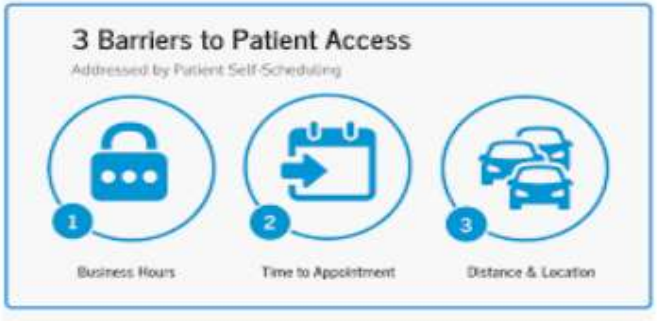
- No impact overall to adjusted panel size across all providers – continues to be net neutral across the system
- Providers with a 100+ panel; **+25.88%** to **-18.98%** variance
- Providers with a 1000+ panels; **+18.00%** to **-15.26%**
  (Swedish, Kadlec and PacMed larger negative variation due to incomplete data migration)

Online Scheduling 2020 Focus: Specialty

Q1	Q1, Q2	Q2+	ongoing	ongoing
	Review MyChart scheduling questions and map visit types and submit build to MyChart analyst. Identify go-live date.	**Educate/train providers, caregivers and patients about online scheduling**	**Go Live!**	**Weekly follow up with clinics**

Clinics Identified

- Oregon (local program manager leading the work)
- SW Washington
- SE Washington (Walla Walla)
- Heritage
- PacMed



Visit Type Alignment

Limited visit types

- Standard types across system
- Standard usage
- Instance alignment
- Submittal process

Approval process: review at Capacity Subcommittee and offer recommendation to COOC for approval

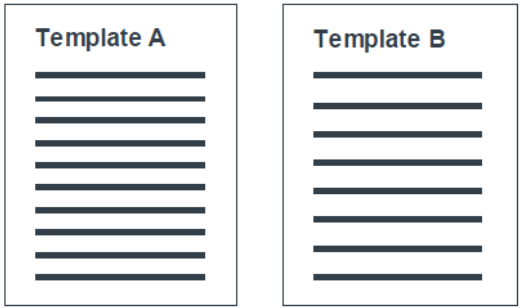
Visit Types

100+ → 15

Reduce # of visit types

Identify standard schedule templates

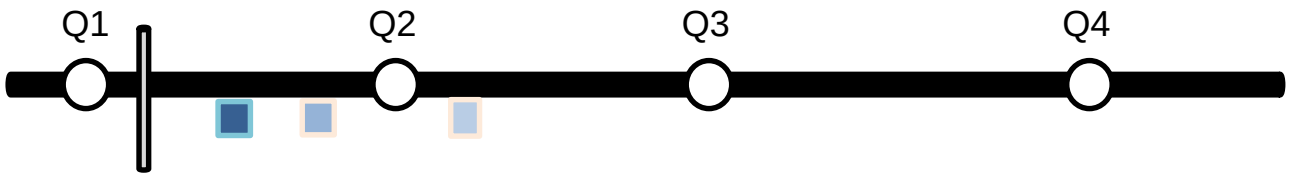
- Two proposed templates
- Engage clinical leaders and providers
- Identify low performing providers for standard schedule opportunity
- Regions own implementation with PE support for tracking and training



Advancing the Work: Growth and Clinic Efficiencies

- Define optimal space models
- Review growth strategies with regions
- Collate capital requests for PE-wide unified carve-out request
- Standardize best practice models that directly impact space planning needs

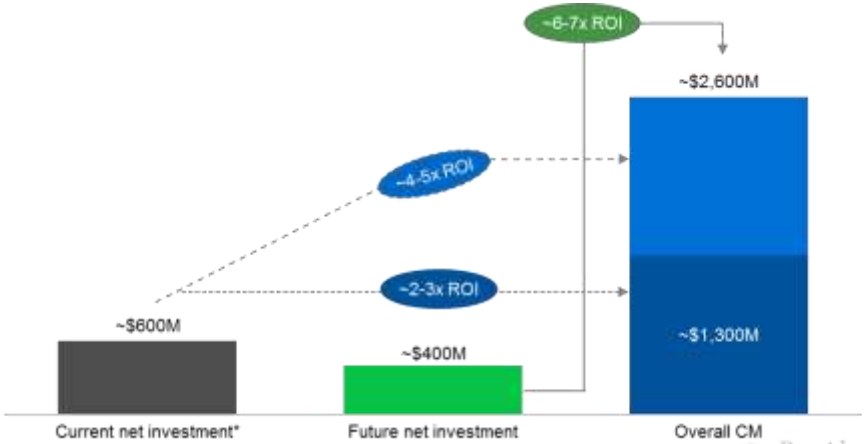
% of time exam rooms in use	• Identify baseline % across regions • Set exams room usage target • Incorporate assessment into growth plans
Work RVUs per exam room square footage	• Identify baseline wRVU/sq ft average across all regions • Set target wRVU/sq ft per exam room • Review wRVU/sq ft valuation into growth planning
Action Items	• Partner with each region to evaluate growth plans • Align efforts on standards of build process • Expand availability of clinical hours/days



PE Real Estate Strategy

Strategic Approach / Current Status

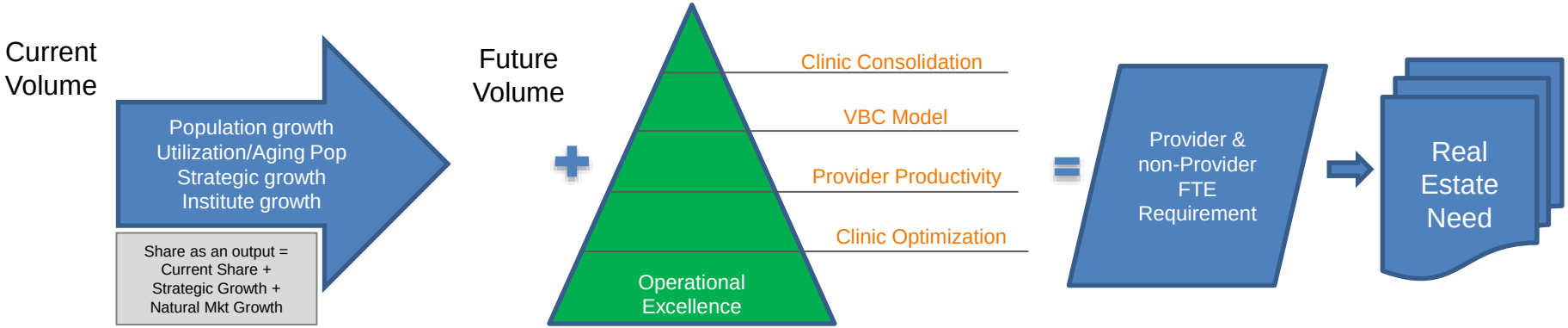
- Collaboration with the Real Estate and Regional Chief Strategy Officers to develop a comprehensive real estate plan for Physician Enterprise
- Review regional growth plans
- Align efforts on standard of build practices
- To achieve efficiencies highlighted by recent BCG analysis requires consolidation and optimizing clinic operations
  - Medical groups have the potential to generate ROI at 6-7x investment



Providence St. Joseph Health

PE Real Estate Strategy

Future Real Estate Need Modeling Proposal

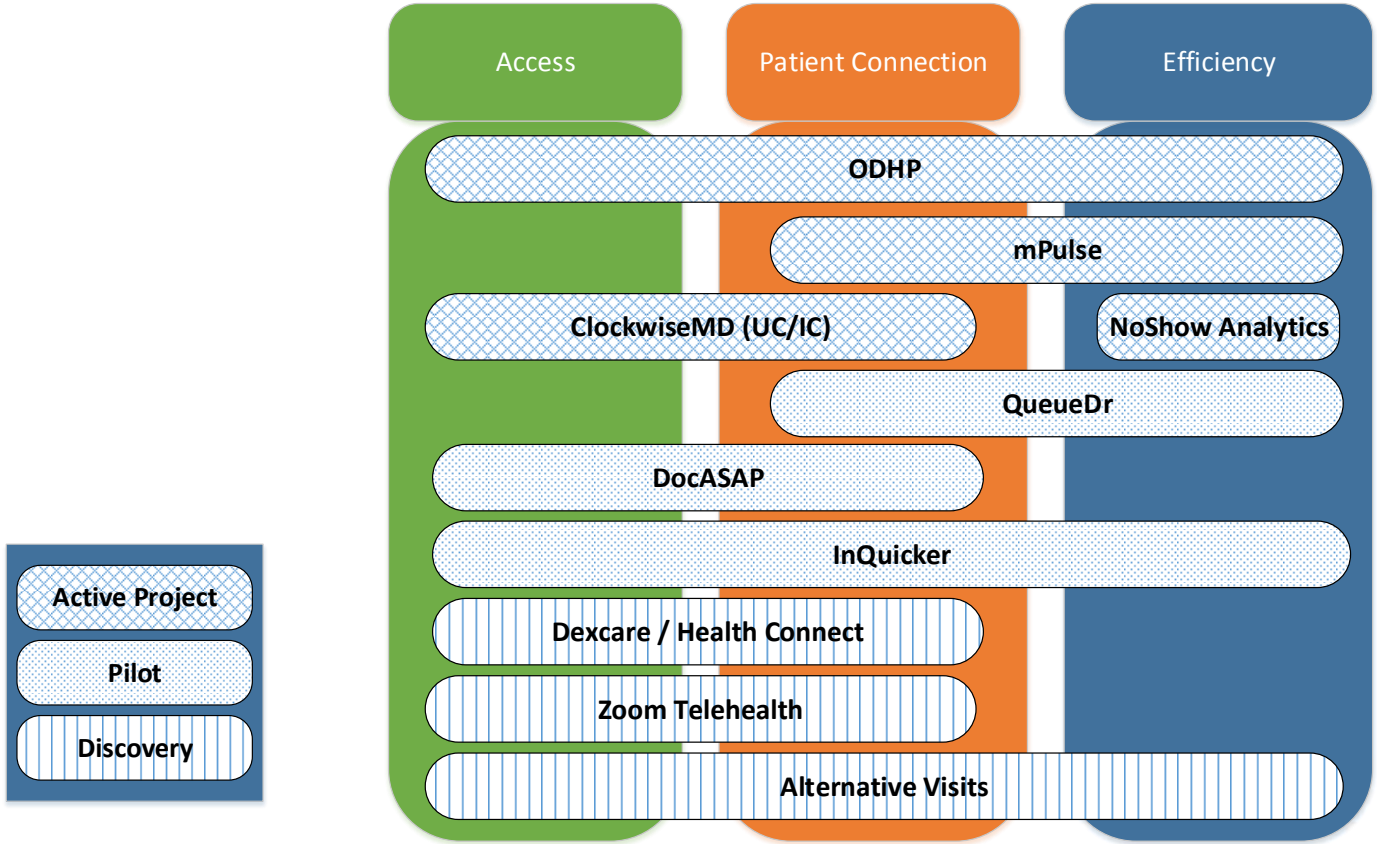


DRAFT Timeline and pending on the kick-off meeting with RESO

Team	Items	January				February	
		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Region	Institute & Strategic Growth						
PE / Regions	Productivity optimization						
	Clinic consolidation						
	Clinic optimization						
	Add ancillary services						
RESO	Real estate modeling						
	Sq. footage & Cost						

Finalize CSIC Presentation /Findings

Technology and EPIC Optimization



Access Dashboard

Jennifer Schaab COO, Physician Enterprise
Jason Largent Director Performance Metrics & Improvement, Physician Enterprise
Kate Dunn Principal Clinical & Operational Business Intelligence Analyst

Performance Analytics

Who We Are & What We Do

- ***Embedded team supporting key PE strategic projects – reporting straight up through PE leadership***
- ***Providing data consultation, data availability, directional data, metric development, data representation (visualization), analytics***
- *7 analysts in total (5 Principal BI Analysts & 2 Senior BI Analysts) – 2 FTEs in support of A.C.N.*

What was the request

Build an Access Dashboard

- *Upon review…multiple dashboards are needed*
  - *Access, Operations, LAIP, Enterprise Performance (MOR)*
- *Existing metrics and new/modified metrics*
- *Disparate data source metrics*

Metrics Held in Common

Measure	Current	Goal
Caregiver Engagement – Highly Sustainably Engaged	43.1%	Threshold: 50.0% Outstanding: 53.0%
Clinical Care – Compassionate	73.4%	Threshold: 76.4% Outstanding: 78.7%
Operating EBIDA ($)	$[illegible]	Threshold: $1.850.0M Outstanding: $1.879.0M

Physician Enterprise AIP/MIP

Measure	Current	Goal
First Year Turnover	27.7%	Threshold: 30.2% Outstanding: 28.2%
Component 1: Ambulatory Quality Metrics	6 of 7	Outstanding to achieve 5 out of 7 metrics
Component 2: Access and Connectivity metric development	2 of 6	Outstanding to achieve 6 out of 6 process steps throughout the year
Component 3: Caregiver ED Utilization Metric	25.0%	Threshold: 25.0% Outstanding: 24.0%
Transform Medicaid Care #1 – Regional Medicaid Improvement Plans Composite	1 of 2	Threshold: 1 of 2 Outstanding: 2 of 2
Digitally Engaged Users	561,552	Threshold: 458,944 Outstanding: 588,172
Digital Experience – Digital Registered Users	2,427,659	Threshold: 2,553,580 Outstanding: 2,822,404
Digital Experience – Digitally-enabled Patient Interactions	118,250	Threshold: 390,682 Outstanding: 402,696

Medical Group Operating Commitments

Measure	Current	Goal
Provider Engagement	TBD	75%
First Year Turnover	27.7%	28.2%
Pt Satisfaction	[illegible]	85.96%
PC Productivity	[illegible]	100%
Spec Productivity	[illegible]	100%
Medical Grp NOI YTD	($297,250,124)	($288,354,985)
Medical Grp EBIDA YTD	($275,498,787)	($266,188,858)
Panel Size	1715	1800
Internal Referral Rate	78%	80%
Digitally Registered Users	2,427,659	2,822,404
Digitally Enabled Transactions	118,250	402,696
Primary Care Patient Access	88.9%	88.7%
Specialty Care Patient Access	92.0%	92.1%
Diabetes Bundle	48.9%	48.4%
Advance Directive	22.3%	20.4%
CV Statin use	77.2%	77.0%
Peds Immunizations	74.7%	74.9%
Breast ca screening	73.8%	73.0%
Cervical ca screening	77.8%	71.4%
Colon ca screening	68.6%	65.9%
Depression Assessment	59.4%	55.4%

Physician Enterprise Initiatives

Measure	Current	Goal
PS+D		TBD
Epic Provider Proficiency (Rating)		Improved Efficiency rating
Medical Assistant First Year Turnover		Decreased turn over
Access:		3rd next avail?
PEC Unification		Timeline metric

Strategic Vision (Enterprise Performance)

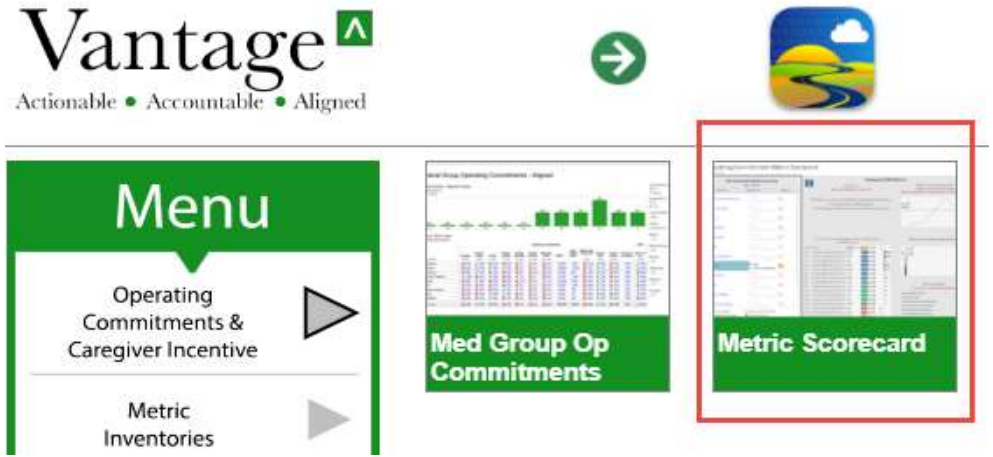
Standard Data Visualization & Story Telling

- ***Minimize "dashboard and report" footprint***
    - ***Single entry point "One Dashboard"***
- ***Utilize standard data sources and process mechanisms to allow for development efficiency***
- ***Make it easy for our audience to find and use solutions***
- ***So how do we accomplish this?***

V2 / Metric Scorecard

Access, Enterprise Performance, LAIP Metric Sets

- ***V2 / Metric Scorecard includes much more than the Operating Commitments…scalable***
  - ***Magic is in metric sets***
  - ***Continuous improvement and enhancements***
- ***Usage of V2 has surpassed the Medical Group Operating Commitments dashboard***



What is Next

Production Release mid-February (Access, LAIP & Enterprise Performance)

- *2020 Targets and Goals updates*
- *Metric Set modification*
- *Hierarchy Updates*
- *Future…new metric development and inclusion*
- *Disparate data sources*
- *Vantage migration to myHIway gallery*
    - *Research & Development of PE Portal*

Attention Vantage Users:
The Vantage Portal will sunset on March 31, 2020.
Moving forward, Vantage content will be hosted as a myHIway gallery.

All Vantage reports are already available in that location: myHIway login page

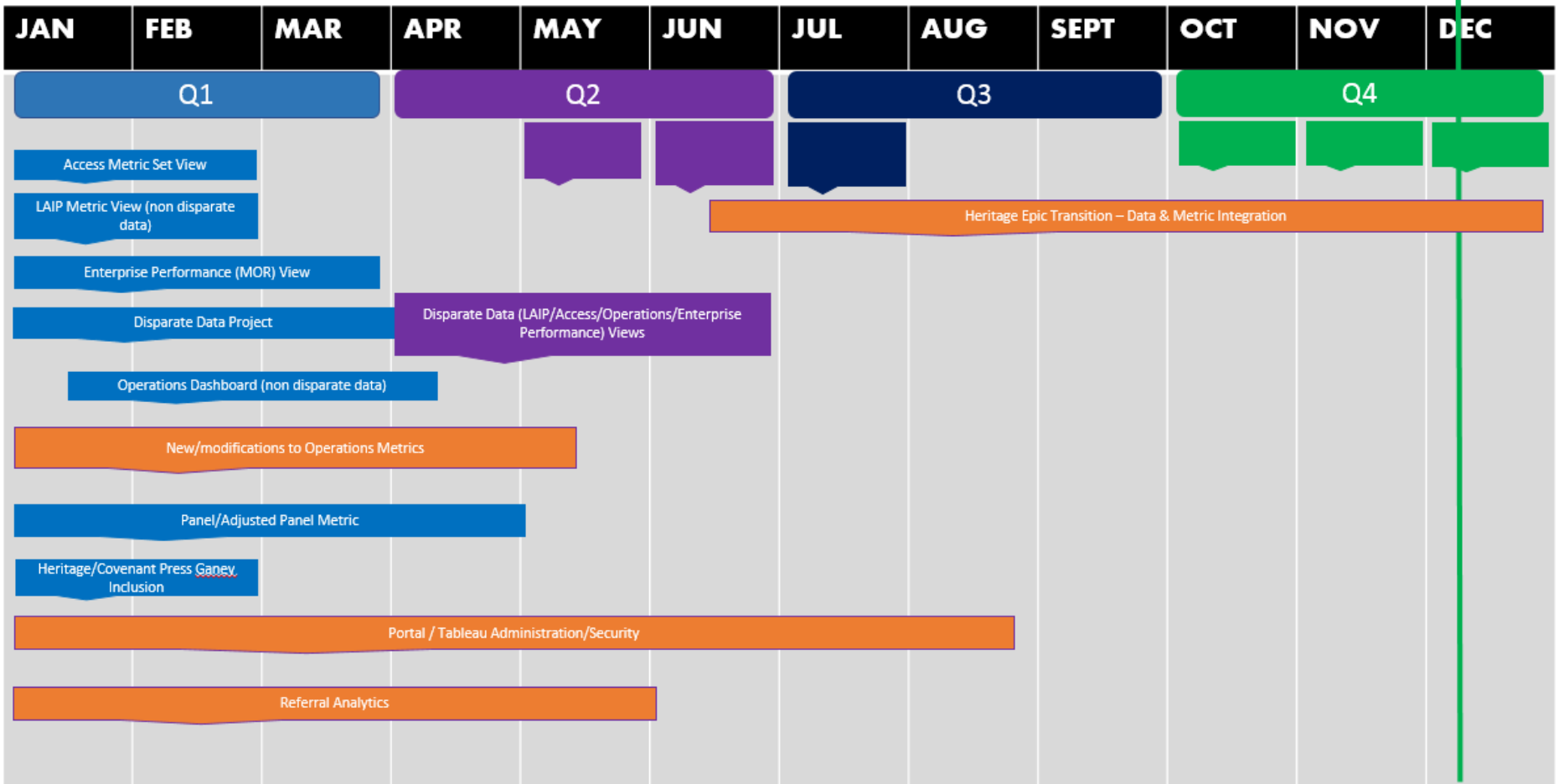
Instructions on how to navigate to the Vantage gallery within myHIway can be found here: How to access Vantage via myHIway

For questions or concerns, please email: healthcareintelligence@providence.org

Providence St.Joseph Health

Performance Analytics Roadmap 2020 (PE Operations only)

Owner: Time



Undefined | Q1 Work | Q2 Work | Q3 Work | Q4 Work | Future Work

One Big Thing – Northern California

Bob Just
Chief Executive, Northern California
James Devore, MD
Chief Medical Officer

Evolution of St. Joseph Health Medical Group in Northern California

January 2020

NorCal Market Overview

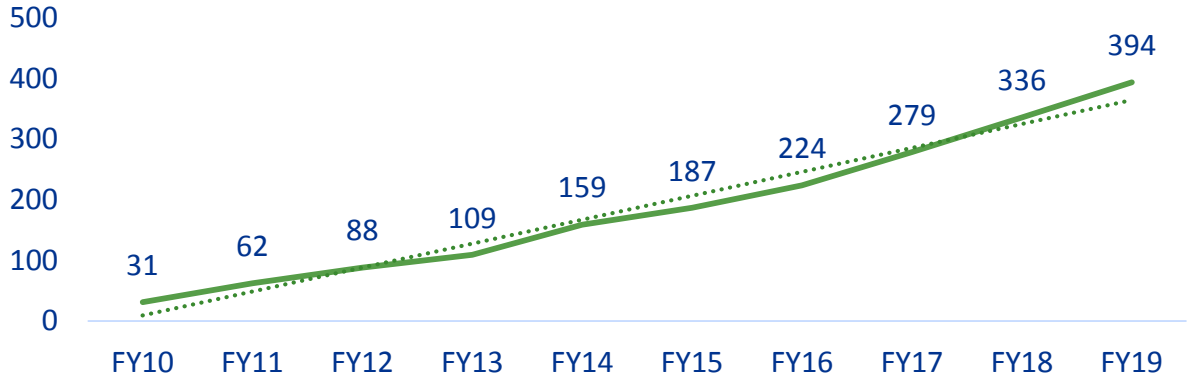
- Sonoma – Founded October 2008
- Humboldt – Founded February 2009
- Napa – Founded May 2010

St. Joseph Health Medical Group

Annadel Medical Group, Queen of the Valley Medical Associates and Humboldt Medical Specialists are now St. Joseph Health Medical Group

NorCal Provider Growth

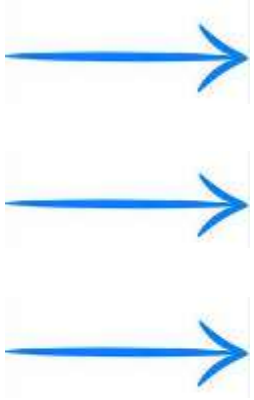
Total Providers in NorCal



Total Provider Growth in NorCal

FY	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19
Growth from prior FY	-	100%	41.9%	23.9%	45.9%	17.6%	19.8%	24.6%	20.6%	17.3%
Cumulated Growth	-	100%	183.9%	251.6%	412.9%	503.2%	622.6%	800.0%	983.9%	1,171.0%

A Framework For Cultural Change



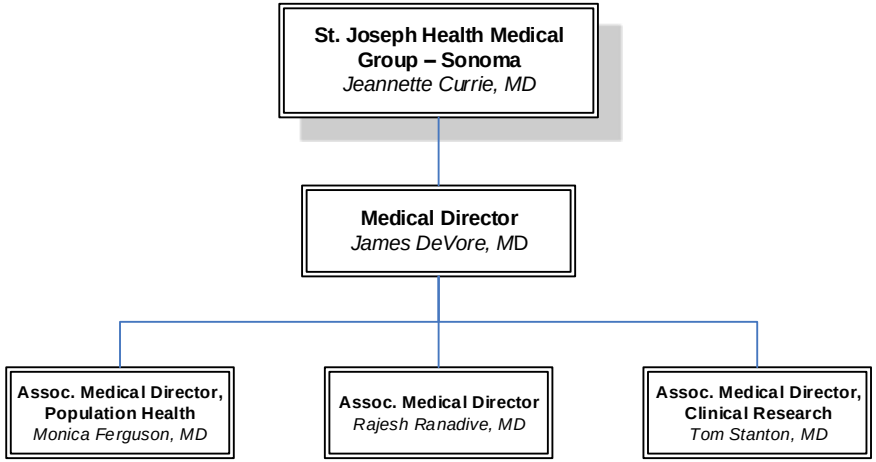
Financial Accountability Taskforce

- Goal to develop a framework that encourages physician engagement and ownership of operational decisions and financial performance
- Education – Understand medical group budgets (i.e. Finance 101 curriculum)
- Application – Learn to utilize available tools/reporting to determine the allocation of resources
- Management / governance – Participation in decision-making and the development of policies that successfully influence overall group sustainability

Taskforce Accomplishments

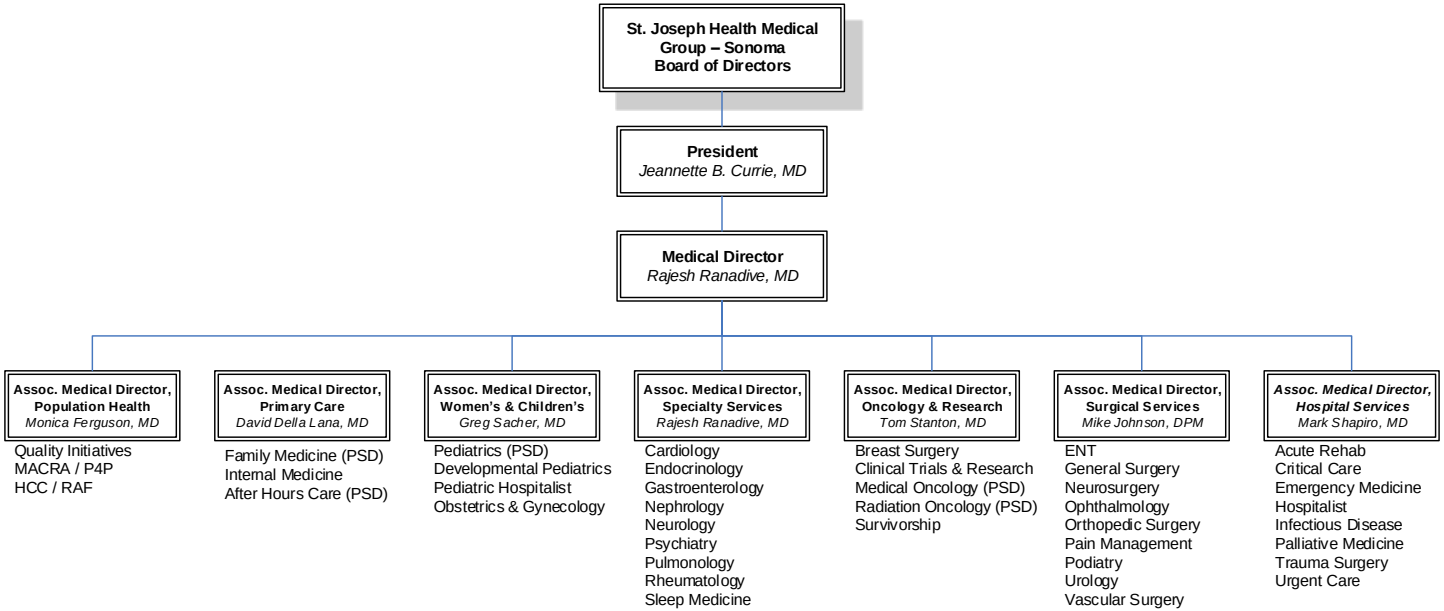
- Physician driven process of evaluating overall group financial performance, productivity, and resource requests
- Assessment and appropriate standardization of clinic hours, appointment templates, and scheduling expectations
- Right sizing of employment contracts to ensure alignment with actual work effort
- Introduction of new contract parameters to ensure greater accountability at the onset
- Greater than $1.7 M per year in improvements

Old Org Chart…



Miscellaneous Administrative Roles:
After Hours Care
Breast Surgery
Clinical Research
Gastroenterology
Hospitalist
Medical Oncology
Obstetrics & Gynecology
Pediatrics
Radiation Oncology
Vascular Surgery

New Leadership Structure



Physician Leadership Forum Objectives

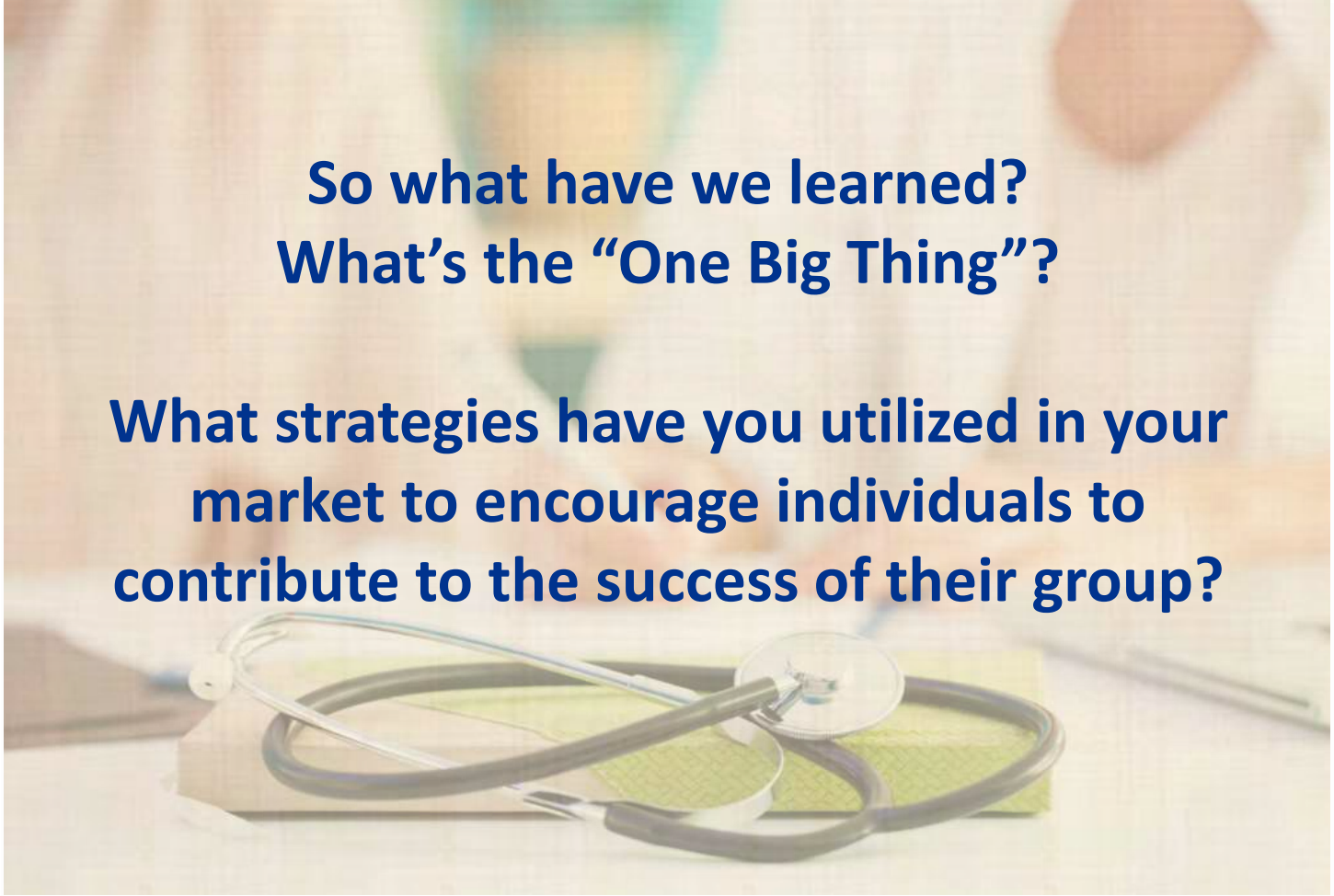
The Physician Leadership Forum was designed two years ago in response to a need to cultivate and advance physician leadership capacity in NorCal region

The objectives include:

1. Accelerate and foster the development of motivated physician leaders
2. Develop potential successors to key leadership roles (Boards, Committees, Associate Medical Directors, etc.)
3. Build a talent pool to ensure continuity and stability
4. Reduce the risk of a talent drain and/or key contributors leaving

Physician Leadership Forum Overview

- Reclaiming meaning, purpose and accountability
- Interpersonal effectiveness
- 360 feedback – personality, performance and leadership
- Coaching
- Leading groups
- Leading organizational change
- Strategy and Finance



So what have we learned?
What's the "One Big Thing"?

What strategies have you utilized in your market to encourage individuals to contribute to the success of their group?

Medical Assistant Laddering

Suzy Bruttig, RN, MSN, FNP Chief Nursing Officer, Physician Enterprise
Chris Peters Human Resources Director

Clinical Ladders

MA Ladder I: Non-certified; < 6 months experience

MA Ladder II: > 6 months experience, competent

MA Ladder III: > 2 years experience, highly competent, informal leader in 3 areas (preceptor, Own It ambassador, safety officer, quality, etc.) or certified scribe

MA IV: > 3 years experience, highly competent, leadership responsibility or primary care/TBC lead or highly skilled in specific sub-specialties

Clinical Laddering Update

Four Progressive Ladders

- JDs and compensation has been formalized and & approved by Medical Group EC, HR & Compensation

Soft Go-Live with Two Regions (Alaska & Northern California)

- HR freeze allows us to be more targeted with roll-out prior to scaling; evaluating next steps on timing and scale

System-Wide Rollout

Approach

- Chris Peters will connect with local HR leaders
- Suzi and Jennifer Schaab coordinating with operations and communication team for local rollout timing and next steps

Remaining Physician Enterprise Regional Timeline – TBD

- Compensation needs to grade each region
- Timeline for scale to rest of Physician Enterprise dependent upon compensation's timeline for completion

Initial Results: Caregiver Mapping

Alaska

87.5% fall within new pay ranges

- No caregivers below range minimum
- 7 caregivers (12.5%) above range maximum

Ladder I: 36%
Ladder II: 55%
Ladder III: 9%
Ladder IV: 0%

Northern California

98.4% fall within new pay ranges

- 4 caregivers (1.6%) below range minimum
- No caregivers above range maximum

Ladder I: 13%
Ladder II: 58%
Ladder III: 21%
Ladder IV: 8%

Things to Consider

MA Certification

Cost

- Dollar amount for program: $1500-2000
- Dollar amount for time Caregiver needs out of clinic to complete certification (dependent upon structure of program)

Hours (Caregiver will need to complete certification): varies by program

Net Increase Investment

- Annual basis
  - AK: no caregivers below minimum
  - NorCal: $996.14
- Certification (tbd based up local programs)

Physician Enterprise Medical Assistant

CLINICAL EDUCATION

Clinical Education

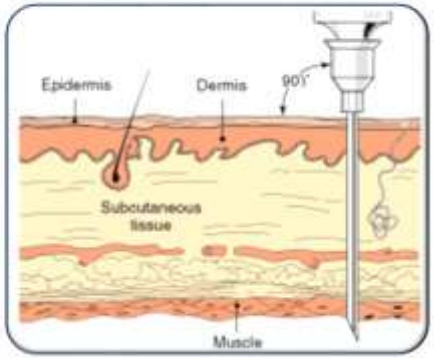
- Standardized; professional
- Evidence based
- Modules Completed:
  - Medication Administration
  - Vaccine Administration
  - Vital Signs
- Healthstream
- My Career Center

Intramuscular Injections

- **Tissue:** Muscle
- **Needle Selection:**
  - ½"-1 ½" Length
  - 18G-25G
- **Needle Inserted:**
  - At 90°
- **Common Uses:**
  - Most vaccines
  - Antibiotics (Rocephin, Penicillin)
  - Other medications per the package insert

Should you aspirate an IM injection?

Maybe. Follow the package insert.
Do not aspirate for vaccines.



Vaccine Injection Site and Needle Size

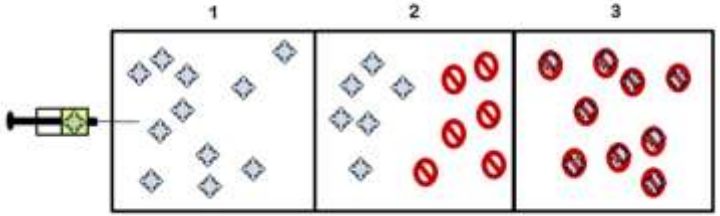
Subcutaneous (Subcut) injection – Use a 23–25 gauge, 5/8" needle. Inject in fatty tissue over triceps.

Intramuscular (IM) injection – Use a 22–25 gauge needle. Inject in deltoid muscle of arm. Choose the needle length as indicated below:

Gender/Weight	Needle Length	
Female or male less than 130 lbs	5/8"*–1"	* A 5/8" needle may be used for patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle only if the subcutaneous tissue is not bunched and the injection is made at a 90-degree angle.
Female or male 130–152 lbs	1"	
Female 153–200 lbs	1–1 1/2"	
Male 153–260 lbs		
Female 200+ lbs	1 1/2"	
Male 260+ lbs		

HOW A VACCINE WORKS

Creating Immunity



A weakened form of a disease antigen – that may be dead or living – is injected into the body.

The body reacts to the antigen by creating antibodies to attack it.

If the certain antigen ever enters the body again, the body's immune system antibodies will be able to fight against it.

Safety Needle Use

- NEVER use a needle for injection that is not a safety needle
- ALWAYS activate the needle the MOMENT it's removed from patient's tissue
- Some safety devices are meant to be activated with a finger, not a surface – read manufacturer inserts
- Dispose of all Needles, Syringes, & Sharps in the designated Sharps Biohazard Container.

Primary Care Summit

Doug Koekkoek, MD
Chief Medical Officer, Physician Enterprise
Lisa Scardina
Executive Director, Clinical Integration

VALUE-BASED PRIMARY CARE

Transforming now
and for the future

PROVIDENCE PRIMARY CARE SUMMIT
MARCH 4–6, 2020

Objective

- Review approach for 2020 Primary Care Summit

ASK

- Engage in the development of your list of regional representatives and book travel
- We'll continue to define breakouts and invite presenters accordingly
- Regions to validate the Spotlight presentation – opportunity to recognize great work across the enterprise

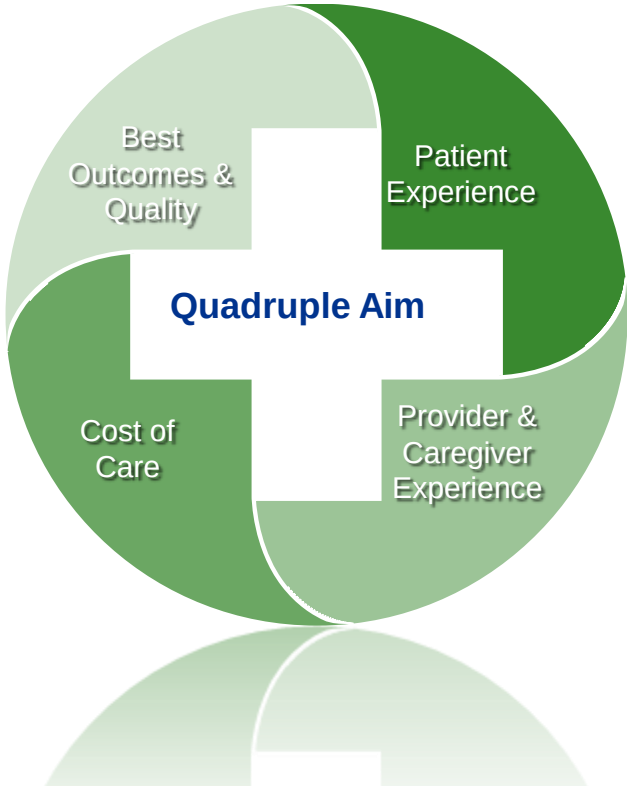
History of the Summit

2020 will be our 4th Annual Summit

Providence St. Joseph Health

Primary Care Value Statements

Guiding our strategies to achieve top performance and foster joy in practice:



We build on our **strong mission, heritage and identity** to best serve our patients

We design care delivery around the core belief that **whole-person, patient-centered care** creates healthier individuals and communities

We develop **relationships with our patients** and partner with them to **manage navigation** through a complex healthcare system

We practice with an emphasis on **collaboration, autonomy, trust, and confidence** within our communities

We promote **full primary care scope of practice,** in partnership with specialists, as good stewards of our resources

We advocate to **align payer reimbursement** and **provider compensation** to support a sustainable practice environment that strives to fulfill the quadruple aim

We affirm a culture that strengthens the **value of the patient/provider relationship** and works to bring back the **joy of medicine**

We **foster team work** with each team member working at their highest ability and we support the team with a focus on **continuous learning and improvement**

We **know the populations we serve** and work in partnership with others in our organization and communities to address key issues impacting health and **reduce cost of care**

Primary Care – Vision

Providence St. Joseph Health Primary Care will maximize the health and well-being of our communities through partnership to deliver the best outcomes, patient experience and caregiver experience at the highest value, one person at a time.

Providence St. Joseph Health

Theme for 2020

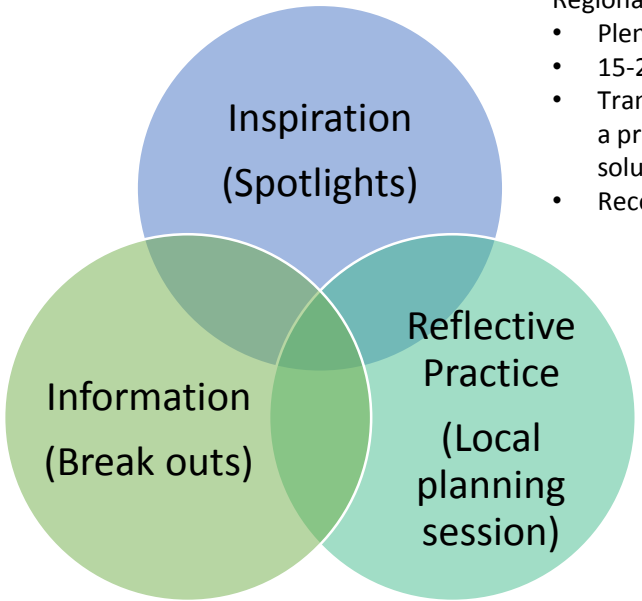
Start: March 4 at Noon
Conclude March 6 at 1:30 pm
Newport Beach Hotel

Feedback from you

- Overall – feedback has been very positive
- Breakouts are great
- Great to have system leaders sharing the vision and being present
- Best when breakout speakers are the ones actually doing the work
- Provide key takeaways from the breakouts in summary form
- Allow time for networking; structure networking to meet new people and find colleagues
- Allow for some “down” time – don’t over pack the agenda
- Consider outside guest speakers for “wow” factor
- Ensure good variety of break out sessions
- Ensure APCs have a voice
- Speak to how we are serving rural and underserved populations
- Help facilitate how groups should get from current state to future state

2020 Primary Care Summit Learning Model

Regional Spotlights
- Plenary session / Grand Ballroom
- 15-20 minutes each in length
- Transformational change: describe a problem and the creative solution
- Recognition as a best practice



Break-outs
- ~50 minutes each
- Leading Practice Sessions: Regional lead with system support
- Integration Sessions: System lead with regional support

Local Planning Session
- ~150 minutes total
- Debrief and develop change management plan as a medical group/market/region
- Determine major themes across the PE, particularly where there are dependencies/barriers

Strategic Context (Main Stage presenters)
Compelling vision (Aim, what we are working to solve)
What the data shows us
How we are organizing for success; how we will work together to achieve

Breakout Sessions (draft)

- Effective Use of the Team
- Value-Based Primary Care - Enabling improved capacity and patient access
- 2 Rounds of 7 different offerings on Wednesday and on Thursday

Leading Practice Sessions **Region-led; System support**	**Integration Sessions** **System-led; regional engagement**
1. Provider Wellness	1. Provider Efficiency in Epic/EMR
2. Digitally Enabled Care, Alternative Visits	2a. Provider Recruitment
3. Standardizing Visit Types	2b. Trends in Provider Compensation
4. Optimizing the Team	3. Patient Panel – definition and management
5. Effective Dyad Partnerships	4. Improving InBasket/Sort the Mail Workflow
6. HCC Coding	5. Ambulatory Pharmacist Role in Value-based Primary Care
7. Embedded Behavioral Health	6. MA Laddering
	7. Clinical Quality: Depression Care and Suicidal Ideation Management

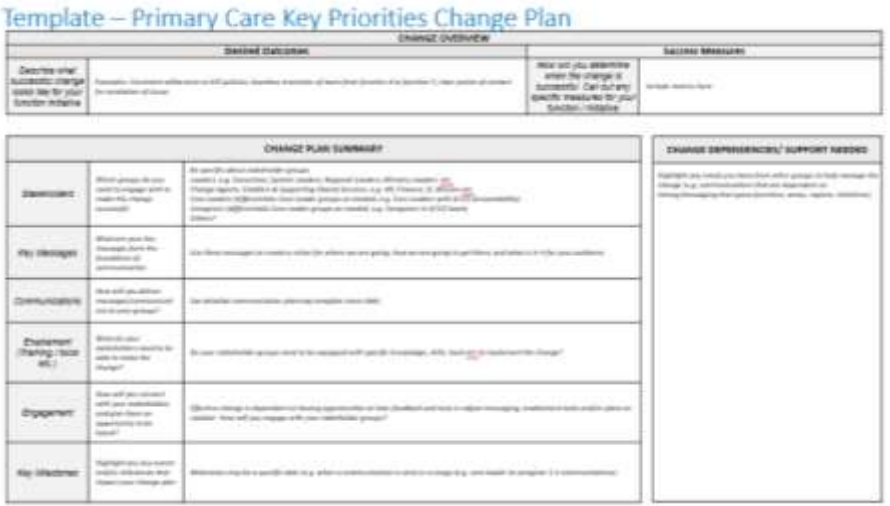
5 Regional Spotlights (draft)

Ideas so far:

1. OR: Geriatric Mini-Fellowship – improving provider engagement and patient care
2. PHC: New MG Critical Care Access - Opioid-Medically Assisted Treatment
3. TBD: MAGs and SAGs – developing effective clinical pathways
4. TBD: Dementia care pathway
5. TBD: Solving an access problem
6. TBD: Best performers in the area of schedule online appointments
7. TBD

Reflective Practice: Local planning session

- ~150 minutes total
- Debrief and develop change management plan as a medical group/market/region
- Determine major themes across the PE, particularly where there are dependencies/barriers


Template – Primary Care Key Priorities Change Plan

Logistics / ASK

We are relying on the Primary Care Executive Committee to lead the development of the content

- Engage in the development of your list of regional representatives and book travel
  - Invitations to attendees going out this week
  - Consider bringing Implementation leaders from your regions to help with local planning session
- We'll continue to define breakouts and invite presenters accordingly
- Regions to validate the Spotlight presentation – opportunity to recognize great work across the enterprise

Physician Enterprise Leadership Updates – Finance

Nate Husmann
Chief Financial Officer, Physician Enterprise

PSJH Physician Enterprise

2019 Financial Performance (thru November)

Physician Enterprise - 2019 Performance (thru November)

Physician Enterprise has been a bright spot with financial performance near or better than budget in every market

EBIDA ($000s)	Month-to-Date				Year-to-Date				Prior Year		
	Nov 2019 Actual	Nov 2019 Budget	B / (W)	B / (W) %	Nov 2019 Actual	Nov 2019 Budget	B / (W)	B / (W) %	Nov 2018 Actual	B / (W)	B / (W) %
PSJH Medical Groups EBIDA	**$ (65,404)**	**$ (68,946)**	**$ 3,542**	**5.1%**	**$ (759,805)**	**$ (793,957)**	**$ 34,152**	**4.3%**	**$ (766,760)**	**6,955**	**0.9%**
Alaska	$ (837)	$ (1,201)	$ 363	30.3%	$ (10,601)	$ (11,980)	$ 1,379	11.5%	$ (11,230)	629	5.6%
Swedish	$ (10,318)	$ (8,788)	$ (1,530)	(17.4%)	$ (108,668)	$ (111,124)	$ 2,456	2.2%	$ (111,933)	3,265	2.9%
Pac Med	$ (1,147)	$ (2,276)	$ 1,129	49.6%	$ (15,381)	$ (24,314)	$ 8,933	36.7%	$ (16,321)	940	5.8%
Washington - Montana	$ (11,366)	$ (14,066)	$ 2,700	19.2%	$ (149,900)	$ (155,220)	$ 5,320	3.4%	$ (127,005)	(22,895)	(18.0%)
Oregon	$ (8,349)	$ (10,220)	$ 1,872	18.3%	$ (108,150)	$ (107,594)	$ (556)	(0.5%)	$ (100,867)	(7,283)	(7.2%)
Northern California	$ (6,095)	$ (5,595)	$ (500)	(8.9%)	$ (59,443)	$ (60,006)	$ 563	0.9%	$ (67,996)	8,553	12.6%
Southern California	$ (24,886)	$ (24,043)	$ (842)	(3.5%)	$ (278,538)	$ (294,924)	$ 16,386	5.6%	$ (294,837)	16,299	5.5%
Texas	$ (2,407)	$ (2,756)	$ 349	12.7%	$ (29,124)	$ (28,796)	$ (329)	(1.1%)	$ (36,570)	7,446	20.4%

- Revenues have bee slightly under target (0.5%), expense management has driven a majority of our improved financial performance (1.3%)
- Many regions started the year with a budget gap or shortfall, and actively implemented operating plans to address / meet financial targets
- Performance relative to prior year is also showing continued improvement

System - 2019 Performance (thru November)

However…2019 was a challenging year financially across PSJH regions, with headwinds in volumes and rates in all markets

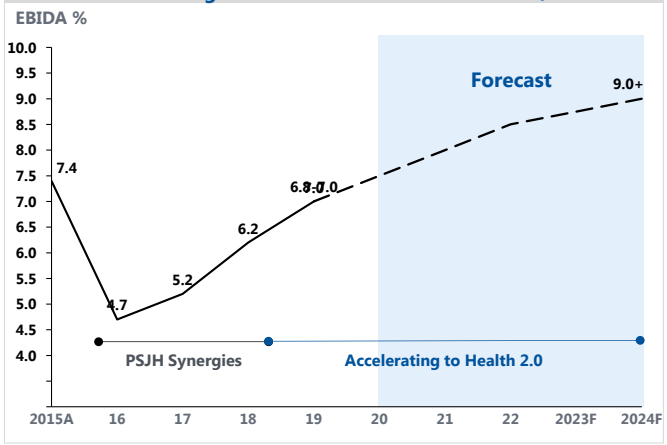
Month-To-Date					Year-To-Date			
Actual	Budget	Variance	Pr. Month		Actual	Budget	Variance	Pr. Year
				TOTAL PSJH consolidated				
2,086,601	2,086,491	(8,890)	2,113,975	Net Operating Revenues	22,888,435	22,910,714	(22,279)	22,130,360
2,056,634	1,994,349	(72,285)	2,107,759	Total Operating Expenses	22,654,631	22,480,003	(174,628)	22,140,957
29,967	112,142	(82,175)	6,215	Net Operating Income	233,804	430,710	(196,907)	(10,577)
109,691	26,042	83,649	57,102	Non Operating Gains Losses	938,923	510,499	428,424	(175,214)
139,658	138,183	1,474	63,318	Net Income	1,172,727	941,209	231,518	(185,791)
140,264	225,734	(85,469)	116,907	EBIDA	1,468,066	1,697,832	(229,767)	1,223,582
				REGION INDICATORS				
				Alaska				
25,400	32,552	(7,152)	28,519	EBIDA	309,647	342,728	(33,081)	304,270
20,647	27,653	(7,006)	23,730	Net Operating Income	256,281	288,058	(31,777)	249,941
				Swedish				
39,194	53,179	(13,985)	56,985	EBIDA	545,180	579,601	(34,421)	514,077
27,028	40,653	(13,625)	44,422	Net Operating Income	406,406	437,284	(30,878)	372,734
				Washington and Montana				
82,600	95,810	(13,210)	107,006	EBIDA	1,011,432	1,078,777	(67,345)	989,259
67,557	80,331	(12,774)	91,967	Net Operating Income	844,828	907,923	(63,095)	816,636
				Oregon				
84,332	79,206	5,127	89,283	EBIDA	907,010	894,559	12,451	877,058
74,064	68,618	5,446	79,226	Net Operating Income	797,788	779,743	18,045	763,701
				Northern California				
23,493	42,048	(18,555)	18,181	EBIDA	257,115	321,679	(64,764)	71,594
18,398	36,010	(17,612)	13,019	Net Operating Income	196,986	254,972	(57,986)	9,611
				Southern California				
165,701	154,240	11,462	100,095	EBIDA	1,227,074	1,237,356	(10,283)	679,671
135,445	122,333	13,111	68,567	Net Operating Income	878,156	883,982	(5,826)	338,935
				Texas				
21,315	24,740	(3,425)	23,362	EBIDA	262,161	250,037	12,124	113,299
16,022	20,517	(4,495)	17,993	Net Operating Income	206,322	198,878	7,444	56,055
				Shared Services, Trusts, and other				
(301,772)	(256,041)	(45,731)	(306,525)	EBIDA	(3,051,552)	(3,007,105)	(44,447)	(2,325,646)
(329,194)	(283,973)	(45,220)	(332,730)	Net Operating Income	(3,352,962)	(3,320,130)	(32,832)	(2,618,191)

Financial Opportunity of Transitioning to Value Based Care

Path to sustainable financial results

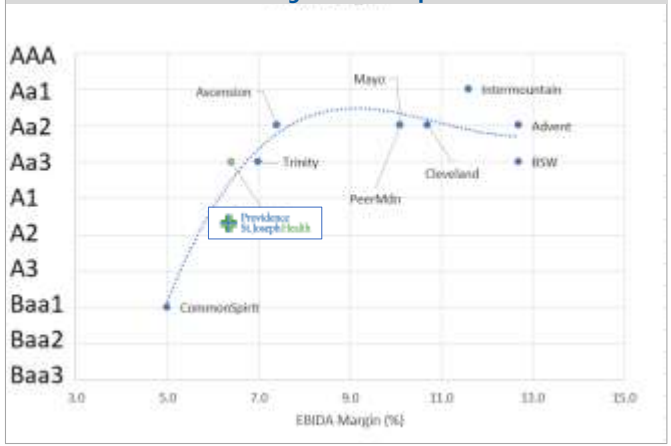
PSJH has set a target of 9.0%+ for sustainable EBIDA Margin, which is in line with many of our peers across the country (e.g. it is a reasonable target)

EBIDA margin transformation: 2015A – 2024F, %



2017 Results exclude PAML-related gains.
2018 and 2019 Margins net of restructuring charge

EBIDA Margin Peer Comparison

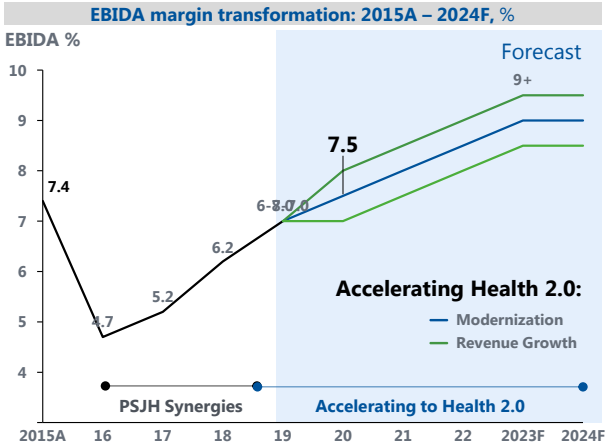


June 2019 Trailing twelve months

Providence St.Joseph Health

This path will not be easy

Modernization and Revenue Growth will be a key component of getting to a sustainable margin. The Physician Enterprise will be a leader in this change, particularly in the transition to more value-based care.



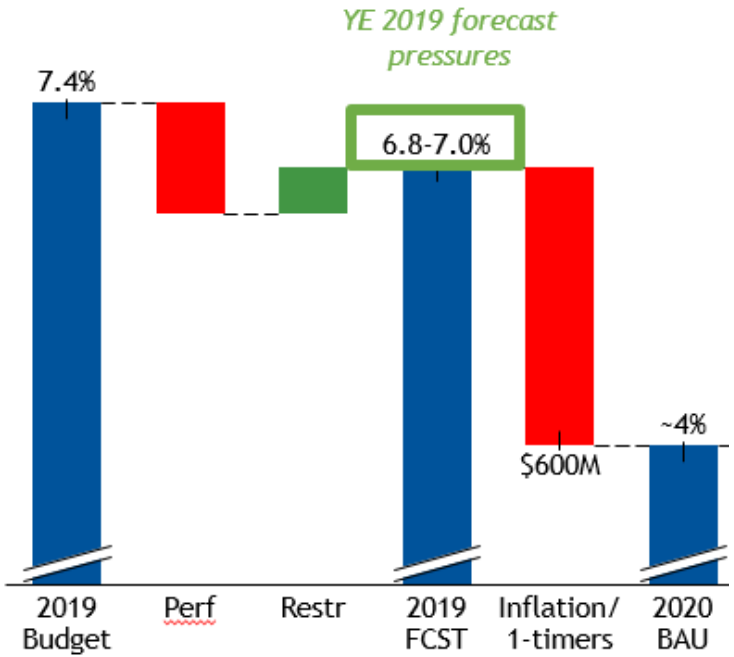
2017 Results exclude PAML-related gains.
2018 and 2019 Margins net of restructuring charge
2020 Margin adjusted for investments

Modernization plans will drive long-run EBIDA margins to 9+%

- 2019 forecast: 6.8 - 7.0% (adjusting for restructure)
- 2020 budget at 7.0% (GAAP) and 7.5% (normalized) driven by:
  - Modernization plans being finalized to deliver targeted $400 – 500M in savings
  - ~$130-150 in strategic investments including Branding, Epic, and ERP
  - Diversification pathway leads to +/- 50 bps of accretion/dilution within the 5-year plan
  - Capital Efficiency
    - Reallocating capital to diversified revenue and process modernization initiatives will boost ROIC and improve capital turnover

Transitioning to Value-Based Care

The current economics of our Fee For Service environment are not sustainable…"the math just doesn't add up", making continued financial improvement even more difficult



- "Business as Usual" would lead to ~$600M in performance declines (e.g. expenses are going up fast that revenues)
- Modernization and Operating Improvement Plans are in place to help offset this in 2020
- Transitioning to more Value Based care can help offset this going forward, where we take more risk and ownership of the transition of services to non-acute settings

Case Study: Medicare FFS vs. MA Risk Capitation

- High level Medicare FFS economics
  - Our cost structure for seniors runs at ~125% of medicare
  - Heavy specialty and surgical mix (2/3) vs. primary care (1/3) drives up this %
  - Vast majority of costs related to variable labor and PSA expenses which are largely market driven
  - We can only earn revenue on practices within the medical group

- MA risk economics – Jude MG example
  - Jude MG has been able to drive margins into the mid-teens, with 150-200% Medicare yields
  - Institutional risk and management of HPN affiliates provides further opportunity to drive incremental margin for the system
  - While Jude MG provides the majority of services due to its size and scope, other ministries provide as little as 20% of services, allowing us to control and drive value from more of the healthcare dollar

OC/HD Average	PMPM
Medicare value of professional services	95.00
Total direct cost	120.00
- % Labor	*27%*
- % Physician PSA	*53%*
- % Other (Supplies/Rent)	*20%*
Cost as % of Medicare	**126%**

Jude MG	PMPM
Professional cap revenue	375.00
Total direct medical cost	300.00
- % Internal cost	*60%*
- % External paid claims	*40%*
MSO support costs	15.00
Net Margin PMPM	**60.00**
Medical Loss Ratio	**80%**
Net Margin %	**16%**

Properly managed, risk capitation can (1) outperform FFS on a contribution margin basis, (2) yield well above Medicare rates and (3) allow us to control more of the healthcare dollar

Case Study: OC Risk Business Driving 2019 Outperformance

	OC/HD November YTD				
	Actual	Budget	$ Var	% Var	
Medical Groups EBIDA (ex Hoag)	**$ (82,424)**	**$ (85,268)**	**$ 2,844**	**3%**	>strong volumes offset by rate shifts to HMO, higher supplies and PSA
Full Risk Capitation					
Total member months (snr and comm)	1,784,579	1,730,513	54,066	3%	>strong underlying volume growth
Capitation Revenue	296,553	275,875	20,678	7%	>volume + rate improvement
HCC Settlement	10,227	5,355	4,873	91%	>CMS settlements ahead of budget + prior year catch-up
Quality & P4P	6,767	1,240	5,527	446%	>outperformance on quality-related bonuses
Other Revenue	1,052	912	140	15%	
Total Full Risk Revenue	**$ 314,599**	**$ 283,382**	**$ 31,216**	**11%**	
			-		
Full Risk Medical Expenses	**$ 296,380**	**$ 279,574**	**$ (16,806)**	**-6%**	>50% volume, 50% higher costs on PMPM basis
Indirect Allocated Expenses	18,767	18,436	(331)	-2%	
Total Operating Expenses	**$ 315,148**	**$ 298,010**	**$ (17,138)**	**-6%**	
			-		
Full Risk EBIDA	**$ (549)**	**$ (14,628)**	**$ 14,079**	**96%**	**>full risk accounts for >80% of EBIDA outperformance**
Total EBIDA	**$ (82,973)**	**$ (99,896)**	**$ 16,923**	**17%**	

Our business continues to shift to risk-based contracts, so we must drive margin from managed care and related contracts

PE Implementation Roadmap 2020

Lisa Scardina
Executive Director, Clinical Integration
Lorrie Baird
Executive Director, Physician Enterprise Operations

Objective

- Review what's on deck for 2020
- Review some key principles and model to support implementation at scale
- Table top discussion for feedback
  - PE 2020 Roadmap
  - Enablers for successful implementation and spread

Feedback from you

- Pace the initiatives – we'll see better results in patient experience and engagement
- Provide early heads up helps to create engagement, sense of enablement and autonomy
- Provide communication plans and tools
- Be sensitive to regional differences
- Avoid duplicate work when we need to give feedback (completing spreadsheets with clinic facts) – this is one more thing that clinic managers have to complete
- Provide more time to give feedback – 2 week turn around is quick, especially when we have to engage our clinic managers so that they have the context and can support the change
- Consider engaging more at the Director level with our operational committee structure – this insight is closer to the field

Harvard Business Review

MANAGING ORGANIZATIONS

Too Many Projects

by Rose Hollister and Michael D. Watkins

From the September–October 2018 Issue

Aligned and Integrated PE and Regional Driver Diagram

In service to our patients and communities

Enterprise Performance Metrics

- Engagement and Experience Metrics
- Quality and Value Metrics
- Growth and Access Metrics

Region OIP and LAIP

- Physician Partnership
- Quadruple Aim
- High Performing Network
- Innovation and Consumerism

Regional Tactics

Selected PE Led/Supported Tactics

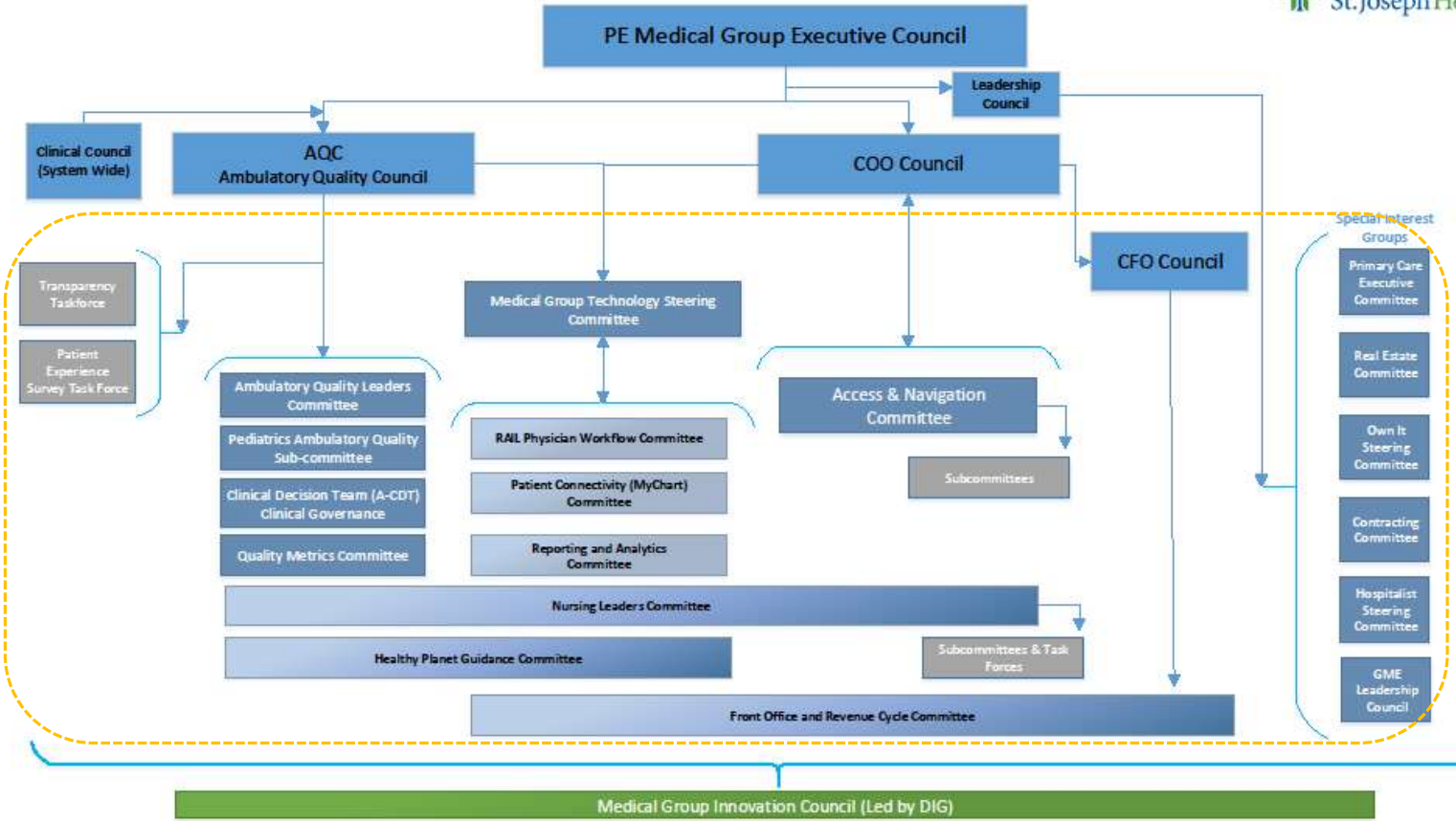
- Binary Fountain (Patient Experience Comments)
- Clockwise MD (reserve appt. online w/ known wait times)
- FIT Kit Delivery & Recall Standardization
- Guide for Provider Schedule Templates
- MA Laddering
- Mission Fidelity Assessment (Medical Group)
- Team Based Care (3-4 care model standards)
- OwnIt Caregiver Rollout
- Own-It Physician Rollout
- Physician Onboarding
- Provider Engagement Action Plan

- HCC POC & Pre-Visit Tool (OR & CA)
- HCC POC & Pre-Visit Tool (All Other Locations)
- Roadmap Data Analysis for VBC Readiness
- Depression Care Pathway 2.0
- Healthy Planet Atrial Fibrillation Registry
- Telemedicine- Alternative Visit Types
- High Perf Network-Referral Management Program
- mPulse: Clinical Outreach
- No Show Predictive Tool
- Online Scheduling: Specialty Clinics (50% of clinics)
- Provider Standard Schedule Templates (hit 60th%tile)
- Standard Visit Types
- Panel Size

- Bluetree: Epic Clinic Workflow Optimization
- In-Basket Optimization
- Epic Forms Consolidation (Front Office/Rev Cycle)
- Telemedicine- Home Blood Pressure Monitoring
- IRIS Interface in Epic
- mPulse: Appointment Reminders
- MyChart Direct Mammography Scheduling
- System MG Board Launch
- Regional MG Board Launch

PE Operational Committee Structure

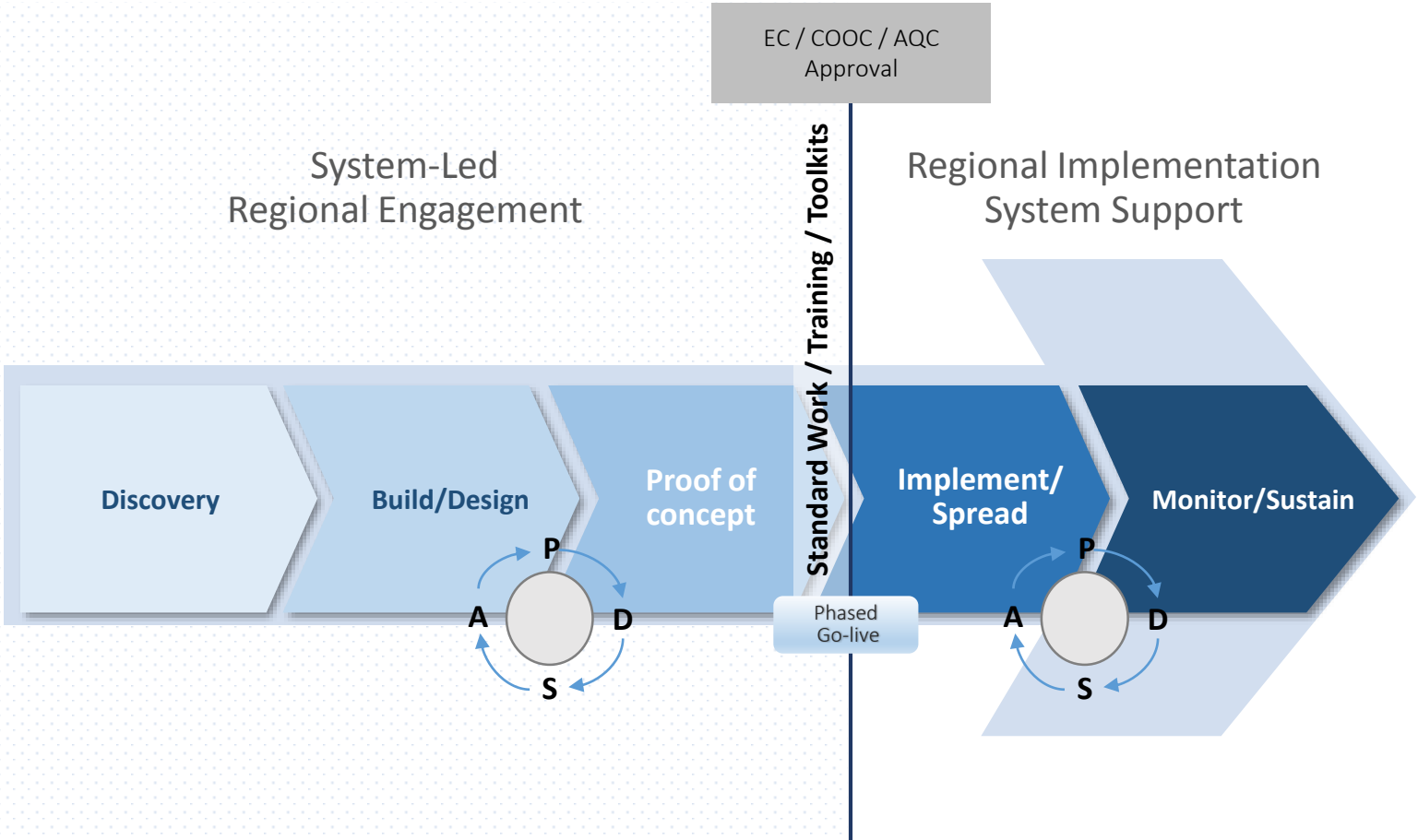
Providence St. Joseph Health



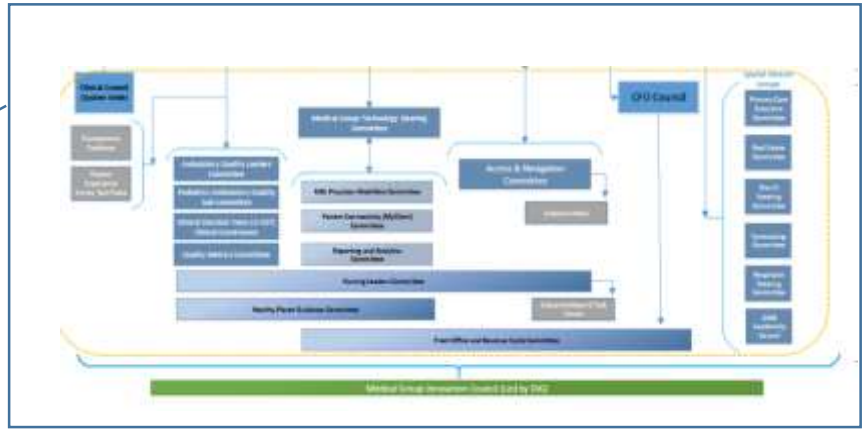
DECISION: Prioritization and pace of regional implementations

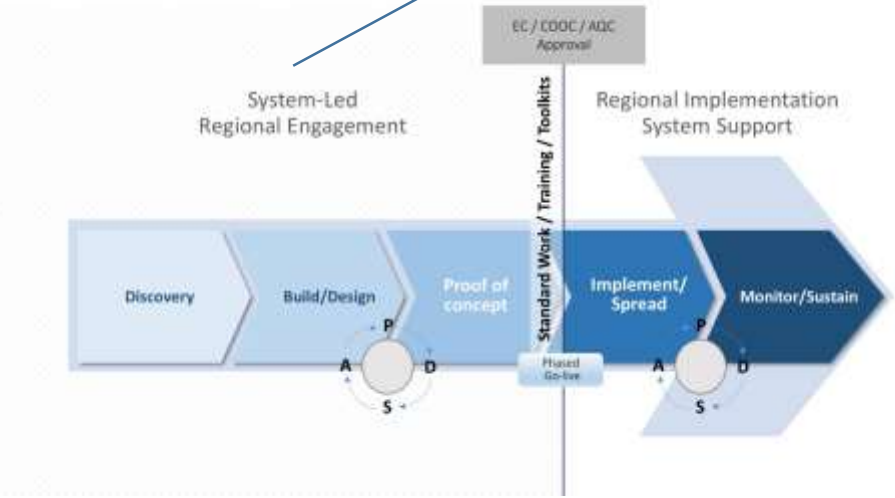
COLLABORATION AND ENGAGEMENT: Initiative-specific decisions; Regional engagement

Life of an Initiative



Regional Engagement



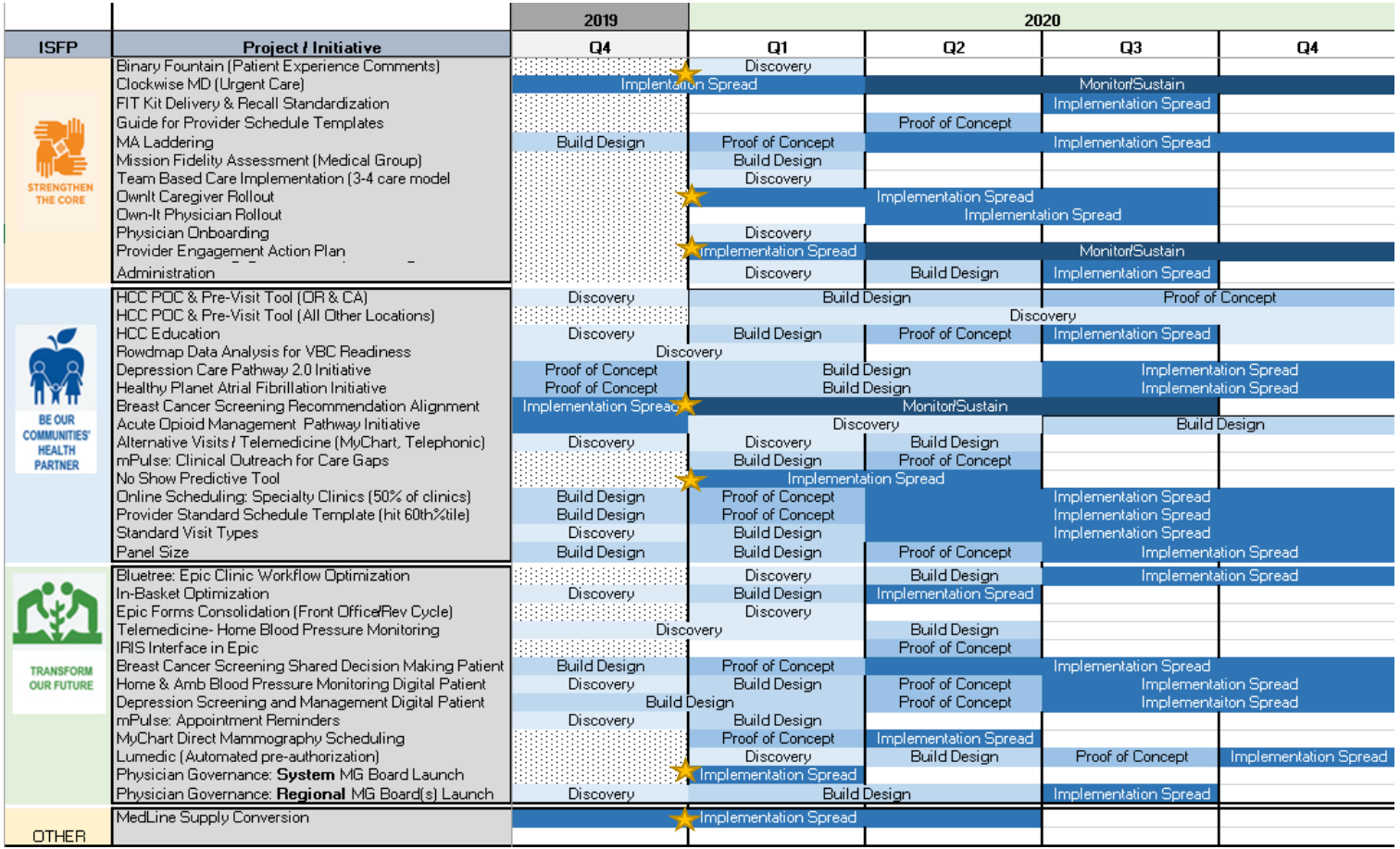


- "Regional Engagement" occurs through participation in the Operational committee structure
- Committees are social networks of medical group leadership and caregivers to:
  - Define; set scope and goals
  - Vett options
  - Feedback and sharing of success stories
  - Refine after proof of concept

Use Cases

Examples	Project / Initiative	Learnings
Model ***NOT*** followed	Fast Pass	- Some things just “come our way” - Our role will be to bring order and consistency to implementation by bringing forward to the right forums and making the right connections
Model ***PARTIALLY*** followed	Breast Cancer Screening	- Ensure that regional representatives gather, summarize, and report front line feedback before a final decision is made - Review delegated accountability for communication between representatives on committees or workgroups and front- line providers and affected caregivers - Elevate the importance and benefits of having multi-disciplinary groups make final decisions when controversial clinical topics lack full clarity or deviate from most current practice
Model ***FULLY*** followed	MA Laddering	- Fully vetted and designed by our committee members with input from leadership - Communicated and approved by councils - Scaled proof of concept roll out in 2 regions - Full scale roll out to be planned after PDSA

Clinic Operations Initiative Roadmap



Note: based on known phases to date

Tabletop discussion: 2020 Roadmap

Picture the ideal state

- Initiatives meet high priority needs across the medical group
- Initiatives are communicated in advance; expectations are predictable
- Tools for implementation and spread are developed and deployed
- The "Why" and the "Aim" are clear

Feedback

1. Discuss the roadmap: **Is a tool like this helpful to your group? Why? Why not?**

2. Each person to validate the items on the list

- Cross out the ones you have already done / aren’t relevant to you
- Indicate in GREEN top priorities for your market in 2020
- Indicate in RED the initiatives that you don't know about and/or are concerned about

2020 Roadmap & Implementation Table Exercise

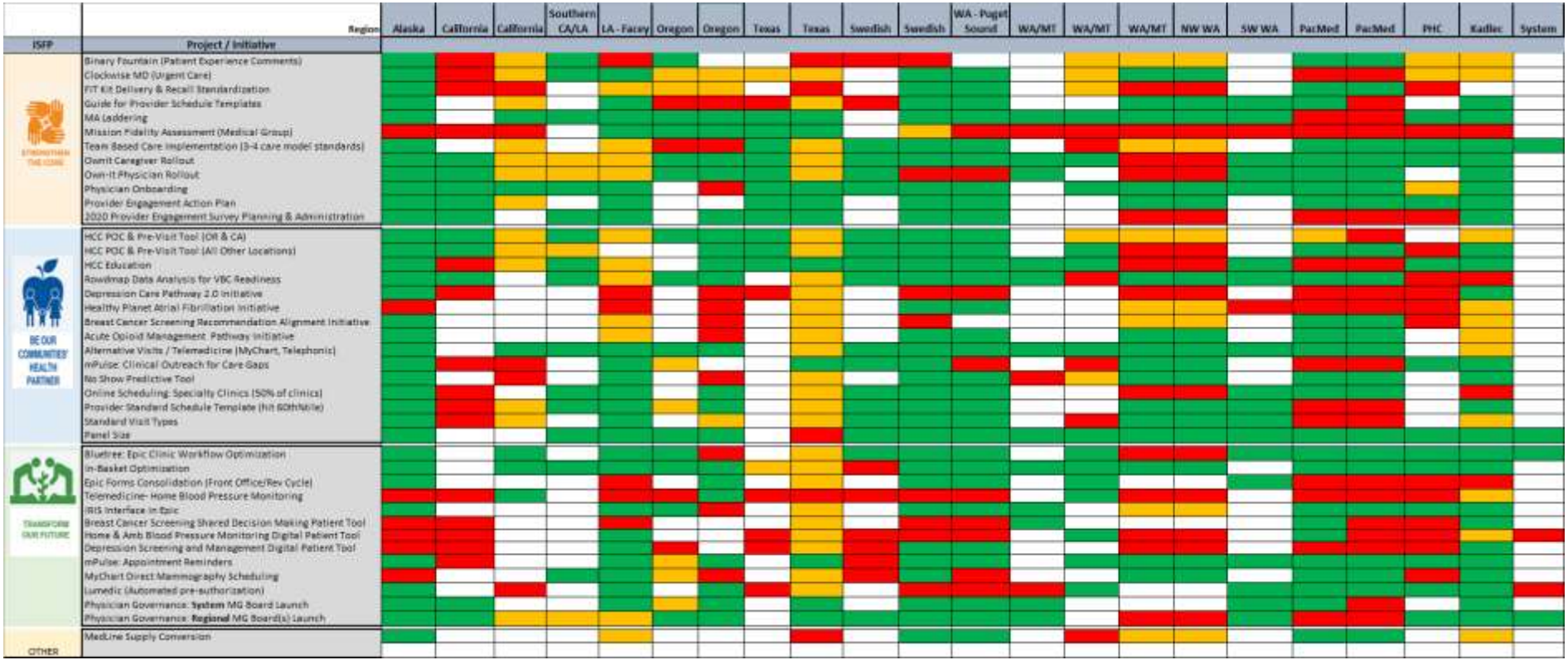
Tabletop discussion: Implementation and Spread Phase

Feedback

What would be most helpful in each of these categories for successful implementation in your medical group?

Operational Committee Structure and Meetings *Working well* *Opportunities for Improvement*	**Standardization tools reflect the new process** *Examples:* • Policy Stat • Workflow Dial *Ideas:*	**Communications** *Examples:* • Monthly Management Report • In Our Circle *Ideas:*
Committee and Workgroup Meetings and Follow Up *Examples:* • Know, Do, Share • Cascade of Meeting Minutes and Presentations *Ideas:*	**Tool kits/Playbooks** *Examples:* • Call to Action • Business Case for Action • Context / Why / Aim *Ideas:*	**Other ideas to support successful implementation**

Clinic Operations Initiative Roadmap



Legend

= top priorities for your market in 2020

= initiatives that you don't know about and/or are concerned about

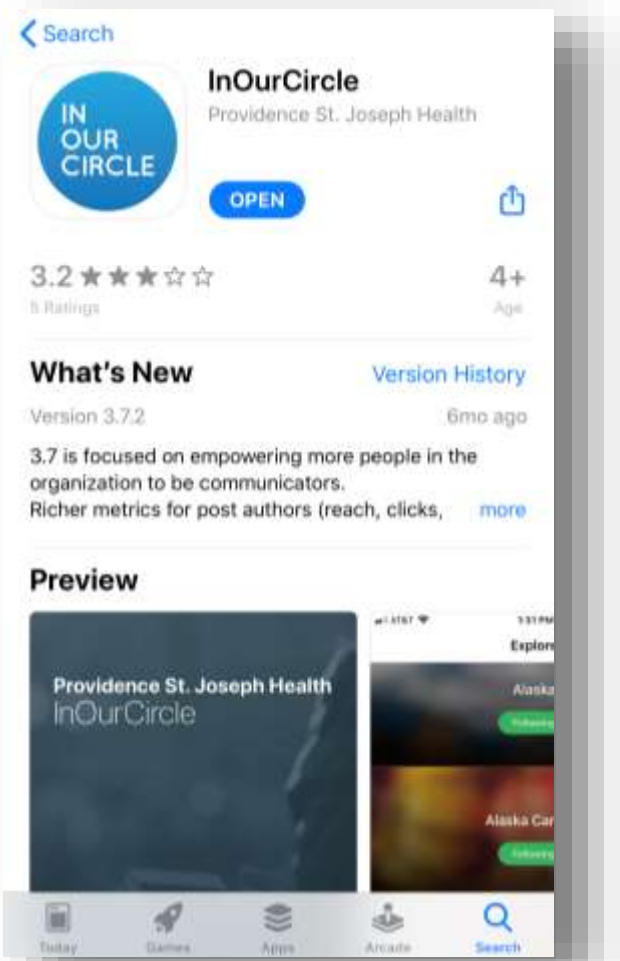
= items that are not relevant to your region (already implemented, not an opportunity in your market, etc.)

Next Steps

- Redesign the Roadmap to better resonate with the regions
- Explore how we will work with regional change leaders to understand the Roadmap and expectations of initiatives coming in 2020
- Collate the input/feedback on tools to be created for the toolkit
- Bring revisions back to April Leadership Council

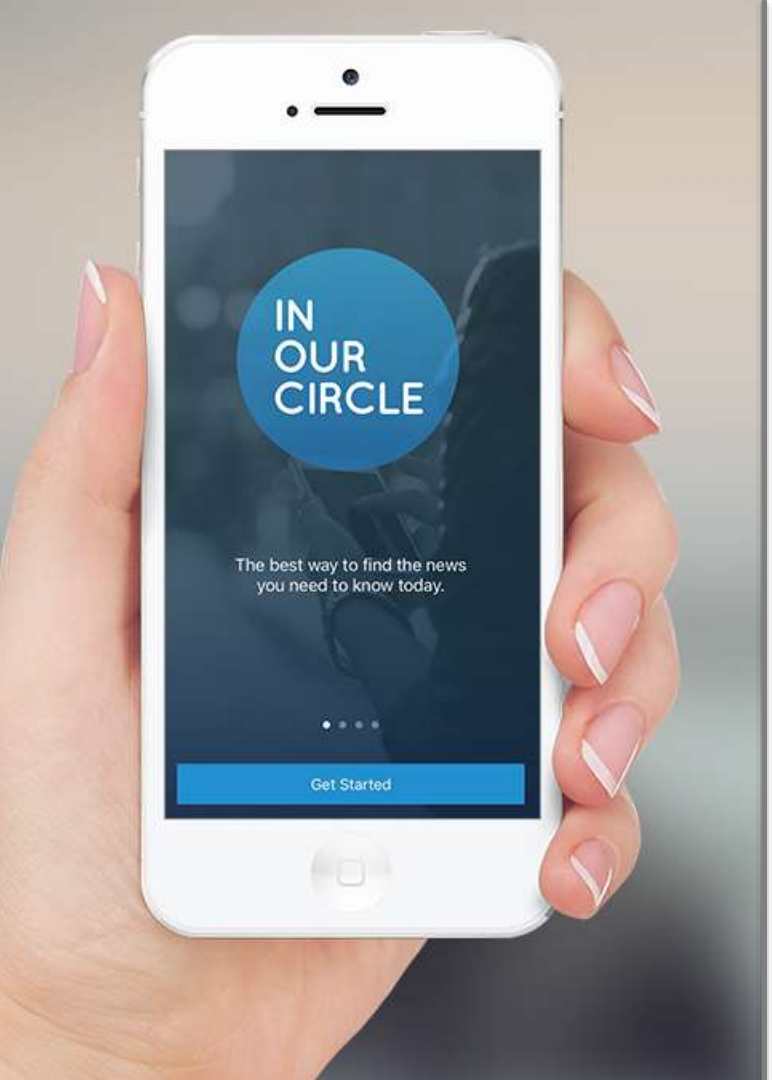
PE Communication Strategy

Morgan Ratcliffe
Executive Director, Physician Enterprise Communications



Before we begin…

- Pick up your cell phone
  (if it's not already in your hand – I see you).
- Go to the app store and download the "InOurCircle" app (also available on Google Play).
- Now pay attention to me again
  while it's downloading.



Introducing In Our Circle

- Our new system-endorsed communication channel
- We launched our Physician Enterprise channel in November
- Regions are phasing go-lives throughout 2020

But why IOC?

Benefits of the tool

- **Automates** the busy work
- Communicates in **real time**
- Provides real-time **measurement**
- **Quick** to digest, local news
- Creates **one-stop** shop
- Caregivers **choose** the news
- Allows for subscription to LOB, department and regional channels, solving for some of our most **complex communication challenges**

We're not the only ones

…who struggle with communicating effectively to an untethered workforce. These guys trust in Social Chorus, too:

Whirlpool CORPORATION

amazon

BOEING®

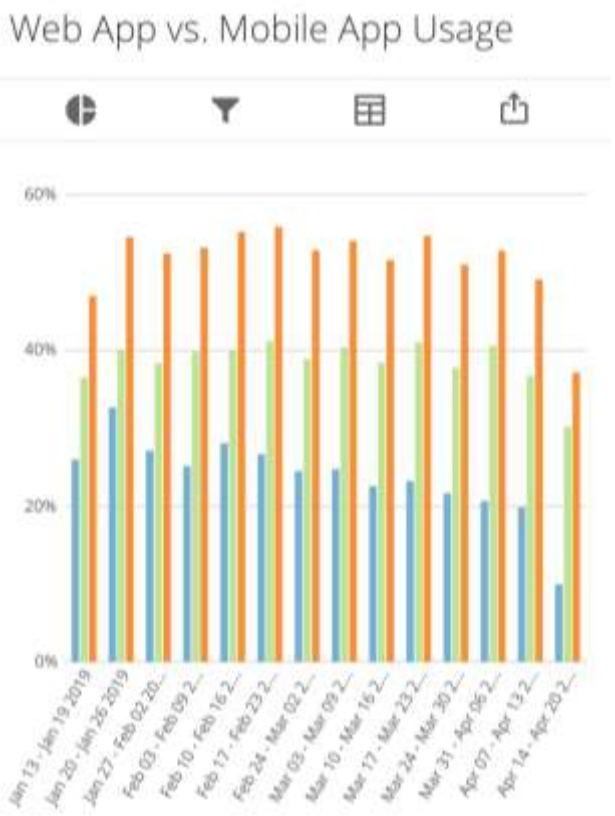
HILTON WORLDWIDE

J.Crew

MGM RESORTS INTERNATIONAL®

How caregivers engage with Choose Well

Choose Well:
Virgin Pulse

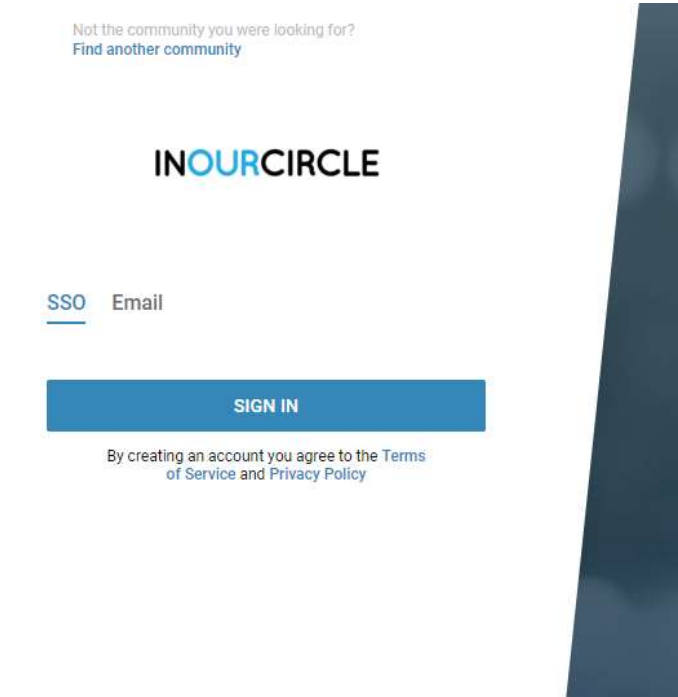


Web
Mobile
Total

"*If you're not on their phones, you're not in their brains.*"
- Brian Ames, VP of employee communication at Boeing

If you’re still not buying it –

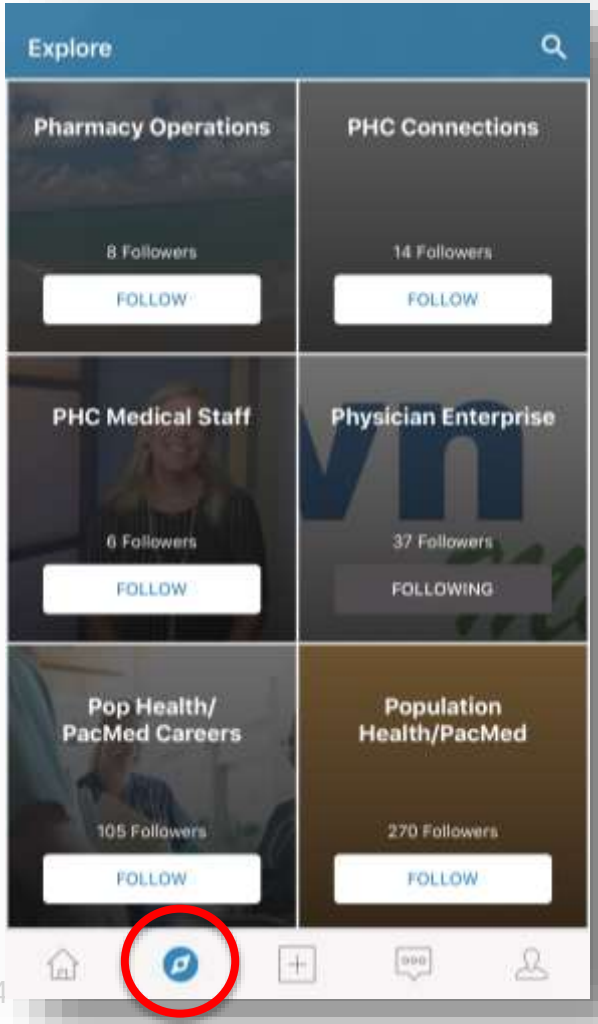
- It’s also available on the web and is SSO enabled
- And we can still send you emails if you like those better.



Early regional pilots: What we're learning

- Ownership at executive and ministry level is paramount.
- Keep content local or relevant and updated daily.
- Adoption and support by ministry and regional leadership leads to higher use and engagement.

Here's where you come in.



Now back to that phone.

- Open the In Our Circle app.
- Use your active directory credentials to login. This will automate with SSO.
- Find the “Explore” tab and follow:
  - Physician Enterprise
  - Your regional and/or service area channels

Why does it matter?


GUIDING PRINCIPLE
Create a unified
Providence provider voice.

Oh, and a few more things.

Beginning in February, we'll be providing some new tools to Leadership Council to stay connected with us:

- Monthly update on need-to-knows and important items to cascade to your team
- A (hopefully) one-page slide which you can quickly insert into standing meetings as a PE-related agenda item

Be on the lookout for all things Physician Enterprise via the Physician Enterprise Communications email.

And send me your IOC content!

ROI Team Based Care Models & Coding Opportunities for 2020

Doug Koekkoek, MD
Hamza Hasan
Practice Manager, Advisory Board

PRIMARY CARE MODELS

MOVING TO STANDARDIZED & MARKET APPROPRIATE MODELS

What problem are we trying to solve?

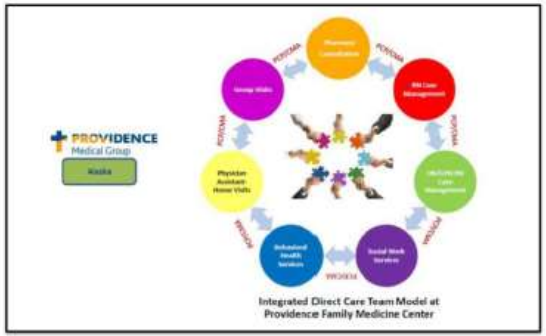
Standards to guide development of new primary care sites

Transform to PC models that maximize Access to grow Market Share for Delivery system

Enable and understand Primary Care Breakeven challenge

Build PC practices that are attractive to physician recruits and can be a sustained career

What we have today?

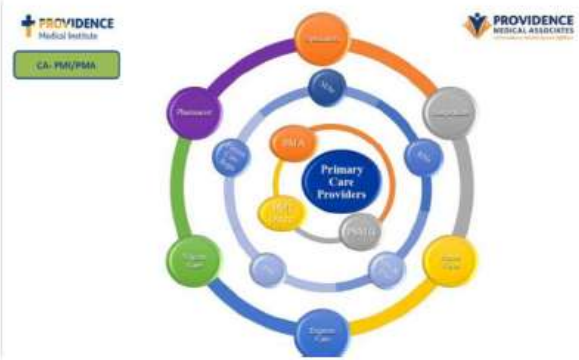


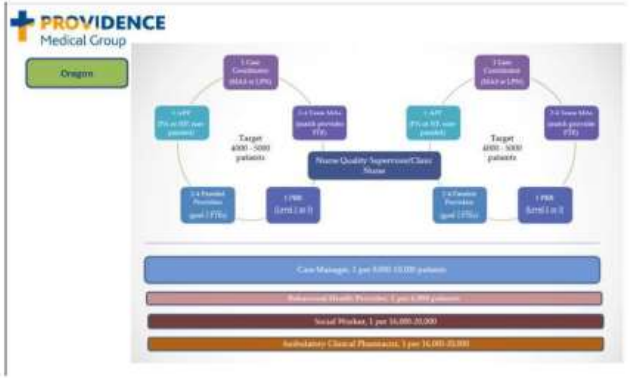
PROVIDENCE
Medical Group
Providence Health Care

Innovation Clinic

Providence Family Medicine
N. Pines, Spokane, WA

- Care Team: MD/ARNP/RNCN/RN/CMA
- Support Team: PSR- Registration (1.0 FTE); CDE – (0.2 FTE)
- RNCN (1) and RN (1) supports entire team
- CMA to MD ratio is 1:1; ARNP to MD ration is 2:1
- Team is supporting virtual Referral Tracking

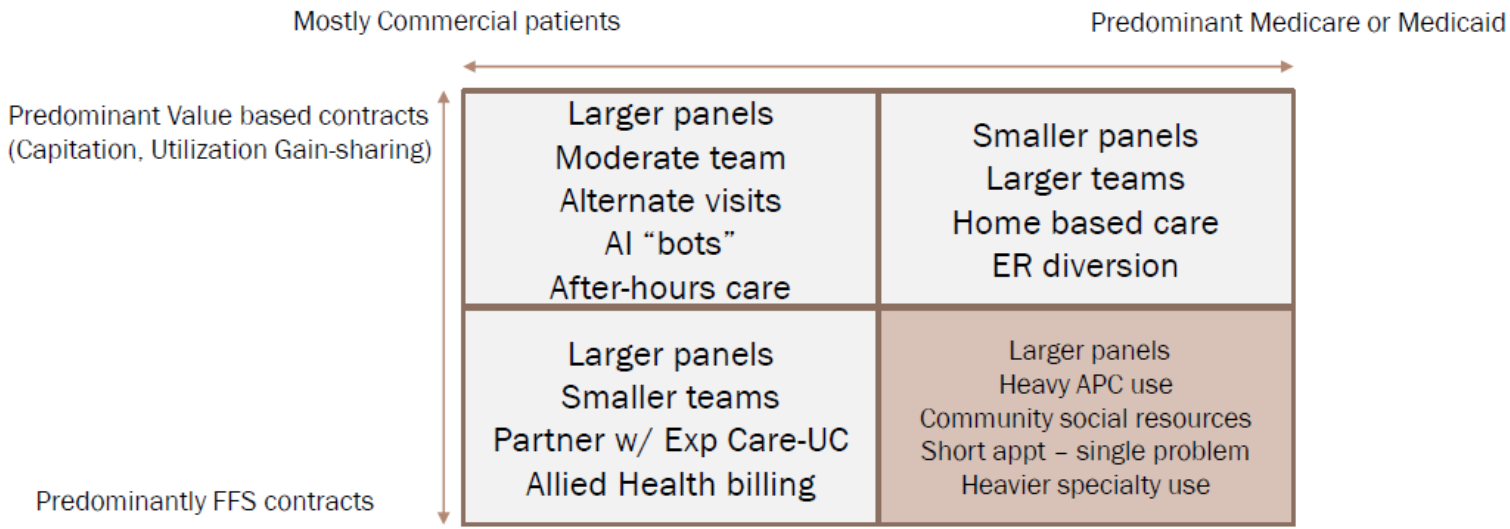




Why the variation?

- Patient demographics & panel acuity differences
- Payor Contracting – Revenue differences
- Workforce availability variation
- Space & Capital availability variation

Framework Grid

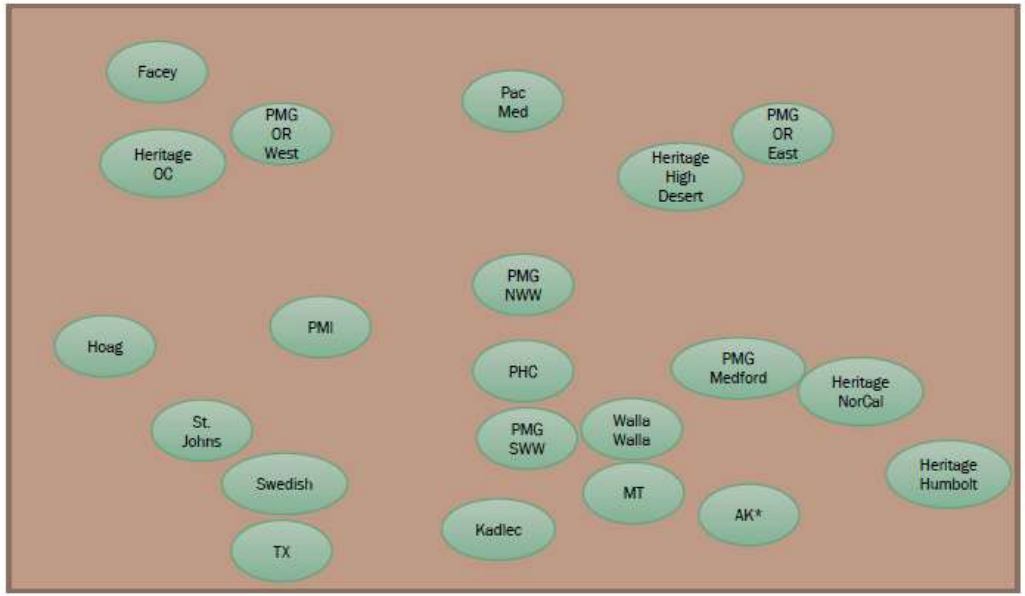


Should we be in these markets? Do we need to actively migrate those practices VB contracts or manage payor mix?

Mostly Commercial patients

Mostly Medicare & Medicaid

Mostly Capitation or contracts with Utilization Gain-sharing



Mostly FFS revenue

* Alaska's Medicaid reimbursement rate is like Commercial in other markets

High Commercial & High Capitation / VB contracts

- Panel size 3000 (for 1 APC & 1 MD) or Panel Size of 5000 (for 1 APC & 2MD)
- Productivity Targets 60th percentile
- Ratios of Allied Health Providers
  - APC 1APC : 1 Physician preferred; alternate 1 APC: 2 physicians
  - Case management 1:15000 patients
  - Clinical pharmacists 1: 18000 patients
  - BHP 1:18000 patients
  - RN clinician 1 RN: 6 providers (APC & MD)
- Other services
  - Central Refill
  - Call Center
  - Referral coordinator
- Extended hours, 25% of visits virtual, automated AI pathways
- Utilize Express Care if excluded from Cap payment

High Capitation & High Medicare/Medicaid

- Panel size 2500 (for 1 APC & 1 MD) or Panel Size 4000 (for 1 APC & 2MD)
- Productivity Targets 50th percentile
- Ratios Allied Health Providers
  - APC 1 APC: 1 Physician preferred; alternate 1 APC per 2 Physicians
  - Case management 1: 10000 patients
  - Clinical pharmacists 1: 15000 patients
  - BHP 1: 10-15K patients (10 Medicaid / 15 Medicare)
  - RN clinician 1: 6 providers
- Other services
  - Central Refill
  - MAP
  - Call Center
  - Referral coordinator
- Home-based care service, ER Diversion Programs,
- 25% virtual visits,

High FFS & High Commercial

- Panel size 6000 (for 1 APC and 2 physicians)
- Productivity Targets 60th percentile – all providers
- Ratios Allied Health Providers
  - APC 1 APC : 2 physicians
  - Case management 1 : 24000
  - Clinical pharmacists 1 : 30000
  - BHP 1 : 24000 (must be billable services)
  - RN clinician : none, utilize APC & physician
- Other services
  - Central Refill
  - Call Center
  - Referral coordinator
- Shorter return visit interval, less team and RN f/u, virtual visits only when billable
- Bill all alternate visit codes when available for phone work
- Bill TCC and CMM codes available
- Utilize Express Care primarily during afterhours to limit overhead

High FFS & High Medicare/Medicaid

- Panel size 2000 (for 1 APC and 1 physician)
- Productivity Targets 60th percentile
- Ratios Allied Health Providers
  - APC 1 APC : 1 physician
  - Case management 1 : 10000
  - Clinical pharmacists 1 : 20000
  - BHP 1 : 20000 (must be billable services)
  - RN clinician : none, utilize APC & physician
- Other services
  - Call Center
  - Referral coordinator
  - MAP
- Shorter return visit frequency, less RN check-ins, and care team management
- Bill TCM and CCM codes when available

High FFS & High Medicare

Should we actively try to reduce the number of clinics in this quadrant?

Manage payor mix – preferential new patient appointment slots to MA and Commercial patients
Migrate patients to MA products
Partner with local FQHCs to accept new Medicaid patients

Critical APC questions

- Increase the ratio of APC to physicians – 1:1, or 2:1?
- Paneled APCs, shared panel, Extender role for APCs?
- APC Fellowships / Onboarding?

Advancing Medical Group Efficiency

Reviewing Key Strategies to Maximize Practice Capacity and Implement Team-Based Care

Hamza Hasan
Research Partner
hasanh@advisory.com

Presented by
Medical Group Strategy Council

Doing what's necessary, but not what's sufficient

Despite progress on cost control, health system margins remain slim

Median revenue and expense growth rates for nonprofit hospitals

DATA SPOTLIGHT

1.7%

Median operating margin among nonprofit hospitals in 2018

Advisory Board reports on margin management

- The New Cost Mandate
- Toward True Sustainability
- Re-Igniting the Growth Engine
- Priming for Growth

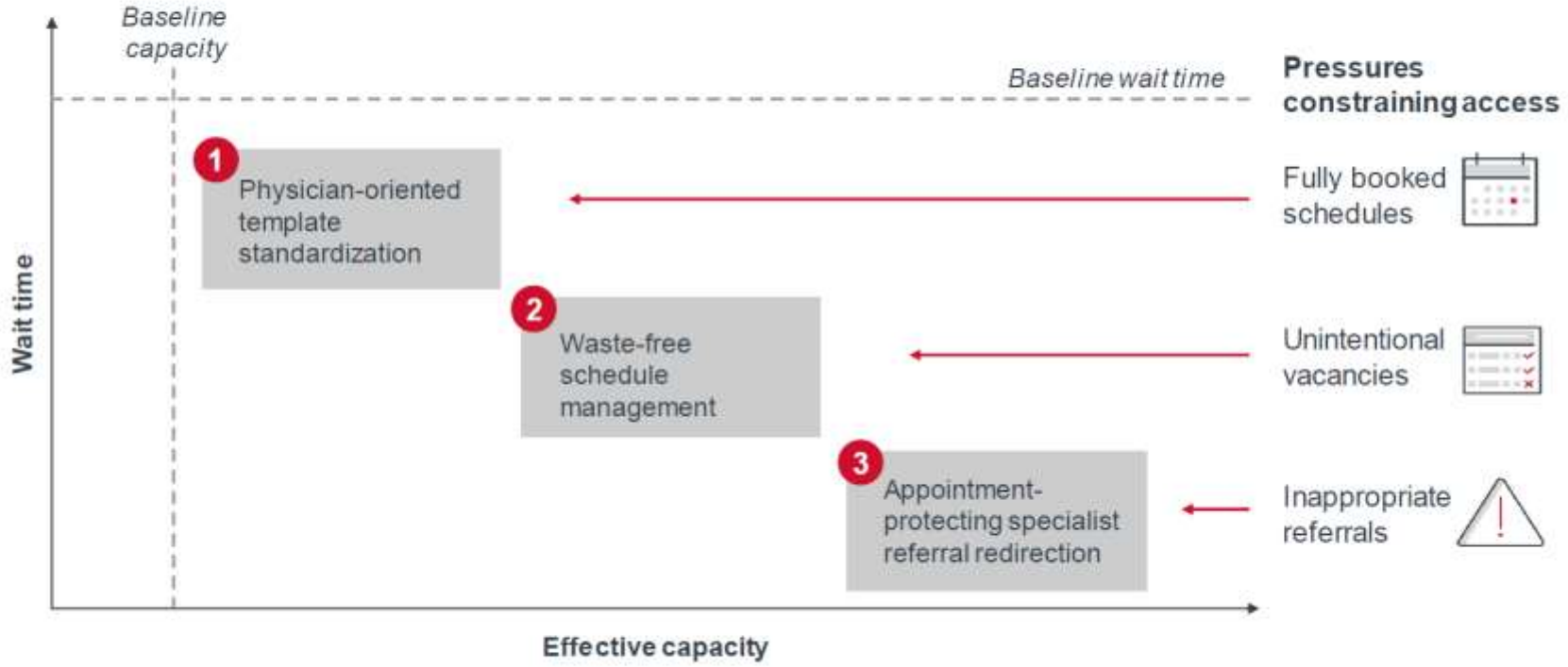
Source: Moody's Investors Service, "Preliminary Medians – Profitability Holds Steady as Revenues and Expenses Converge," April 25, 2019; Moody's Investors Service, "Revenue Growth and Cash Flow Margins Hit All-Time Lows in 2013 US Not-for-Profit Hospital Medians," August 2014.

1 Maximizing Practice Capacity

2 Attaining Top-of-license Care

3 Finding New Revenue Opportunities

Three steps to maximizing practice capacity



Inconsistency abounds in physician scheduling

Devolved control limits network capacity and extends wait times

Ballooning number of appointments and templates

Heard in the research:

14,000 Defined **imaging** types within one system

150 **Primary care** appointment types within one system

> [Within the same clinic,] almost every provider has different appointment types, time guidelines, and scheduling protocols that they prefer."
>
> Director of Special Projects, Ambulatory Services
> HEALTH SYSTEM IN NORTHEAST

What does standardization get you today?

Additional provider capacity

What does standardization prepare you to do?

Expedite the referral process

Deploy online scheduling

Offer virtual visits

Principled flexibility supports physicians' goals

St. Luke's Health System designs three templates to match practice styles

1 **Decreased visit types and right-sized appointment lengths**

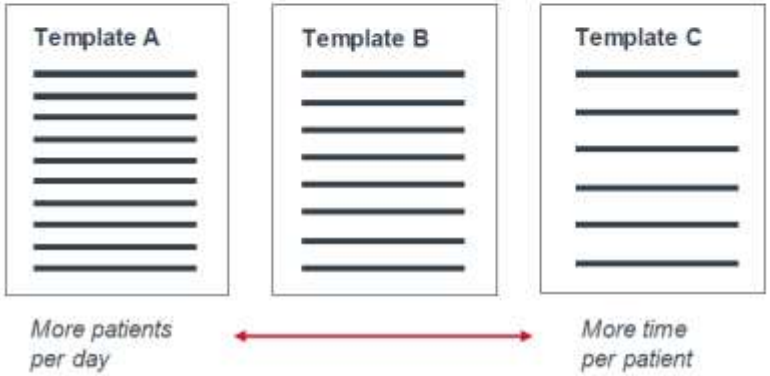
Reduced number of primary care appointment types from 150 to 12

2 **Generated three standard templates per specialty**

Variable speeds within template options to accommodate provider pace and preference

3 **Invited providers to choose their template**

- Made personalized template recommendations depending on provider's history
- 90% chose suggested template



DATA SPOTLIGHT

150 → 12

Reduction in number of primary care appointment types

55,000

Primary care visits added per year without hiring additional providers

Source: Medical Group Strategy Council, "The Medical Group Capacity Playbook," Advisory Board, 2019.

Socialize access in physician terms

Highlight a clear and compelling value proposition

Two complementary approaches for garnering physician buy-in

	Sentara highlights patient perspective	InterMed underscores financial imperative
Message	Access improves patient experience and care quality	Patient access is key to maintaining projected physician compensation
Evidence	Correlation between patient access and patient experience scores, according to data and patient anecdotes	Group financial performance data: first quarter charge volumes, five-year utilization
Delivery avenue(s)	Video testimonials, monthly meetings, standing agenda item, annual training	All physician meeting

Source: Medical Group Strategy Council, "The Medical Group Capacity Playbook," Advisory Board, 2019.

Appointments frequently go unused

Clinics reliant on patients and front desk staff to realize full capacity

Two causes of wasted appointments

Cancellations

- Patient cancels in advance but clinic unable to reschedule
- Front desk staff burdened with tracking and rescheduling
- Clinic has no efficient waitlist process

Squandered advanced notice

No-shows

- Patient does not cancel in advance
- Front desk staff may or may not be able to anticipate who will no-show
- Clinic reliant on proactive communication from patient

Blindsided at last minute

No notice, no problem

Identifying patients most likely to no-show is the critical first step

Two strategies for anticipating your no-shows

Option 1 – Manual estimates

Use existing, observational knowledge to infer which patients will no-show

- Mine data from practice management system
- Good option for those without advanced analytics or small budget

Case example

Carson Medical Group targets new patients booked further in advance as more likely to miss their appointment

Option 2 – Predictive algorithm

Use analytic tool that processes several variables to predict likelihood of no-show

- Available in some EHR platforms, although homegrown solutions are often more accurate
- Good option for those with the budget for development

Case example

Crystal Run Healthcare uses a self-developed regression analysis to create prioritized list of patients likely to no-show

Strong no-show indicators: past no-show history, time to appointment, payer, distance to office, new versus established patient, appointment type

Source: Medical Group Strategy Council, "The Medical Group Capacity Playbook," Advisory Board, 2019

Deploy targeted double-booking strategy

Northwell takes proactive approach to ensuring appointments don't go unused

Northwell Health Physician Partners deploys predictive overbooking in orthopedic clinic

Identification

Patients who missed three or more visits in past rolling year are flagged as likely to no-show again

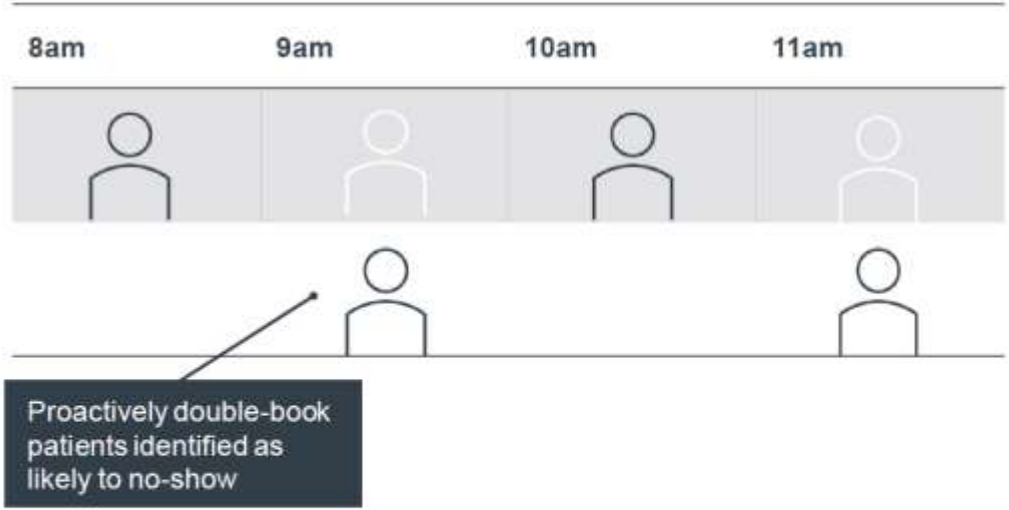
DATA SPOTLIGHT

Results

300 Appointment slots added

92% Of added appointment slots were used[1]

Scheduling intervention



1. During a 24-week pilot

Source: Medical Group Strategy Council, "The Medical Group Capacity Playbook," Advisory Board, 2019.

Low-value referrals all too common

Unrestricted access to specialists has cascading negative results

> "When you inappropriately refer up just to move the patient along, you take your most expensive and revenue-generating resources and remove their revenue stream."
>
> *SVP and Chief of Strategy, Integration and Innovation Officer*
> HEALTH SYSTEM IN MIDWEST

Where are referrals coming from?

94% Increase in referrals to specialists from PCPs over a 10-year period

2.5x As many inappropriate referrals are sent by advanced practice providers, compared to ER physicians in urgent care[1]

Problem scope

30-50% Percentage of specialty visits that are unnecessary or low-value, by one Chief Medical Officer's estimate

Financial repercussion

$8B U.S. annual spending wasted due to clinician-related inefficiency, including inefficient use of high-cost physicians

1. In one health system's experience

Source: Barnett ML, et al., "Trends in Physician Referrals, 1999-2009," *Archives of Internal Medicine*, https://www.ncbi.nlm.nih.gov/pubmed/22271124; Merritt Hawkins, "2017 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates," 2017; Shrank WH, et al., "Waste in the U.S. Healthcare System: Estimated Costs and Potential for Savings," *Journal of the American Medical Association*, https://jamanetwork.com/journals/jama/fullarticle/2752664

Two approaches to protecting specialist capacity

Proactive intervention not optional

Outbound referrals

Hardwire decision-making protocols with technology and analytics

Prevent low-value referrals

Incoming referrals

Install checkpoint to confirm appropriateness of incoming referrals

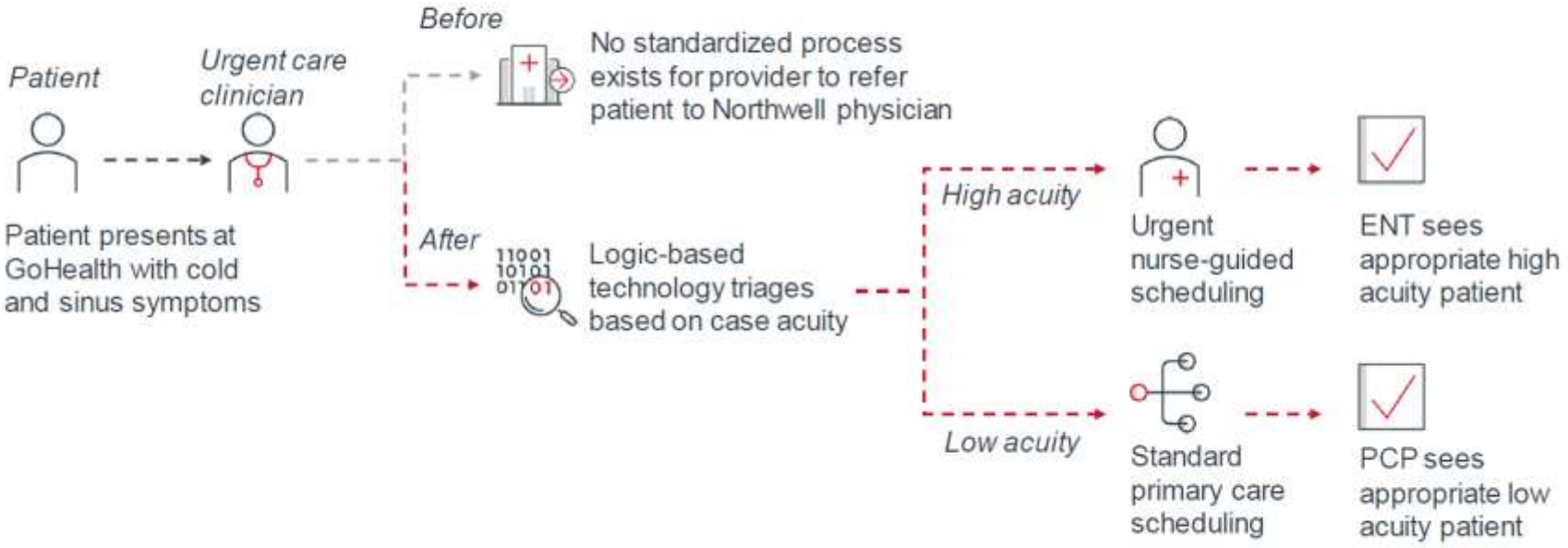
Train PCPs and referring providers to manage lower acuity, complex cases

Filter out low-value referrals

Redirect demand to prevent low-value referrals

Northwell's cross-system process protects specialist capacity

Northwell Health transforms GoHealth urgent care patient journey



A picture is worth a thousand words—and 22 days

Virtual consults reduce unnecessary referrals and time to diagnosis

Stanford's PhotoCareMD process

During appointment
PCP submits eConsult

- PCP takes photo of patient's condition with Epic integrated app
- Includes any additional notes about the case

Within 24 hours
Dermatologist responds

- Dermatology specialist provides consultation
- Offers diagnosis and treatment plan

Appointment follow-up
PCP manages patient care

- PCP communicates diagnosis to patient and executes treatment plan
- If necessary, patient expedited to dermatology clinic for specialty appointment

DATA SPOTLIGHT

Results

73%
Of cases resolved through eConsult

22-day
Reduction in average time to diagnosis

17-minute
Reduction in average consult time

Source: Kim GE, et al., "Implementation and Evaluation of Stanford Health Care Store-and-Forward Teledermatology Consultation Workflow Built Within an Existing Electronic Health Record System," *Journal of Telemedicine and Telecare*, https://doi.org/10.1177/1357633X16799805.

1 Maximizing Practice Capacity

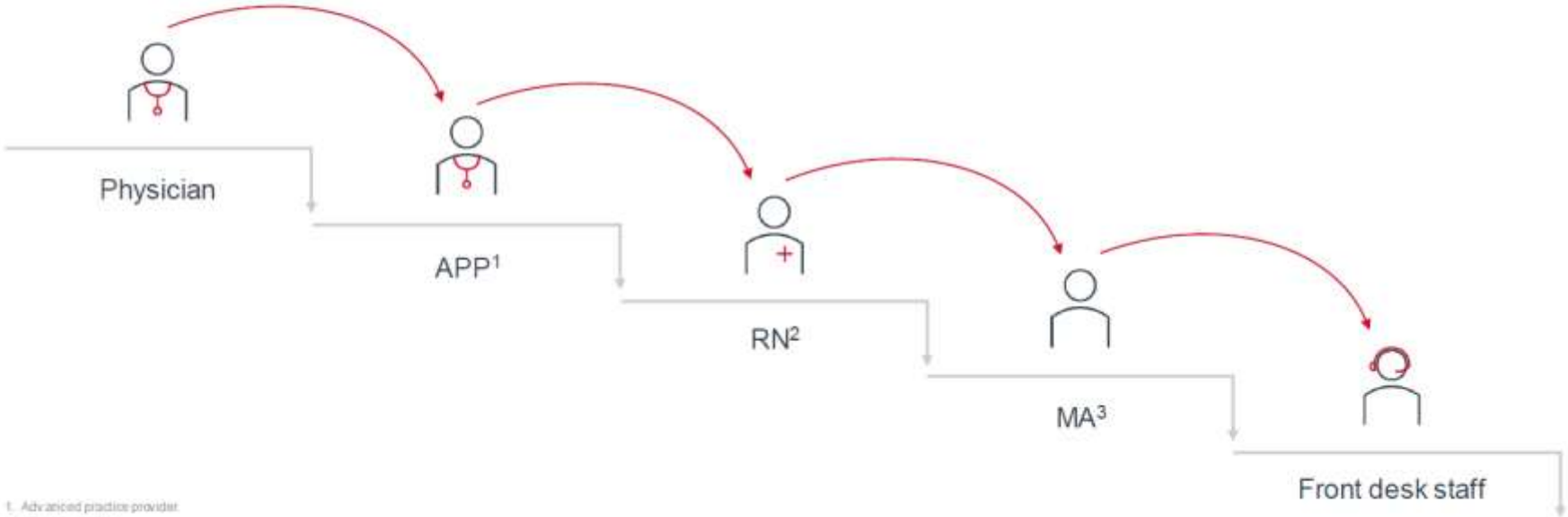
2 Attaining Top-of-license Care

3 Finding New Revenue Opportunities

No shortage of care team pilots

But most just shift work from physician's plate onto others

Status quo: Trickle down care team redesign



1. Advanced practice provider.
2. Registered nurse.
3. Medical assistant.

Care team pilots have limited long-term sustainability

Three pitfalls of trickle down care team redesign

Some care team members still working **below top-of-license**

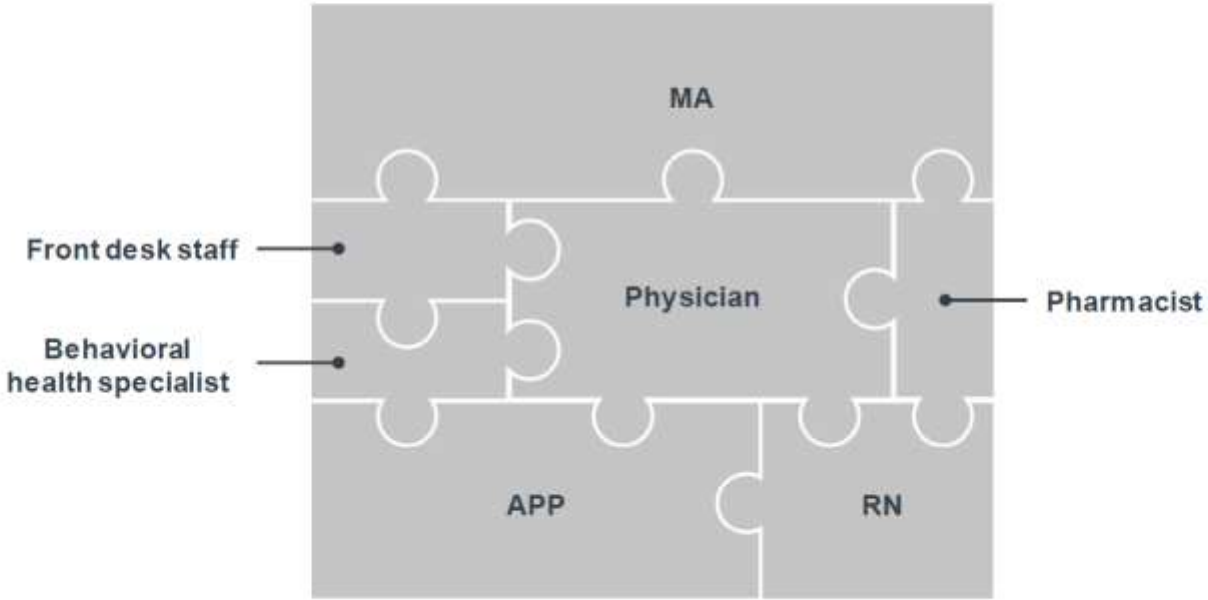
Physicians an increasingly **smaller subset** of workforce

Non-physician team members **disengaged, burned out**

Need for comprehensive approach to the care team

Evaluate all roles at once to ensure team works in tandem, at top-of-license

Solution: Holistic care team redesign



Holistic approach pays for itself with one MA retained

Short-term costs of pulling team offline worth it for long-term retention gains

Cost of holistic care team redesign

$30K

Cost of taking **4 physicians, 2 APPs, 2 RNs, 3 MAs, 2 receptionists** offline for one week

=

$34K

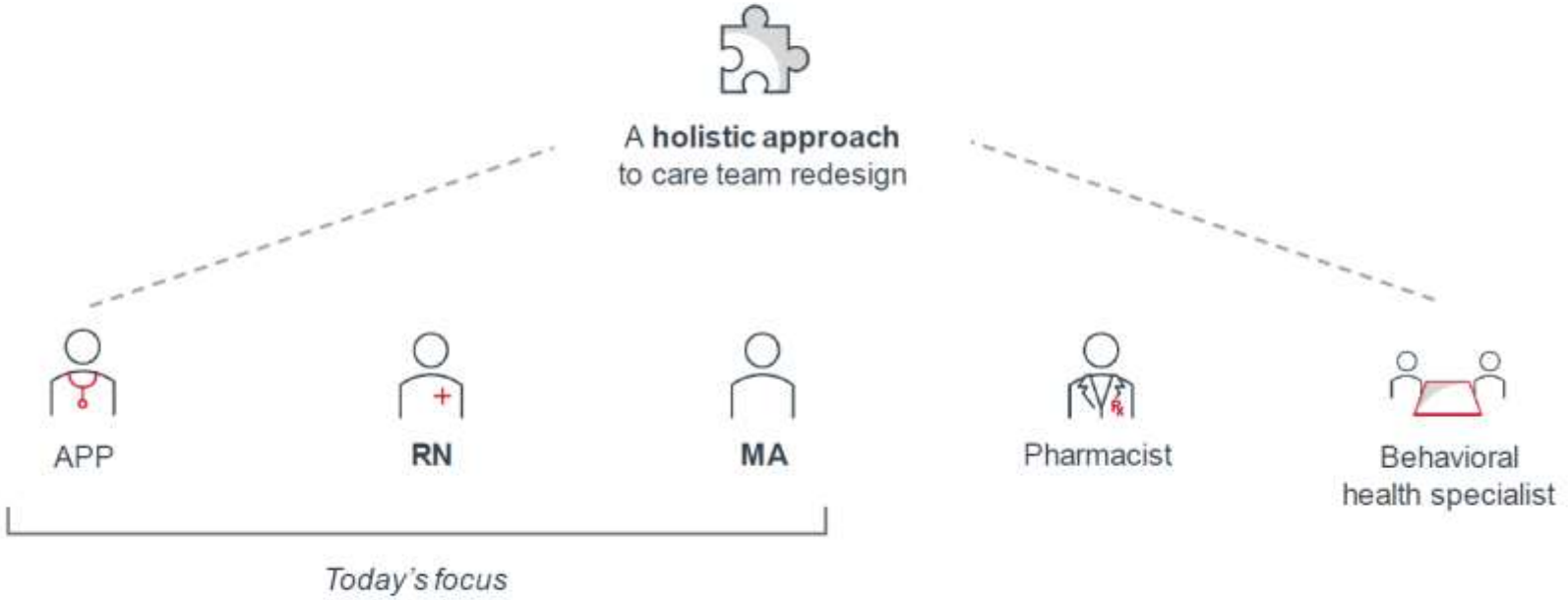
Cost of **one MA turning over**[1]

1. Advisory Board analysis suggests the cost to replace an employee that has turned over is 50% to 150% of annual salary. The cost of one MA turning over represents 100% of average MA salary in family medicine according to Advisory Board benchmarks

Source: Integrated Medical Group Benchmark Generator, Advisory Board; Medical Receptionist Salaries, Glassdoor

Maximize the ROI of team-based care

Decrease turnover, generate greater value through top-of-license task allocation



An evolving view on the role of APPs[1]

From physician extender to autonomous provider

PAST

APPs as physician extenders

- Physician-dependent role
- Physician determines APP role in the visit
- Physician manages panel, offloads patients and tasks to APP

FUTURE

APPs as autonomous provider

- APPs empowered to practice autonomously
- APPs determine appropriate care for patients
- APPs oversee patient panel and care team

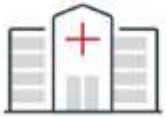
1. An advanced practice provider is defined as a non-physician clinical provider (nurse practitioner or physician assistant) with specialized education, training, certification, and licensure who provides varying levels of health care services.

Source: Morris J, "Optimizing the Value of Advanced Practice Providers," Studer Group, August 12, 2016.

Bolstering primary care in areas of extreme shortage

OSF deploys APP-only clinics in rural primary care deserts

OSF's new take on hub-and-spoke model



Hub: Primary care practice in larger community with 1-2 physicians, 1-2 APPs

Spokes: APP-only practices in more rural communities; APPs have significant prior clinical experience

A win-win for medical group and APPs

Benefits to medical group:

- Can enter **new market** at lower cost, lower risk
- **Easier to place APPs** in rural practices than physicians
- APP-only practices have **high patient experience** scores
- Group sees **lower APP turnover** in rural, autonomous roles

Benefits to APPs:

- Can practice autonomously
- Feel sense of empowerment, ownership

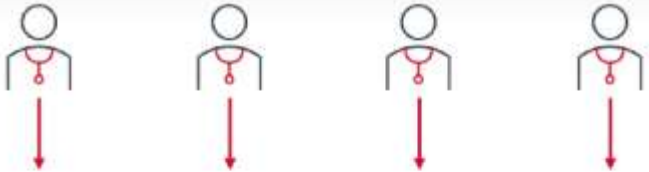
Not just a rural trend

Lemon[1] assigns APPs dedicated panels of high-risk patients in urban setting

Lemon Health System's team-based geriatric care model

Challenge: needed more clinician time to care for small pockets of high-risk MA patients

Solution: embedded APPs to co-manage high-risk MA patients alongside physicians



APPs responsible for co-managing 75 highest-risk MA patients from each of four PCPs

300 APP panel size

Early returns

Measured high patient and clinician satisfaction from team-based pilots with plans to deploy further

"Primary care physicians have embraced team-based care. Embedded APPs bring small-panel medicine to standard primary care and enhance top-of-license practice by all team members."

Ambulatory leader at Lemon Health System

1. Pseudonym

Autonomy requires rewriting expectations

Huntington places similar performance standards on APPs and PCPs

HIMG's[1] autonomous APP model details

Experience
APPs can become independent after developing patient relationships and clinical expertise

Production-based compensation plus bonus
APPs switch to compensation model after seeing 15 patients/day[2]

Restrictive covenant
APPs must sign covenants limited to 30-mile radius

Inclusion on governance committees
APPs represented on majority of governance committees

CASE EXAMPLE

Huntington Internal Medicine Group

52-physician, 27-APP independent medical group • Huntington, WV

- Experienced primary care APPs built up panels and functioned as autonomously as physicians
- APP compensation shifted to a percentage of total profits (50-55%, compared to physicians' 100%), minus a percentage of overheard (not 100% since they bill at 85%)
- Signing of same restrictive covenant as physicians ensures they cannot take patients if they leave the group

FOR MORE RESOURCES
on this topic, read **"Get the Full Value from your Advanced Practice Providers"** on **advisory.com**

1. Huntington Internal Medicine Group
2. APP compensation mimics physicians, i.e. (revenue – overheard) * % profitability

Medical Assistants (MAs)

Key takeaways:

- Well-designed MA roles simultaneously increase group productivity and decrease MA turnover.
- Groups should extend the MA role beyond pre-visit tasks—but in a way that provides balance for MAs.
- As you hire more MAs, provide opportunities outside of their standard clinical practice to improve retention.

Current approach to care team design driving MAs away

56% Of MAs plan to seek training and/or employment in **another health care occupation** in the next five years

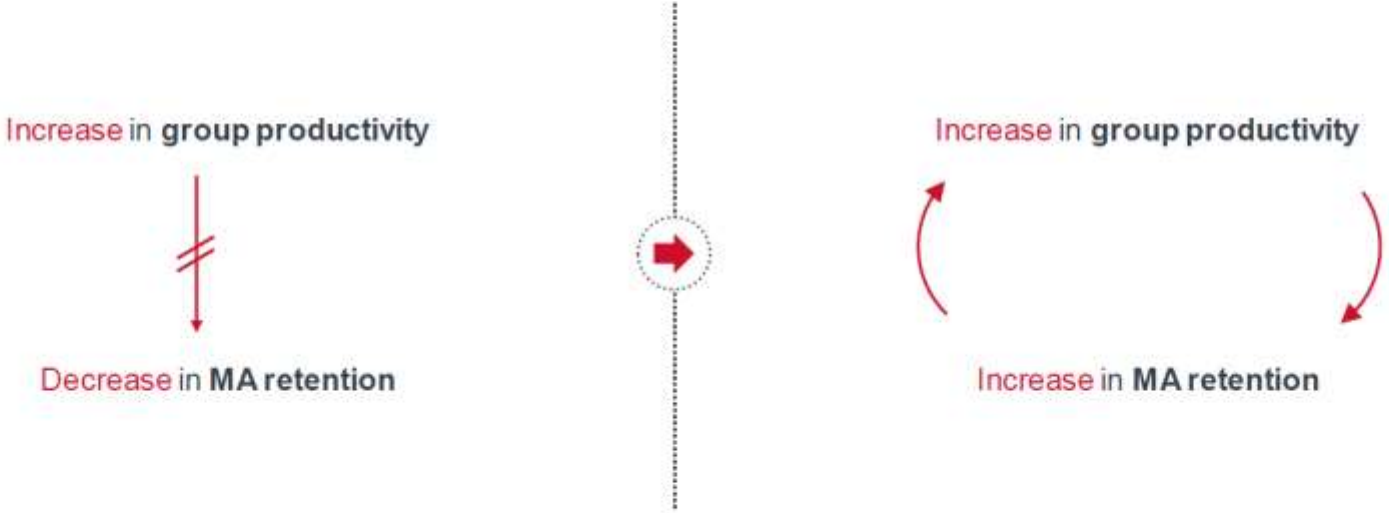
21% Of MAs plan to seek training and/or employment in an **occupation other than health care** in the next five years

> "The biggest risk we have is not market share, it's the ability to recruit and retain support staff"
>
> Dr. Stuart Freed, CMO
> CONFLUENCE HEALTH

Source: Confluence Health, Wenatchee, WA; Skillman S et al, "Frontline Workers' Career Pathways: A Detailed Look at Washington State's Medical Assistant Workforce," Center for Health Workforce Studies, December 2018.

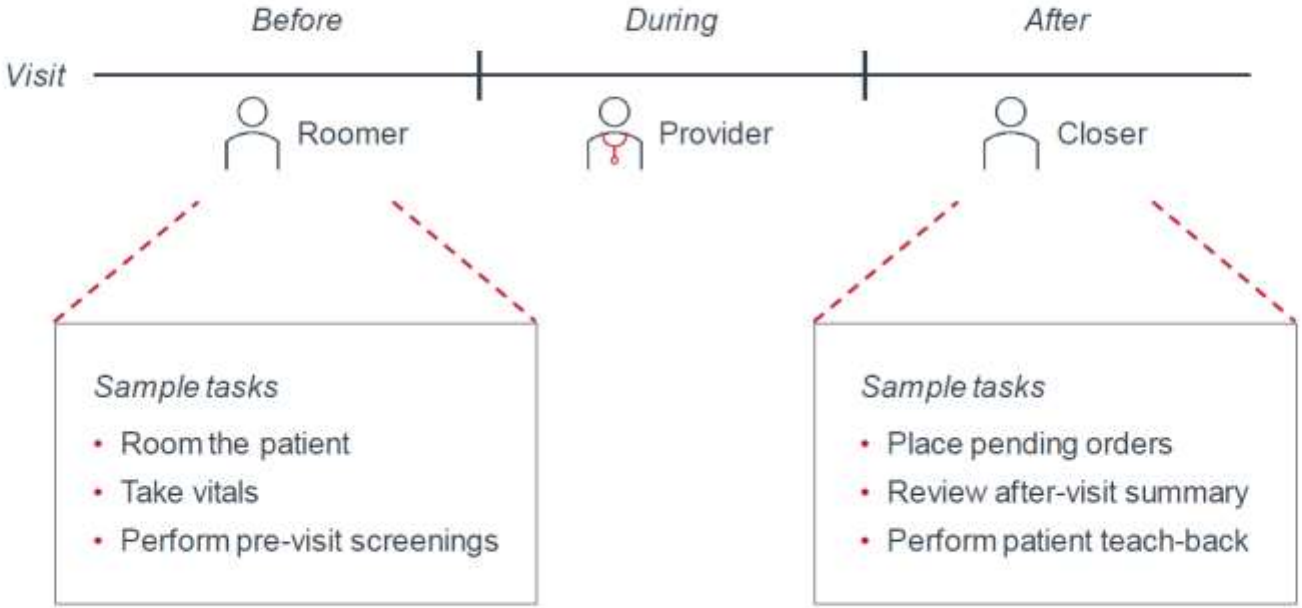
Facing a catch-22 with MA deployment

Group productivity and MA retention do not need to be at odds



Add a new MA role to cover post-visit work

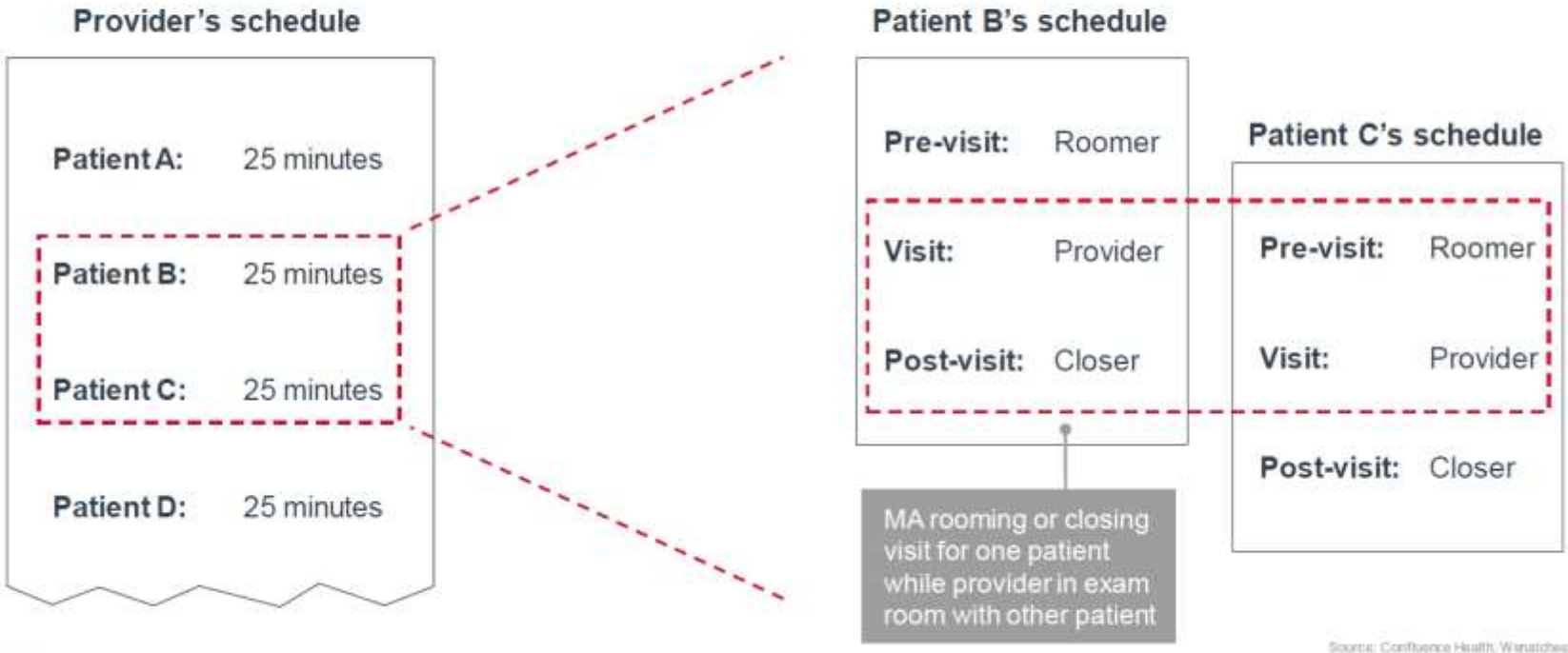
Confluence Health deploys MAs as "roomers" or "closers"



Source: Confluence Health, Wenatchee, WA

Adjust team's scheduling practices to maximize productivity

Confluence staggers schedules to decrease staffing ratios, increase efficiency



Source: Confluence Health, Wenatchee, WA

Evidence of win-win for group productivity, MA engagement

Benefits to group profit

Increase in provider productivity

Staff team more leanly with 1.5 MAs instead of 2

Benefits to MA turnover

MAs see more patients but perform fewer, scoped tasks

More time built into MAs' schedules to complete tasks

Source: Confluence Health, Wenatchee, WA

Comparing two models for deploying MAs

Models in brief

	Bellin Health	Confluence Health
Model	Deploy MAs as care team coordinators to provide continuous support before, during, after visit	Deploy MAs as "roomers" or "closers" who perform tasks either before or after provider visit
Staffing ratio	• <15 visits: 1 MA • 15-19 visits: 1.5 MAs • 19+ visits: 2 MAs	1.5 MAs per provider
Results	• 5.2% increase in panel size • 6.5% increase in primary care visits • 90.2% of MAs still employed by group	• Increase in group productivity • Decrease in MA turnover

Source: Bellin Health, Green Bay, WI; Confluence Health, Wenatchee, WA

Productivity gains possible by extending MA role to after visit

Potential provider time savings

Place pending orders

1 Minute of provider time spent per visit ----→ 20 Minutes of provider time spent per day[1] ----→ 1 Visit per day lost due to provider time spent on task that could be done by MA

Educate patient on care plan

3 Minutes of provider time spent per visit ----→ 60 Minutes of provider time spent per day[1] ----→ 3 Visits per day lost due to provider time spent on task that could be done by MA

1. Assuming 20 visits per day.

Registered Nurses (RNs)

Key takeaways:

- RNs should spend less time performing triage.
- As your group takes on more risk, shift RNs into value-based care roles.
- Allocate RN care management support to the patients—not physicians—who will benefit most.

How do you deploy your RNs?

Range of tasks performed by ambulatory RNs


Process paperwork, patient forms


Injections, infusions, suture removal


Triage and respond to clinical messages


Contact patients about lab, test results


Scribe for providers


Collect patient vitals


Perform chronic care management


Perform screenings


Perform annual wellness visits


Coordinate referrals

Easy to use RNs below top-of-license

Groups pay more in RN labor costs for tasks that could go to MA

$41K	X	15%	=	$6K
Difference in salary between RN[1] and MA[2]		RN time spent on tasks that are below top-of-license[3]		Annual cost of tasks performed by RN that could go to MA

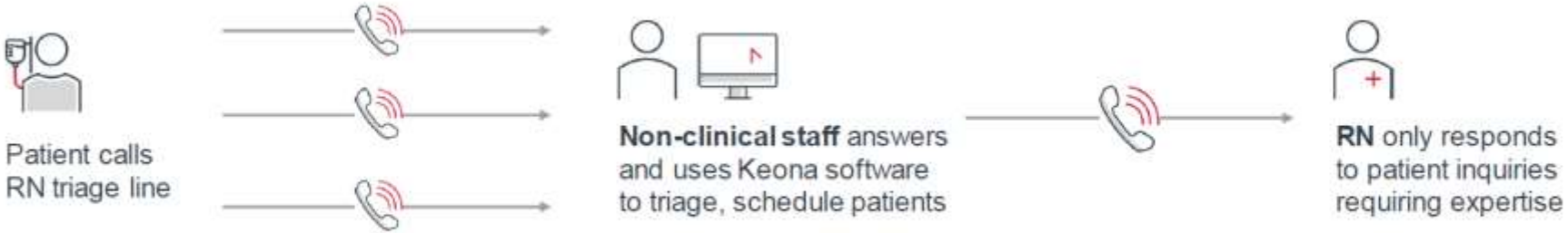
1. In outpatient clinic
2. In family medicine
3. Estimate based on Advisory Board interviews and analysis

Source: Stoltzowski L, "Medscape RN/LPN Compensation Report, 2019," Medscape, October 9, 2019; Integrated Medical Group Benchmark Generator, Medical Group Strategy Council, Advisory Board

Technology empowers non-clinical staff to perform triage

Status quo RN triage

Virginia Women's Center arms non-clinical coordinators with triage software to decrease RN involvement



Source: Virginia Women's Center, Richmond, VA

Protocols mirror RN decision making, reduce triage burden

Virginia Women's Center coordinator uses Keona to ask patient questions, assign triage level

Triage level	Recommended action for patient coordinator	RN involvement
1 Emergency	Transfer patient to RN for immediate consult	Advise patient over phone
2 Urgent	Schedule patient for same-day appointment	Review triage decision in EHR
3 Routine	Schedule patient for next available appointment in 7 days	Review triage decision in EHR
4 Home care	None	None
5 No health issue	None	None

RN time required:
1-20 minutes

RN time required:
10 seconds

Source: Virginia Women's Center, Richmond, VA

Create new RN role to support transition to value

RNs well suited for care management roles

Confluence Health deploys RNs in two roles

1 Clinical RN

- 0.25 RN per provider
- Embedded in practices
- Tasks include triage, immunizations

2 Care management RN

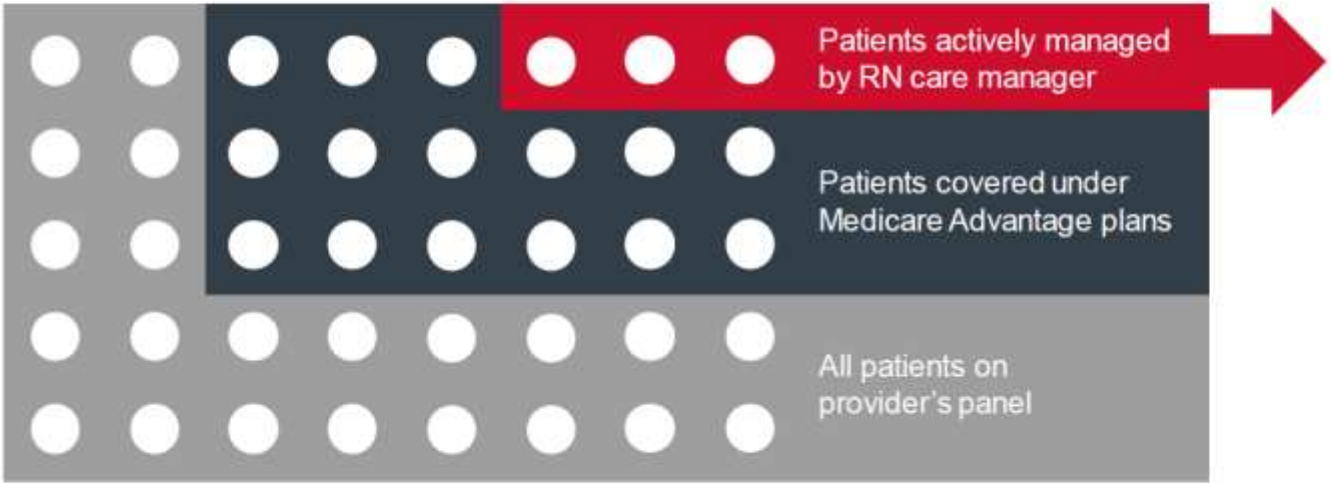
- 1 RN per 150 active patients
- Shared across provider panels
- Tasks include patient navigation, chronic care management

Source: Confluence Health, Wenatchee, WA

Allocate RN support based on payer

Target patients who would benefit most from care management services

Confluence's RN care managers work with subset of MA[1] patients



1. Medicare Advantage.

Source: Confluence Health, Wenatchee, WA

Bringing holistic care team redesign to your medical group

Build buy-in at all levels throughout entire process

Three implementation steps

Design

Incorporate frontline staff into role redesign

Rollout

Provide support during ramp-up period

Sustain

Hold care teams accountable for sustaining new model

1 Maximizing Practice Capacity

2 Attaining Top-of-license Care

3 Reviewing the Medical Physician Fee Schedule Changes

Few surprises, familiar themes in the final rule

Reduce clinician burden

Makes changes to coding and documentation requirements to reduce paperwork, increase time spent with patients

Promote value-base care

Adds and refines ways to incentivize providers to invest in care management, team-based care, and take on risk

Expand access to OUD[1] treatment

Finalized three policies to pay for opioid treatment services, part of administration-wide efforts to expand access amid opioid crisis

1. Opioid use disorder

CMS; Advisory Board interviews and analysis

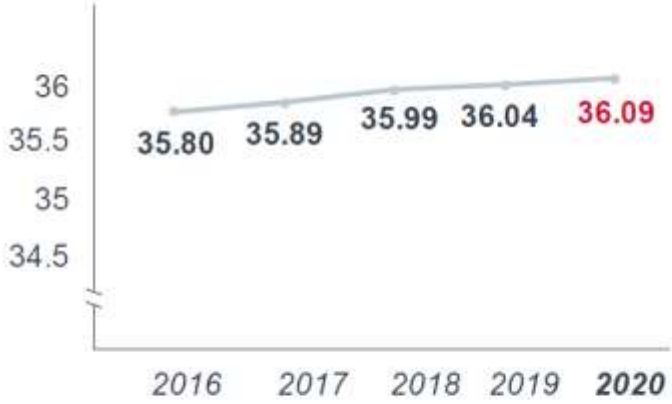
Physician payment remains relatively flat

2020 is the first year without mandated MACRA payment update

2020 Conversion Factor Calculation

2019 PFS conversion factor	$36.04
	X
Statutory update factor[1]	1.00
	X
Budget neutrality adjustment	1.0014
2020 PFS conversion factor	$36.09

Conversion Factors 2015-2020



Medicare payment calculation

For more details on how physicians are paid, read our Physician Fee Schedule cheat sheet.

1. As mandated under MACRA and the Bipartisan Budget Act of 2018, 1.00 update factor due to 0% increase for 2020

CMS; Advisory Board interviews and analysis

Payment cuts and gains by specialty, site

Based on aggregate estimate charges

Estimated impact of 2020 coding changes[1] on select specialties, sites of care

Making modest gains

Clinical social worker	4%
Clinical psychologist	3%
Geriatrics	1%
Orthopedic surgery	1%
Psychiatry	1%
Urology	1%

No net change

Cardiology	0%
Family practice	0%
Gastroenterology	0%
General surgery	0%
Internal medicine	0%
Radiology	0%
NP/PA	0%

Taking hits

Ophthalmology	-4%
Diagnostic testing facility	-3%
Optometry	-2%
Neurology	-2%
Cardiac surgery	-1%
Interventional radiology	-1%

1. Updates to RVU values. Does not include impact of E/M coding changes which take effect in 2021

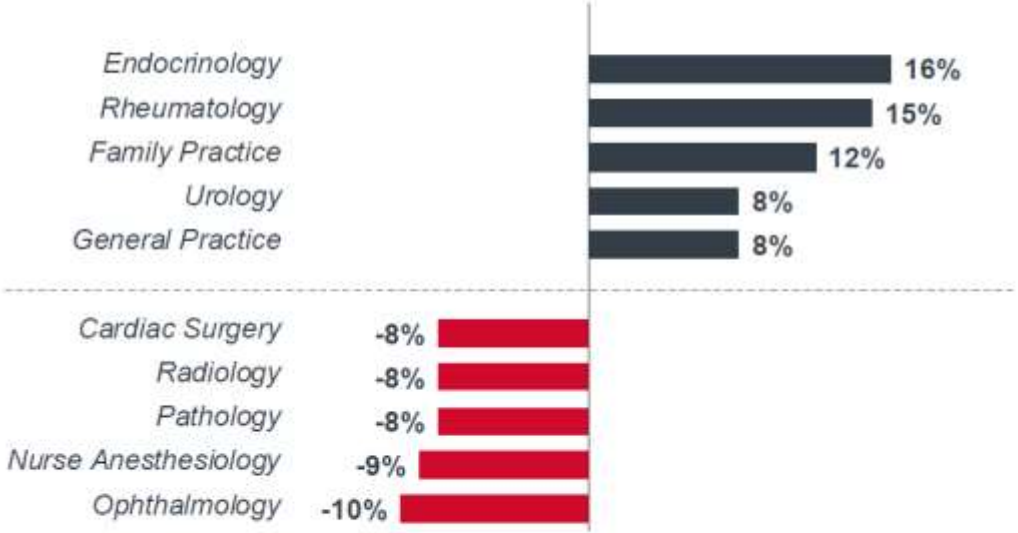
CMS; Advisory Board interviews and analysis

Specialties with more existing patients benefit most

Those that do not bill as many outpatient visits should expect decreases

Estimated impact of E/M coding changes by specialty

for CY 2021, including impacts from proposed work, PE, and MP RVU changes[1]



CAUTION

Amounts could change dramatically before CY 2021

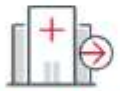
Note that changes in next year's proposed or final rules could greatly impact these estimates

1. For the whole table, visit https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other and view table 120.

CMS; Advisory Board interviews and analysis

A push for increased utilization of care management services

CMS removes barriers for billing, introduces new payment opportunity

TCM 

Transitional Care Management

- Pays for post-discharge services
- Increased payment for existing TCM codes (99495 and 99496)
- Reduced restrictions on when TCM codes can be billed
  - Allows concurrent billing of 14 codes currently restricted from being billed with TCM
  - CCM codes (99490 and 99491) now eligible for concurrent billing

CCM 

Chronic Care Management

- Pays for care management for patients with **two or more chronic conditions**
- Established new code G2058
  - Pays each additional 20 minutes of non-complex CCM services
  - Can be billed two times per patient, per service period

PCM 

Principal Care Management

- **NEW!** Established new codes G2064 and G2065
  - Pays for care management for patients with a **single, high-risk condition**
- Opportunity for specialist reimbursement of care management

CMS; Advisory Board interviews and analysis

Overview of finalized changes

Impact likely felt across specialties, especially office-based providers

Policy area	*Rule would…*	*Expect impact for…*
E/M[1] visit payment system	Largely maintain the current five-tier system of coding and reimbursement, but change time requirements and RVUs[2]	All providers offering office visits, particularly those focused on long-term complex care
Team-based care and care management	Increase PA autonomy and reduce documentation requirements for team-based care; update care management code requirements to increase utilization	Population health leaders, especially for family physicians managing long-term patient care
Opioid use disorder treatment	Establish pathway to bill for methadone treatment; create a bundled payment model for opioid use disorder treatment	Pharmacy managers, social workers, and leaders of opioid stewardship efforts
Quality Payment Program	Make relatively few changes to APM[3] policies and individual MIPS[4] categories for 2020; solicit feedback on implementing new MIPS[4] reporting framework in 2021	All MIPS-eligible clinicians or providers participating in MIPS APMs

1. Evaluation and Management.
2. Relative Value Unit.
3. Alternative Payment Model.
4. Merit-Based Incentive Payment System.

Source: CMS; Advisory Board research and analysis.

Maximizing Practice Capacity Break Out Session

LC Break Out Session: *Maximizing Practice Capacity*

Group 1

- **Primary Care – what can be done outside clinic (such as referrals)**
- **Likelihood of cancellations – double book (share info w/DIG)**
- Templates that fit different tiers of compensation models
- Sustainability model – reverse engineer narrow options
- RNs & APCs added to Exec Council

Group 2

- What are guidelines for MA and RN ratios to patients
- Support services locations
- APP utilization by patient category

Group 3

- Epic inbox management
- Data & analysis on unused appointments
- Standard clinic protocols
- Schedule management
  - No shows/cancels
  - Appointment types
- Innovative ways to see patients (non-face-to-face)
  - Manage the panel (Compensation)
- Get doctors to share the responsibility of seeing our patients
- Online pre-visit forms
- Protocols for lab results (automated)

Group 4

- PC Improvement Project (Facey)
- Virtual care
  - Subscription model
- Scribes (consider MAs)
- Pre-visit questionnaire
  - Pre-check in questionnaire

Group 5

- Balance capacity w/Provider burnout & patient care
- Mandatory templates
- Effective centralization of services
  - Refills
  - Scheduling
  - Pre-authorization
  - Phone triage
- Alternative visit model (adjusting follow up time)
- Care team & patient education

Themes: Schedule Management/ Team based care team models/Online intake forms

LC Break Out Session: *Attaining Top-of-License Care*

Group 1

- Get RNs/APCs truly integrated
  - APC onboarding & fellowships
- Close the clinic to re-tool for efficiency
  - Team based meetings over time
  - We've changed since APCs started Express Care, etc.
  - Care team needs to know who they should be booking – process with care coordination
- Use RNs to manage chronic disease – need engagement with MD/DO
- Process to get to "What does this mean to you" – everyone part of the process
- MA competency – work in Value Based Care

Group 2

- Stratification of patients
- Patient call routing
  - Triage standards (RN)
- MA Laddering promote
- RN Core Manager – standard role definition

Group 3

- Training to skill sets/push boundaries
  - Link to clinical protocols
- Standardize culture change
  - Agree on what RNs/MAs/others can do
- Standard orders & protocols
- Move away from wRVU based compensation (pooled plan/incentives across levels)
- Pooled incentives for specialists

Group 4

- Increased protocol driven care
- Clear(er) JDs

Group 5

- Team based initiatives
- Communication channels
- Alternative payment models
- Aligning APP/Provider/Specialty governance

Themes: Patient stratification/ Top of license team roles& responsibilities/ Culture shift to Value Based Care

LC Break Out Session: *Finding New Revenue Opportunities*

Group 1

- CCM & TCM analysis
- Basic coding education
  - HCC education
- 1-800-Prov to direct patients to appropriate care

Group 2

- Trans management coding
- Chart audits (doc)

Group 3

- Precision medicine – genomics
- Targeting specific populations based on characteristics (using big data)
- Improve access for patients
- Sell care management tool to employers (compete with health plans)
- TCM/CCM codes
  - Advance Care planning
- Smart Forms – Tie documentation to charge drop

Group 4

- Virtual care - subscription

Group 5

- Value based/risk contracting
- Alternative visit model
- Acute care contracts with our medical groups
  - Discovery toward alignment

Themes: Care Management role & revenue opportunities / Alternative visits / Contracting / Automated charges

Plus/Delta & Closing

Plus/Delta

- **Plus: What went well?**
  - Finance update (Nate)
  - Location – Downtown Seattle
  - Advisory Board engagement
  - Talking about the right topics
  - In Our Circle download
  - MS Teams use
  - Safety Story

- **Delta: What can be better?**
  - Slides sometimes hard to read
    - Projection quality
    - Text size/amount of content on one slide
  - More Specialty focus

Future Topics

- Government programs
- Mission Assessment
- Tech Updates – CIO
- Become a learning organization
- Expand on Safety Story & what we're doing to solve the issues
- Specialty work / clinical institutes
- Medical Neighborhood concept
- MAG/SAG
- High Risk CM & Nurse Nav work
- In-flight TBC models
- Cotiviti market-by-market
- Care Team 'Chicken/Egg'
  - Contracting conversation to ensure pencil out
- How to Move a Market (outside speaker)
  - Timing of when to move (Doug's grid)
  - Tool development to understand where each market is at
- Bluetree & Providence workflow w/policy changes
- Scripting – new Press Ganey metric

ADJOURN

Thank you for your participation!