

THE Physicians Report

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Evolving Practice Models

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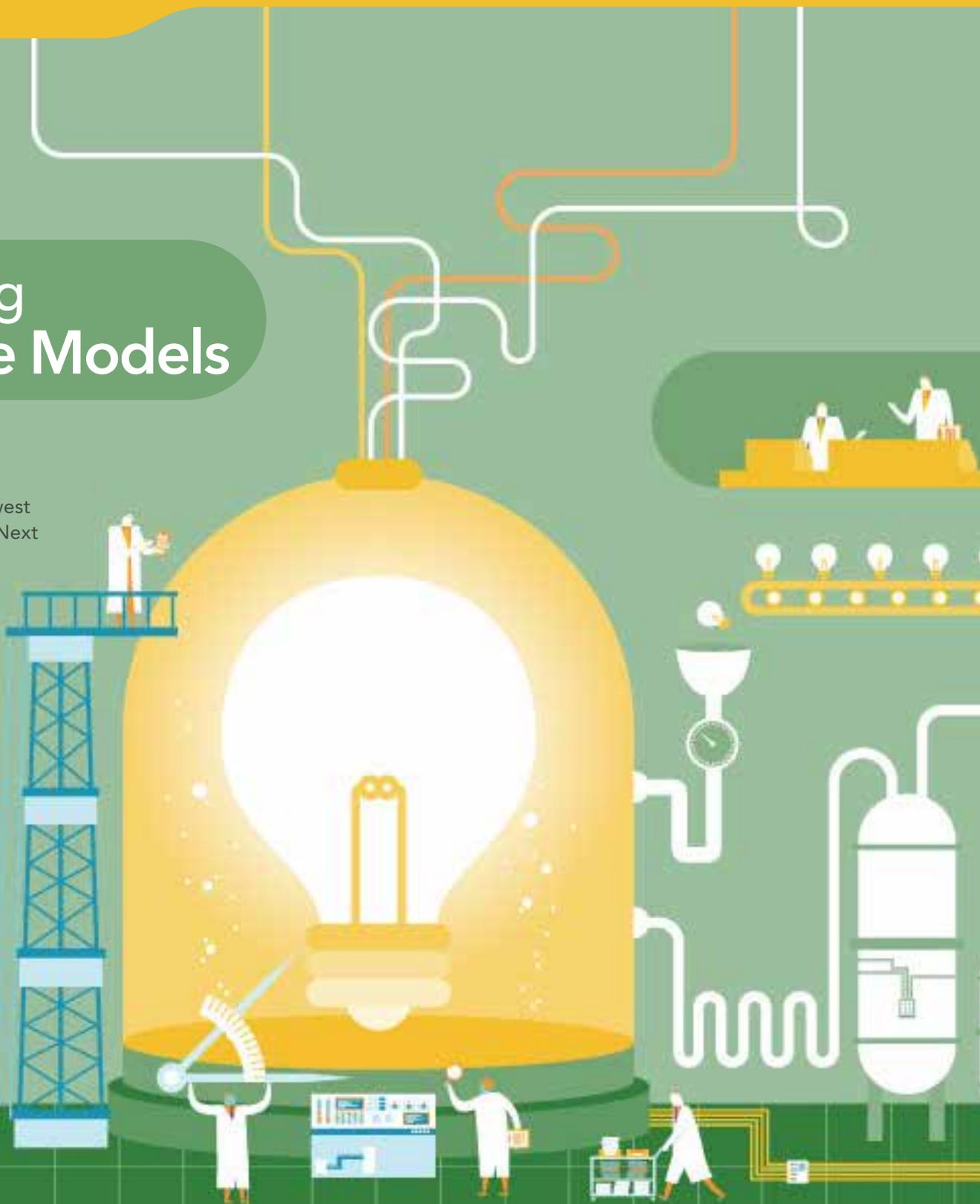
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Taking Accountability for Population Health



IN 1994, I was a young health care executive excited about health care reform. Things didn't work out like many of us hoped. This go-round, I am both excited and apprehensive about health care reform and alternative delivery systems.

The Polyclinic has participated enthusiastically in health care innovation. Our efforts have included full risk capitation, both commercial and Medicare Advantage, incentive contracts based on generic prescribing, ER use rates, hospital admission rates, etc. We were Washington State's first Medicare ACO and first commercial ACO. We have participated in state collaboratives on diabetes, heart disease, and medical homes, and we have studied the efforts of others in the region and the nation. What have we learned?

Be careful how much you spend while building new solutions. Elaborate organizational structures are less likely to produce meaningful change than programs that tighten the connection between patients and their providers. Information technology systems can be an important element of improved coordination of care, but they are only a tool. Without change in work processes and incentives and accountability, improvement is unlikely.

Don't fall in love with models. Apply resources only where they can have real impact. Medical homes and case managers make great sense for the frail, elderly, and patients with multiple chronic conditions, but they are a waste of resources for healthy 35-year-olds.

Physician leadership is critical. Every organization may say it is "physician-led." The proof will be in whether physicians feel like they are leading.

Payers must create funding to support innovation by providers. In our full-risk

Medicare Advantage contracts, we took some of our monthly capitation payments and added case managers and other patient support staff to reduce hospitalizations and ER visits, saving money and enhancing patients' lives. Providers cannot fund this type of innovation out of their existing fee-for-service payments.

Lead, but don't get too far ahead of the market. There is a lot of rhetoric about moving from pay-for-volume to pay-for-value, but the vast majority of our payments are still for volume. Emphasize "virtuous volume," e.g., childhood immunizations, preventive care, and regular care for chronic conditions.

Follow the value equation, but recognize whether the market will reward increasing the numerator or decreasing the denominator, or both:



We need to do this. If we can't make a convincing case that our efforts will reduce health care costs and deliver those savings, then payers and purchasers will simply push down our prices.

We don't have much time.



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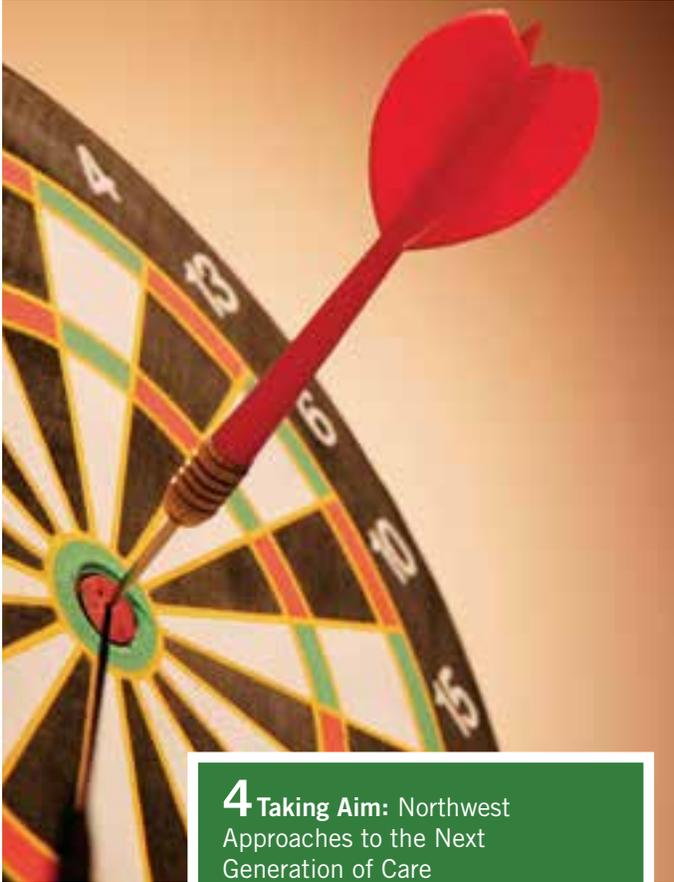
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**Northwest Approaches to
the Next Generation of Care**

Taking Aim

In 2008, when Don Berwick first coined the notion of a Triple Aim, little did the general public understand — or even most health care professionals — the impact this simple model would have on the U.S. health care system. Today, it is widely understood that the U.S. health system is the most costly in the world, accounting for 17% of the country's gross domestic product with estimates it will reach 20% by the end of this decade.¹

Change and improvement processes are rampant, and while Berwick's vision of impacting care quality, population health, and reducing costs still remains elusive to most, the Northwest is home to several organizations aiming in the right direction.

One organization in Vancouver, Washington, is focusing on physician-patient relationships to make a difference. "We want to create a community solution," says Duane Lucas-Roberts, CEO of The Vancouver Clinic, about his organization's approach to developing a clinically integrated network (CIN). "Our goal for Columbia IPA [independent practice association] is to create a coordinated approach to quality care, and lower costs at the same time. That goal isn't anything new, but the way we are organizing ourselves to achieve it is."

It is easy to notice, as one surveys the region, that as groups organize themselves into CINs, each is doing it differently. Continues Lucas-Roberts, "We see ourselves as just a part of the overall

solution. The hospitals are the other part. The patient plays a role, too. But we're organizing ourselves — starting with the physician and patient relationship. That's where care really starts and it's that ongoing relationship that will have the most impact."

While The Vancouver Clinic develops their physician-centric solution, just four hours away efforts are under way at Yakima Valley Memorial Hospital (YVMH), where the hospital is leading a community-wide charge to create a CIN. But whereas The Vancouver Clinic efforts pivot around the primary care physician and patient relationship, YVMH saw the value of the hospital leading the charge and financing the start-up of Signal Health, LLC.

Headed by Dr. Richard Spiegel, Signal Health has recruited more than 300 physicians, which include all of the hospital's employed physicians and others (about three-quarters of the total according to Spiegel) that are independent. "If we only deal with the outpatient or clinic side of care, we could hope to reduce emergency department visits, or testing. But we want to look at this as a system — hospital, outpatient, ancillary services. We are all working as a whole toward quality, health, and cost."

POINTS OF ACCESS

Though the fulcrum of their efforts may be different,

they both see the emergency department as a leading indicator of how this new model can work. "In Yakima, there is a culture of first going to the emergency room for care," notes Spiegel. "In a rural population like ours, culturally, the ED is seen as a place to get primary care. The opportunity for us is not only to reduce the costs of care in the ED, but also to educate patients and change their behavior in how they access care." One common method being experimented with is the use of urgent care clinics. Physicians at Memorial Hospital, who participate in SignalHealth, have opened up convenient care clinics in Yakima, which are less expensive than the ED — in large part due to the staffing of the clinics by nurse practitioners who cost less than emergency medicine physicians.



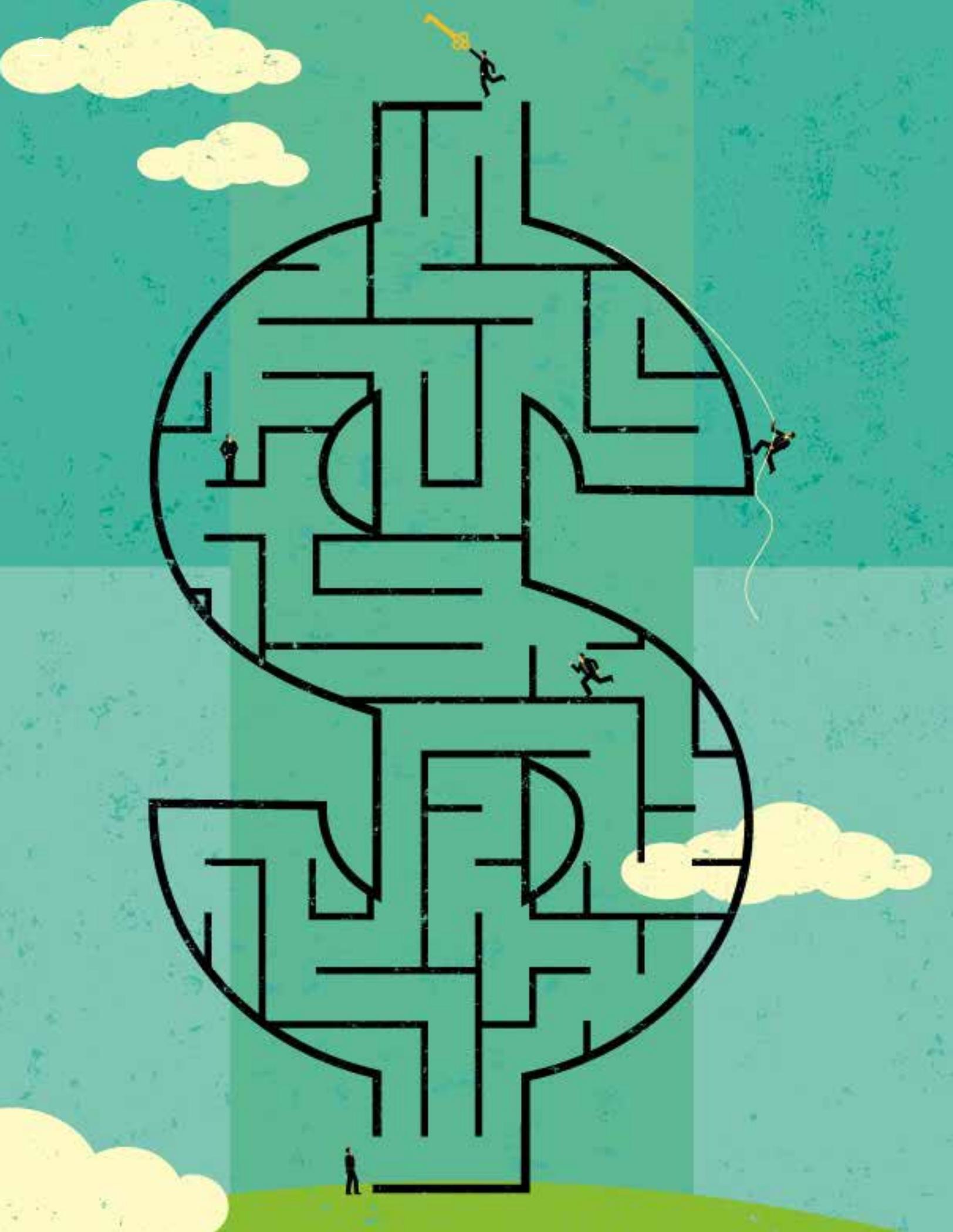
"The result was a reduction in emergency department visits — from 1,000 to 200 visits."

DUANE LUCAS-ROBERTS, CEO
THE VANCOUVER CLINIC

Lucas-Roberts recalls his own emergency department challenges while working in Walla Walla, Washington. "Our population was a full-risk Medicaid group of about 2,000 patient lives, most of whom were kids." According to Lucas-Roberts, this population was running about 1,000 ED patient visits per 1,000 patients per year — about five times higher than the commercially insured population. "We knew we had to change patient behaviors but that ours needed to change first." The clinic set up a system where the emergency department was required to contact the primary care physician before seeing the patient except in emergent cases. The primary care physician would consult with the patient and either see the patient in the ED, or schedule an office visit. "The result was a reduction in ED visits — from 1,000 to 200 visits per 1,000 patients per year," notes Lucas-Roberts.

And this is possibly the most compelling and perplexing part of the new models of care — getting patients to change their approach to their own health and consumption of care. The traditional fee-for-service model, coupled with insurance programs that distanced patients from their care dollars, created a multi-generation mindset of how the insured health care system works: Physicians treat, patients consume, insurers pay. This is the model that led us to today's health care fiscal

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UNLOCKING VALUE WITH CLINICAL INTEGRATION

Independence Through Interdependence

Jeff Ellis and Martie Ross,
Pershing Yoakley & Associates, PC

Fee-for-service reimbursement rewards independence: each provider is paid for providing a discrete service, without regard to others' performance. There is no incentive for providers to work together in providing patient care.

Value-based payment systems, however, demand interdependence: providers are rewarded for quality and efficiency achieved through collaborative care.

The structure to develop and support such interdependence is the clinically integrated network, or CIN. Regardless of the specific type of value-based payments — pay-for-performance, shared savings, bundled payments, or global budgets — they require that providers be accountable to each other and the community they serve.

Developing a CIN is a journey, not an event. The first step in that journey is a common understanding of why everyone is suddenly talking about clinical integration, and what it means to the future of health care delivery.

THE TRANSITION TO VALUE-BASED PAYMENT IS ACCELERATING

The Centers for Medicare and Medicaid Services (CMS) is promoting this transition in the Medicare program through a number of initiatives including, for example, the Medicare Shared Savings Program, value-based purchasing of hospital physicians, and bundled payments.

Commercial insurers, as well as employers, also are aggressively pursuing value-based purchasing arrangements. More and more payers are introducing pay-for-performance provisions in their standard provider agreements.

Achieving measurable improvements in quality and efficiency demanded under these new payment models requires coordination and collaboration among a community's providers. Independent physicians are seeking ways to work together for these purposes while protecting their individual interests.

Clinical integration is a new model for health care delivery. It promotes collaboration among a community's independent providers to furnish high-quality care in a more efficient manner. Physicians, hospitals, and other providers share responsibility for, and information about, patients as they move from one setting to another over the entire course of their care.

Working together, clinically integrated providers develop and implement evidence-based clinical protocols, focusing on patient engagement and coordinated management of high-risk and rising-risk patients. Utilizing shared information technology, these providers conduct ongoing clinical care reviews to identify opportunities for improvement and ensure adherence to protocols.

While the antitrust laws generally prohibit joint contract negotiations among independent providers, those laws permit

(Continued on next page)

clinically integrated providers to collectively negotiate with payers. Working together, these providers can compete for payer contracts based on demonstrable quality and greater efficiency in care delivery.

In short, clinically integrated providers are accountable to each other and to the community they serve to deliver high-quality care in an efficient manner. They accomplish this by (1) collectively establishing and enforcing standards of care, (2) coordinating patient care (especially for high-risk, high-cost patients), and (3) jointly negotiating and managing payer contracts.

DEFINING THE INTEGRATED NETWORK

A CIN is the lean infrastructure needed to support clinical integration among a community's independent providers. The network develops a governance structure through which these providers develop and implement clinical guidelines, monitor compliance, enforce standards, and reward performance.

Other network activities include, for example, identifying, implementing, and maintaining supportive technologies (including data analytics); analyzing care processes to identify efficiencies; encouraging patient engagement; negotiating pay-for-performance payer contracts; and distributing incentive payments to members.

While a hospital can provide administrative expertise for a CIN, network leadership is shared with physicians. Physicians have the knowledge, skill, and experience needed to achieve improvements in clinical quality and efficiency.

Unlike organizations such as integrated delivery networks (with hospital-employed physicians) and large multispecialty physician practice groups, which base their clinical integration strategies on economic integration, a CIN respects and preserves the economic independence of its physician members.

Key characteristics of a successful CIN include the following:

- Well-defined governance structure to promote organizational goals while protecting individual interests
- Physician-driven, professional management
- Data-driven reporting, foundation, philosophy, or approach
- Relentless focus on managing high-risk and rising-risk patient population
- Adherence to evidence-based clinical guidelines

Provider worries about federal regulators are well grounded. Since 2001, the federal government has prosecuted more than 30 provider organizations alleging price-fixing arrangements. The Federal Trade Commission (FTC), however, does not view collaboration through a CIN as collusion among independent

providers. To the extent joint contracting is both necessary and subordinate to a CIN's broader effort to improve quality and efficiency, the government views CIN arrangements as beneficial to consumers and pro-competitive. Thus, providers' full commitment to achieving critical integration is critical.

A CIN IS NOT NECESSARILY AN ACO

The term *clinically integrated network* dates back to the mid-1990s, when the FTC first acknowledged that independent providers working together to improve quality and efficiency could engage in joint payer negotiations.

The term *accountable care organization* was first used about a decade later in reference to a group of providers that assumes responsibility to provide care for an assigned patient population. Typically, an ACO bears some financial risk associated with providing such care.

An ACO is a more formal arrangement, structured to satisfy specific payer requirements. For example, only an ACO that meets certain regulatory requirements is eligible to participate in the Medicare Shared Savings Program.

A CIN may elect to form an ACO for purposes of contracting with a particular payer. That decision, however, may be deferred until the CIN is fully operational.

A CIN's governance structure must further its members' common goals while protecting their individual interests. This is achieved through the selection of governing board members, balancing voting rights among participants, reserving certain fundamental decisions to the respective parties, delegating organizational functions through carefully drafted committee

charters, and more.

Before deciding on a particular structure, however, there should be consensus around common goals, i.e., identification of the functions the CIN will perform. Stated another way, the form the CIN takes should follow from the functions it will perform, not vice versa.

CINs fund their operations in a number of different ways, including, for example, contributions from the participating hospital, physician dues, the sale of investment interests, revenue generated by selling services, and withholdings from payer reimbursement and/or pay-for-performance payments.

PAY-FOR-PERFORMANCE AND SHARED SAVINGS PROGRAMS

Under a pay-for-performance contract (often referred to as a



P4P contract), an individual provider continues to submit claims and receive fee-for-service reimbursement. If the provider achieves a certain goal specified in the contract, the provider receives an additional incentive payment. A P4P contract may provide for a penalty if a provider fails to meet a specified target.

Many commercial payers are looking to include P4P provisions in their contracts with individual providers. Generally speaking, a CIN can negotiate more favorable P4P terms. Also, a CIN supports an infrastructure that enables its members to achieve P4P measures.

Under a shared savings program, a CIN is eligible to receive a portion of a payer's savings generated through greater efficiency in care delivery. This is accomplished through a multistep process:

- 1) The payer assigns a specific patient population to the CIN, usually based on patients' primary care providers. The payer calculates a total cost-of-care benchmark for that population based on historical data.
- 2) Both CIN and non-CIN providers continue to receive fee-for-service reimbursement for all services furnished to patients in the population.
- 3) At year-end, the payer calculates its actual total cost of care for the patient population, including services furnished by non-CIN providers.
- 4) If the actual cost is less than the benchmark and if specified quality measures are met, the CIN will receive a share of savings based on a predetermined formula. If the quality measures are not met, however, the CIN does not receive any shared savings.
- 5) A CIN may opt for a "two-sided" shared savings program. If the actual cost is more than the benchmark, the

CIN repays a portion of the difference. But if the actual cost is lower, the CIN will receive a larger percentage of the savings.

- 6) The CIN decides how shared savings (or losses) are distributed among its members. Typically, a portion is retained by the CIN to pay expenses.

PHYSICIANS AS CIN MEMBERS

To ensure compliance with the antitrust laws, CIN participation should be open to any physician who satisfies established minimum requirements for membership and maintains compliance with specified performance standards. Part of the CIN planning process involves identifying reasonable and appropriate requirements and standards.

Typically, a CIN's governing body develops a network participation agreement that specifies the rights and duties of CIN members. Community providers are given the opportunity to review this agreement prior to making a formal commitment to CIN participation.

At a minimum, a physician member of a CIN is expected to adhere to CIN-approved protocols and otherwise participate in and support CIN operations. Depending on decisions made by the CIN's governing body, a participant's ability to contract with payers independently or through another network may be limited.

The implementation of clinical protocols and performance measures is an ongoing process of education and continuous quality improvement. No provider will be expected to perform at a certain level without adequate support to achieve that goal. While the intent is to improve quality and outcome metrics, successful CINs must be willing to terminate repeat offenders. To protect individuals' rights, the CIN may establish a review process to afford a physician the opportunity to challenge an adverse decision. No participant should be excluded based solely on subjective criteria.

EVALUATING OPPORTUNITIES

As CINs develop and mature, physicians will have many opportunities to affiliate with different networks. To evaluate those opportunities, a physician should ask critical questions regarding the CIN's operations:

- What financial commitment is required and what financial rewards can be expected?
- What is the CIN's payer contracting strategy?
- What support services does the CIN provide to member physicians?
- What experience does management have in operating a CIN?
- What are the CIN's technological capabilities?
- What is the CIN's operational plan to improve quality and lower total cost of care?
- What are the opportunities for physician involvement in CIN governance and operations?

The answers to these questions will give a strong indication of the CIN's likelihood for success. In turn, a physician's affiliation with a strong CIN likely will be a key factor in a physician's ability to thrive under new payment and delivery models. [PR](#)



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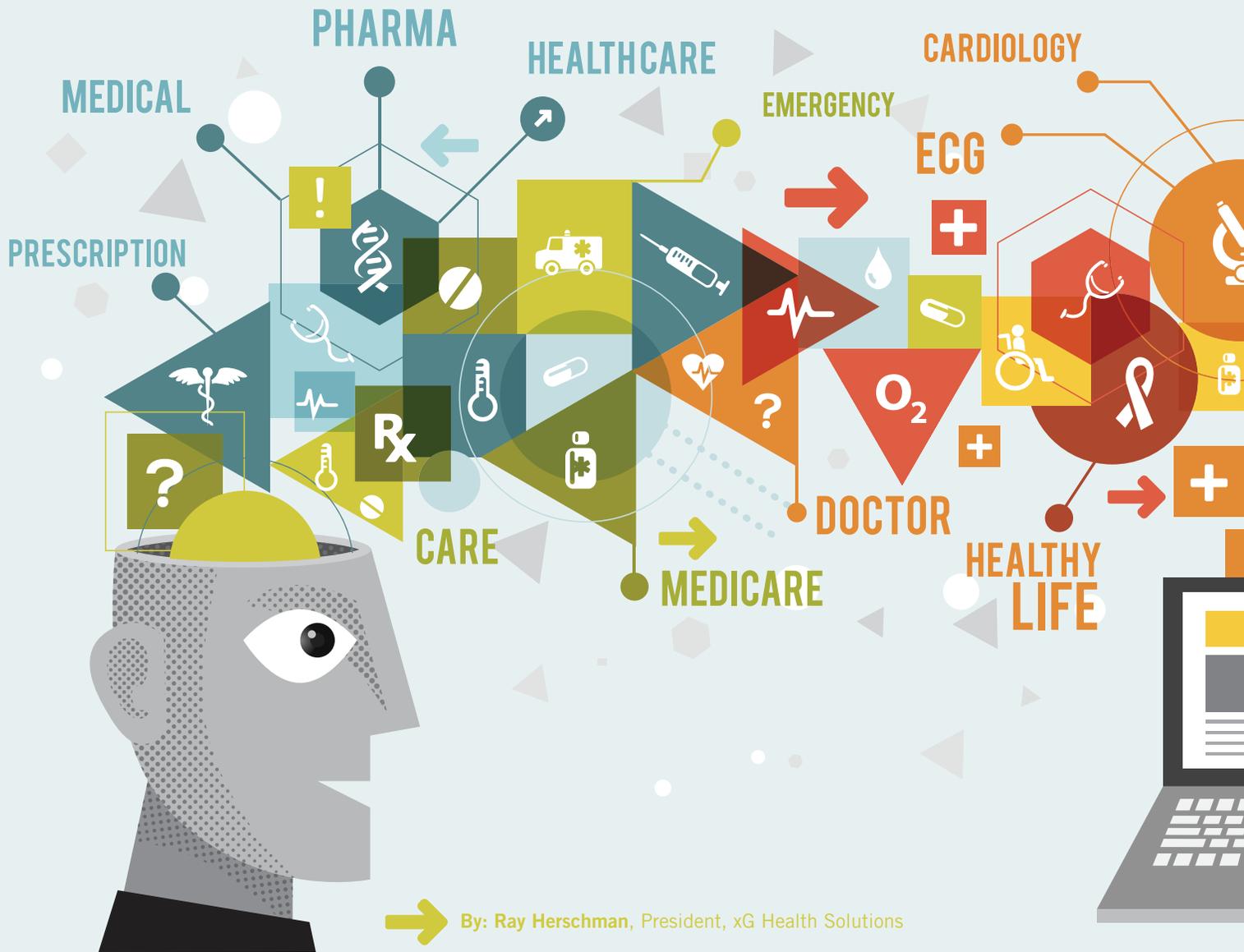


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TAKING ACCOUNTABILITY FOR POPULATION HEALTH

THE ROLE OF DATA



For providers to accept accountability for population health and payments based on episodes of care, they need control. This control comes, in large part, from information.

Many providers now have access to rich and timely clinical data through their electronic medical records (EMRs). However, it is not enough. Providers taking responsibility for not only health processes and outcomes, but also the total cost of care for a population, must have visibility to the place of service, relative costs, and overall quality of care for their patients beyond their four walls. This information resides in administrative data held by payers.

Accountable care organizations (ACOs) and clinically integrated networks (CINs) are emerging as contracting entities through which the full continuum of providers — hospitals, physicians, ancillary service providers, and skilled nursing facilities — share accountability for the health of a defined population. These organizations will increasingly be paid via value-based reimbursement models that align economic incentives among payers and providers.



Implicit within value-based payment arrangements must be access to this data so providers have the total picture they need to effectively manage population health. Complete data and related analytic and decision support capabilities are foundational to provider success in value-based care delivery. As providers start down the road of value-based contracting, they face several choices related to data and analytics.

These choices have long-term implications for provider organizations' budgets and focus.

How practices access payer information

Providers and payers who agree that sharing information is key to measurably improving quality and costs are in the midst of sorting out their roles in this new world. Payers have long held data close, but new accountabilities are driving at least three different ways for providers to access administrative data.

Borrow. Some providers rely on quarterly paper reports or payer-specific Web portals to access information about their patients. While any information is welcome for providers who have made do without it for so long, this path has several challenges.

First, there is significant variation among payers in what reports they provide, how they stratify risk, and how they categorize and group the data. Second, each payer has only a percentage of a provider's total patient panel, resulting in a lack of credibility and stability in performance measures. Third, the information is often aggregated and latent, making it difficult to use for patient outreach and provider-level improvement.

Finally, because payers are challenged with having to provide reports to their entire provider network, reporting is relatively static and standardized. Far more important than standardized reports is data interpretation which, at the in-depth level necessary to be a high-performing ACO/CIN, has historically not been a core competency of either carriers or providers. From a provider perspective, using multiple sets of metrics and payer portals to manage a patient

population is not practical or sustainable over time.

Build. Recognizing these limitations, some providers are investing millions of dollars in technical infrastructure, labor, and consultants to develop their own data intake, transformation, data warehousing, and analytic solutions. This can be all-consuming even with one payer, not to mention multiple payers, each with their own data formats and idiosyncrasies.

This path also requires corresponding investments in recruiting, hiring, and training clinical and medical economics analysts. Committing to tools, upgrades, and staff can be costly, overwhelming even large practices and drawing time and financial resources away from running the business, delivering high-quality care, and developing critical performance-improvement initiatives.

Partner. An emerging alternative is for providers to work with a neutral, third-party intermediary with experience managing the complexities of aggregating multi-payer data on behalf of providers. This approach leverages technical infrastructure and staff across a broad pool of providers and patients to drive down the costs for all users.

Providers gain a "virtual single-payer view" of the patient population they are accountable for managing. This "utility" model is also beneficial to payers, as they are relieved of the ongoing cost burden of dealing with hundreds of point-to-point data transfers with each provider entity. Instead there is a trusted, neutral third party that acts as a single hub through which their data is transmitted to providers in a secure and confidential manner.

Leveraging payer data

Once information is secured, whose job is it to interpret the information, size

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Medical Neighborhoods Are Transforming Care Delivery in Rural Settings

By Phyllis Simpson Sherard, PhD,
Judit Olah, PhD, and Greg O'Barr, M.Ed,
Wyoming Institute of Population Health



Fragmented health care delivery systems are associated with inefficiencies, highly variable health outcomes, not being financially sustainable, and no longer being acceptable to patients, providers, and insurers.

Delivery system and payment reforms championed by the Affordable Care Act recognize the fundamental role of local communities, health plans, and medical practices to develop multi-stakeholder initiatives to reform our nation's health care.

However, in vast and sparsely populated states, accountable care organizations (ACOs) like those envisioned in the CMS Medicare Shared Savings Program may be unlikely to form. Wyoming, for example, has virtually no managed care presence and is home to no large, integrated health systems that span the entire state. Additionally, Wyoming's most rural communities are located vast distances from the state's two largest hospitals. To add to the challenge, the rural settings lack specialty services, and small hospitals lack the market power to contract for the services close to home that would be necessary to preempt referrals outside of the ACO. And yet, despite these obstacles, Wyoming is moving forward with a statewide effort to transform rural care delivery.

The Wyoming Institute of Population Health, the recipient of a \$14 million health care innovation award from the Centers for Medicare and Medicaid Innovation, has brought together hospitals, providers, and communities all across Wyoming to address three drivers of rising health care costs: 1) failures of care delivery, 2) failures of chronic care management and transitions across sites of care, and 3) overtreatment, often associated with failures of care coordination or care communication. Fourteen hospitals and 21 medical practices, representing more than 50% of Wyoming's primary care providers, are voluntarily participating in this innovative initiative.

Five key strategies are being implemented in Wyoming's medical neighborhoods:

1. Patient-centered primary care medical homes (PCMHs), focused on wellness and comprehensive primary care services, form the core of Wyoming's medical neighborhoods and serve as consistent, central coordinators of care for medically complex patients.
2. Care Transition RNs provide education and facilitate continuity of medical care as patients with complex conditions transition

between hospitals and post-acute sites of care. Working with PCMHs and other providers, these RNs work with patients to establish individualized care plans, improve the patients' confidence to self-manage, increase patient and family engagement, and decrease health care costs by reducing avoidable hospital readmissions and associated penalties.

Fourteen hospitals and 21 medical practices, representing more than 50% of Wyoming's primary care providers, are voluntarily participating in this innovative initiative.



3. Telehealth Physician Desktop Solutions have been deployed across Wyoming, expanding the state's telemedicine system to increase access to specialists, improve coordination between sites of care for high-risk patients, and facilitate effective medical decision making.
4. Pharmacists are being integrated with PCMH interdisciplinary care teams to support medication therapy management. These community pharmacists play a vital role as the medication-utilization connection between patients and their health care providers.
5. Access to donated, in-date, prescription medications for uninsured and underinsured patients has been expanded statewide to help providers develop and support comprehensive care plans for low-income patients.

Projected to save Wyoming an estimated \$33 million in health care costs over three years, the initiative's five component strategies have been designed to ensure that patients achieve the greatest possible care experience and benefit from well-coordinated, effectively communicated care and seamless transitions between sites of care.

Quality Management and Payer Partnerships

In Wyoming's medical neighborhoods, PCMHs provide a comprehensive framework for quality management. Participating PCMHs have become learning organizations,

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(Taking Aim, Continued from page 5)

crisis and one that requires solutions by all parties — with patient behavior now under the microscope.

THE INFORMATION AGE

“Population health management data and analytics is the key to all this,” says Ann Wheelock, CFO of The Vancouver Clinic. But these are not new topics, and something that health care has looked at before. “One of the reasons why IPAs were not successful in the 80’s was that there just wasn’t enough data, or the ability to analyze it like we do today.” Wheelock notes that today’s ability to view patients both individually and as parts of groups, to build and use reports about patient populations, helps to create care and case management strategies that have direct impacts on patient health and lowering costs. “Even the ability to track patient follow-up is better today than ever before with remote monitoring and in-home visits,” she says, noting that these new ways of delivering care are often less expensive in the long run.

“We have a care management pilot in two clinics and the hospital,” says Spiegel at Signal Health. “We are tracking the high-utilization, high-cost patients and providing nurse care and case management. Some of this involves patient education, calls, even home visits. We helped a female patient get better by just helping her to organize and better understand her medications.” The notion is that if you can ensure a patient is taking their medication correctly, using their equipment properly, or even making it to their ongoing appointments, then you will see lower instances of illnesses becoming acute, and chronic patients getting better — leading to patients consuming less costly health care, and less care in general.

But patient engagement and education is not the only answer. Over at Signal

Health, Dr. Spiegel is leading the charge to work out standards in how their integrated physicians are approaching disease management, COPD, or other clinical processes. They’re creating a provider portal where physicians can see how they’re doing on quality and cost metrics.

This type of approach also enables Signal Health to look at specific groups and see how they can address population health in different ways, and how the individual providers are doing in working with those patients and groups. “We’re also building a health information exchange as a one-

indicators that suggest the solution to this shortage may also positively impact cost, quality, and outcomes.

A recent RAND report² noted that increased use of new models of care could increase patient access to lower cost care, in settings that foster a team approach and higher levels of communication about patient treatment. “Growing use of new models of care that depend more on nonphysicians as primary care providers could do much to reduce the nation’s looming physician shortage,” said David Auerbach, the study’s lead author and a policy analyst at RAND,



“One of the reasons why IPAs were not successful in the 80’s was that there just wasn’t enough data, or the ability to analyze it like we do today.”

ANN WHEELOCK, CFO
THE VANCOUVER CLINIC

stop location for patient information,” says Spiegel. “With this tool, we’re less likely to miss or duplicate prior care, and can track over-utilization of resources. Having this level of data about patient interactions and health outcomes enables us to create performance reports for all our physicians.” And because care utilization and patient health outcomes are linked to payment from payers and physician compensation incentives, this information is transparent to all physicians creating peer-level accountability.

THE WHO & WHERE OF CARE

Still, with a renewed focus on patient outcomes, cost containment, and even updating payment models (bundled services, shared risk, and gain sharing), the Triple Aim that Berwick launched faces possibly its most daunting challenge: the projected physicians shortage (mostly in primary care) over the next decade. And there are some

a nonprofit research organization. The study noted that if nurse-managed health centers were to account for just 5% of primary care offered in the U.S. (currently it accounts for just about .5%), it would reduce the projected physicians shortfall by 25%.

In addition, there’s a renewed focus in primary care medical homes (PCMH), this time with a focus on their application in the commercial space. “Medicaid has used medical homes for a long time with great success,” notes Wheelock. Usually, when patients join Medicaid, their insurer initially assigns them to a primary care physician at a nearby clinic or health center. “Most commercial payers don’t assign a primary care physician (PCP). That’s been out of vogue for both the insurer and the patient. But we want to encourage future payer partners to assign a medical home — it is going to be critical to our success.” 

² RAND Corporation, “Nurse-managed Health Centers and Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage,” accessed June 5, 2014, www.rand.org/content/rand/pubs/external_publications/EP51621.

According to the RAND report, PCMHs account for nearly 15% of primary care nationally. And though their efficacy is still being tested, if medical homes grew to provide half of the primary care in the country, the nation's projected physician shortage could drop by another 25%. And lastly, the use of telehealth technologies or other electronic health applications is suggested as another method of reducing the amount of care having

to be delivered by physicians in an office setting, reducing the demand for physicians by yet another 25%.

Which model to use and which providers to employ may seem simple and straightforward to the untrained eye. But finding a model that delivers the right care, at the right time, at the right place, delivered by the right professional, at the right price, all overlaid with increasing patient

responsibility for participation, consumerism, and outcomes, has stymied many seasoned professionals. And while some suggest that the best path forward is simply to detach from a fee-for-service system and retool to a value-based care model, or that the solution is in retooling the health insurance model itself, perhaps in the end the target for health care is not as narrow and singular as some proposals suggest. [PR](#)

(Rural Settings, Continued from page 13)



and clinical quality reporting and performance evaluation have become core functions of their practice management. Data on quality, performance, and costs are available and used for learning and continuous quality improvement. Timely analysis and practice-wide evaluation feedback allow for quick corrective actions where needed; transparency increases patient engagement, improves provider satisfaction, and increases staff engagement.

PCMHs have made dramatic progress in the area of quality metrics reporting in Wyoming's medical neighborhoods. Practices are now reporting to the Institute nine clinical outcome measures (five preventive and four high-risk monitoring indicators). Cost-containment goals (e.g., avoidable ED visits, hospital admissions, and readmissions) have been successfully linked with quality goals.

With little experience in measuring and reporting cost and quality, the practices were initially challenged by the resource burdens associated with regular reporting. Over time, however, payer incentives and the Institute's support to help the PCMHs identify and meaningfully manage their complex

patient populations have enabled the reporting transformation at the practice level. All of Wyoming's payers are increasingly responding to the quickly evolving PCMH quality and performance evaluation transformation and offering care management incentives to further propel the momentum of quality reporting capabilities in primary care. Though PCMHs were initially designed within the rollout of CMS's Pioneer ACOs, Wyoming has found its own path to linking of performance-based reimbursement relationships between care providers and its major payers.

Critical Success Factor: Collaboration

Health care transformation requires a paradigm shift from the outdated model of patient care delivered in silos—a model posing danger to patient care, satisfaction, and safety—to a care delivery model that is well communicated and well coordinated across the care continuum. Population health delivered in a medical neighborhood requires a patient-centered care delivery model, comprehensive assessment of the patient's needs in a primary care setting, and development of individualized care plans to manage and improve the health of that patient that draw upon a broad range of services across the health care

continuum and the community.

It sounds very simple, but the medical neighborhood concept, to be successful, must create collaborative relationships among health care providers that previously viewed themselves as disconnected, competing organizations. PCMHs are coordinating the care of their patient panels and are reporting improved clinical outcomes associated with chronic disease management and preventive screenings. Specialty providers are utilizing telehealth to bridge geographic distances, and clinical site-to-site consultation is on the rise across Wyoming. Hospitals are sharing accountability for the care of complex, high-risk patients and are now collaborating on the development of care transition plans. Wyoming, with its historic tendency to form collaborative relationships that work, has developed a unique solution to the challenge of health care reform. [PR](#)

About the Wyoming Institute of Population Health: *The Wyoming Institute of Population Health, a division of Cheyenne Regional Medical Center, is committed to building bridges between communities and health systems. The Institute was created to develop strategic platforms that proactively address the evolving needs of patients, providers, and communities across Wyoming. (307) 663-2914*



WHY THE
COACH APPROACH
MAKES SENSE FOR MEDICINE



IMAGINE YOUR

patient Annette works upstairs from your clinic at a company employing 500 people. Since she can easily pop downstairs between meetings for a same-day appointment to see you, you've seen more of her this year than her previous provider did during the past five years combined. She has kicked cigarettes, set goals for her exercise and diet, and lost 23 pounds. Healthier than ever, she is taking pride in living a lifestyle to fend off bigger health problems, such as heart failure or diabetes.

Combining proximity with coaching, Vera Whole Health is improving health and lessening the need for more critical care—and the costs that go with it. Many health organizations are developing ways to increase efficiencies while they deliver care, and Vera Whole Health, in Seattle, has a model that is also getting health results. First, by embedding their clinics within corporate walls (or in very near proximity), they're seeing patients who might not have previously sought care. Second, by pairing physicians with health coaches, they see greater patient activation.

THE COACH APPROACH

"Having launched many fitness organizations, both nonprofit and for-profit, I have always been passionate about helping people live well and transform their health," says CEO Ryan Schmid. "While I don't have a medical background — I was a student athlete with a business education — I knew that the lifestyle and behavioral-change angle was where I could make a difference." With 70% of costs lifestyle-related,* patient behavior is an important part of the equation — but one that providers have little control over.

Vera started as a fitness organization. "A lot of people would show up to make good on a felt need to get in shape, but a lot of what is really going on for them is 'between the ears.' At Vera Whole Health, we realized an opportunity to build relationships that coach people into lifestyle change," says Schmid. Leveraging that insight, Vera Whole Health now contracts with medium-to-large employers, in parallel to an employer's insurance plan, embedding primary care clinics on-site that feature the pairing of physicians and health coaches. Employers pay a per-member, per-month fee for their employees and their families to use Vera's clinic services free of charge. For something Vera does not offer—an MRI, for instance—Vera can refer to the most cost-effective local resource, where patients can use their insurance plan benefits.

coaching into their practices.

Vera teaches that one of the key differences between a provider and a coach is that "the physician is doing the 'telling' by providing expert medical guidance; the coach is doing the 'asking' by drawing out of the patients the goals they think they can accomplish to address the required changes in health that are required," says Schmid. "The provider can spend an hour with the patient to develop a care plan, then take them to meet their coach." Their coach sits with them to determine their health goals and the behavior changes that will help them become realized. Then the physician and coach will meet and compare notes. "They are very much a team; it is not a disjointed referral."

Ryan feels that physical and mental health are completely intertwined.

"YOU MAY HELP someone lose 10 pounds, but what happens six months down the road during a stressful event? Life is going to happen, so our objective is to help people develop the skills to self-manage, to be confident about managing themselves down the road."

RYAN SCHMID, CEO
VERA WHOLE HEALTH

WHAT IS A HEALTH COACH?

Vera has two kinds of coaches: Care providers such as PAs, NPs, physiologists, or dieticians who have been specifically trained in coaching, as well as coaches who are not licensed providers of any kind. To ensure the quality and consistency that is required, Vera's entire care team completes a rigorous, proprietary certification process that includes 150 hours of hands-on training for integrating health

"A good coach will sit down with a patient to get a clear understanding of what's going on with them mentally first, then address their health issues." A good coach is also not prescriptive, but taps into which stage of change the patient is in — whether contemplation, preparation, action, etc. Once they understand the patient's mind-set, the coach draws out the patient's goals, addressing obstacles. For instance, if patients say, "I've never lost 50 pounds, how am I going to do this?" their coach may ask them what

(Continued on next page)

*"Everyone Wins When Healthcare Is a Game," Accenture, accessed May 14, 2014, <http://www.accenture.com/us-en/Pages/insight-everyone-wins-healthcare-game.aspx>.

skills or disciplines they used to achieve their biggest goals at work, looking at how they can accomplish things that initially seemed daunting. Patients gain confidence, then, by realizing how they already get themselves from point A to point B to reach goals.

Doctors like this model of primary care because they are able to spend more time engaging with each patient, averaging 8-10 patients a day.



“You may help someone lose 10 pounds, but what happens six months down the road during a stressful event? Life is going to happen, so our objective is to help people develop the skills to self-manage, to be confident about managing themselves down the road.”

POPULATION MANAGEMENT

As in much of health care today, data is central. Vera tracks its own data, plus uses third-party software to access claims outside of Vera. “Since we are contracting with employers on top of their health care plans, we have captive audiences. They are micro-audiences, actually. We have access to their employee claims data and can slice and dice that data to target groups with which we can make the biggest impact,” says Schmid. They look at risk stratification levels, targeting risky and costly patients. But even with the ability to segment their micro-populations, Vera concentrates on engaging 100% of them. “We can have specific messages or treatment plans by group. It is really exciting that we can take the best practices in population management and

apply it to these micro-groups,” he says. Time and again, Vera makes the biggest impact on the higher-risk patients with the highest health care costs—bringing down costs by improving their health and helping them thrive.

“Previously, health and fitness coaching was broad and not that well-defined. It was hard to differentiate between coaches, and quality was lacking or inconsistent,” says Schmid. Vera Whole Health originally developed Vera University to train the health coaches they pair with physicians in their own clinics. “Once we had mastered training our own coaches and greater staff on integrating coaching into patient care, we realized there was a market for health coaching certification, so have made our educational program available outside our own walls.” Read more about [The Coach Approach, a 2 1/2-day course offered by Vera University in partnership with Experix, on page 22.](#)

AWARENESS AND EXPOSURE

Schmid reminds us that the non-users of medical care are not necessarily healthy. In fact, often they are an emergency medical situation waiting to happen. “In some cases, close to one-half of the people on a plan do not generate a claim. Controversially, these stats get translated into the assumption the patients are healthy,” he says. Vera discovers, as it begins to engage with these new patients, that many of them are walking around with conditions that

are behavioral in nature. He says that when you do finally engage these non-users, they are often shocked to realize they have skin cancer, hypertension, Type II diabetes, or the like.

Vera’s close proximity to patients enables the clinic to provide more engaged, proactive, and preventive care; the care team is able to get very tuned-in to the effect daily life is having on their patients’ health. “Our providers are so connected to the organizations and their people. We treat each company as its own ecosystem. And due to our proximity, awareness and exposure are fundamental parts of our business model’s success,” says Schmid.

RESULTS

Doctors like this model of primary care because they are able to spend more time engaging with each patient, averaging 8-10 patients a day. They feel they are being paid to do what they wanted to do in the first place — take care of people, not adhere to production quotas.

What’s in it for the employers is that they have healthier, happier, and more productive employees. With convenient access to same-day visits and predictable, consistent care, employees are thriving. As for costs, self-funded employers saved 10-12% in their health care costs, with fully insured employers seeing 8-13% in premium reductions. For most companies, the Vera Whole Health benefit is also a great recruiting and retention tool.

“It is a bold statement for an employer to say, ‘We want to take care of you as best as possible,’” says Schmid. He is particularly proud to list Seattle Children’s Hospital as one of Vera’s flagship clients. It says a lot that the people who take really good care of other people believe this model is the best way to care for their own. 

(Roll of Data, Continued from page 11)

and prioritize interventions, and recommend interventions? The answer for most providers is that this is no one's job. Some organizations find themselves with a host of new tools and reports, few of which provide meaningful insights into how and where to prioritize energy and resources to measurably improve patient care and meet financial targets. Reports and tools are necessary, but insufficient for providers to succeed as population health managers.

There are several options delivery systems have for moving from reports and information to action.

Build. Well-trained, highly skilled clinical and medical economics analysts are essential for sustainable and successful population health management organizations. Provider organizations can hire their own analytics teams, but

most have historically not needed to develop and hire associates with these cognitive skill sets. Acquiring and developing these resources is extremely difficult

in today's competitive marketplace. Furthermore, delivery systems will need to plan and budget for scaling their analytic capacity across their entire enterprise to ensure the reliability, consistency, and sophistication necessary to drive sustained performance improvement as value-based payment evolves over time.



Partner. Alternatively, many provider organizations are now seriously considering the value of contracting with emerging service organizations focused on providing data analytic interpretation as a service. This "service as a service" model is akin to "software as a service" in that both centralized and distributed resources can be made available on demand, at a far lower cost than if those resources were owned or hired by each individual provider organization. This new model, however, goes several steps further to include regular access to highly specialized, dedicated analysts that are accountable for and measured on their success in helping providers improve clinical outcomes and financial performance.

While some software and IT vendors are quickly recognizing the necessary shift toward analytics, not all organizations have analytic expertise tried and tested in a clinical environment. Key elements of an effective analytic approach in either the build or partner model include the following:

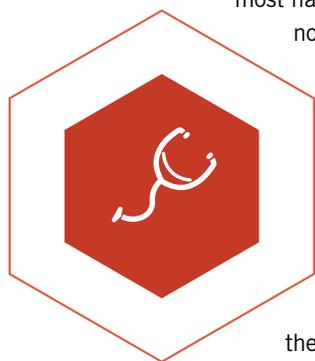
- Dedicated, highly trained analytic staff who have experience supporting clinical care teams with interpretation of results and drill-down analyses based on provider questions and hypotheses;
- Direct access to experienced clinical, informatics, statistical, and other subject matter expertise to provide advanced analytic insights; and
- Ongoing innovation and learning, in order to continuously bring new, market-leading

insights, learning, and methods to providers.

To improve value for patients, consistently improve the clinical care quality, and drive affordability overall, providers need an unprecedented level of collaboration and partnership from payers. This collaboration should include these key elements:

- Ready access to timely and complete administrative and claims data
- Eligibility and benefits data for those patients attributed to them;
- New reimbursement models to align incentives with value
- Investments in both care management services within provider organizations and actionable information at the patient, population, provider, and integrated delivery system levels

This type of collaboration and this level of investment were not priorities or easily justifiable under traditional fee-for-service reimbursement models. With so many forces aligned around moving from volume- to value-based care, providers have a platform to negotiate the necessary control (through data) in exchange for taking accountability for improving population health and entering into reimbursement models that align incentives intended to achieve this end. 



Ray Herschman is the President and Chief Operating Officer of xG Health Solutions, the primary provider of Geisinger's Health Care Performance

Improvement Intellectual Property (IP). xG Health provides experienced professionals to partner in developing and implementing strategies focused on improving quality and reducing the long-term cost of care.

PERSONAL INSURANCE AS AN

Income Protection Tool

The following stories are based on actual physicians and how they eased the financial burden on their families during an interruption in income.



Financial Ripple Effect

What happened

Dr. Byun's parents left their home country when he was young, seeking better opportunities for their kids. Forever appreciative of the sacrifices his parents made during those hard years, he was proud and delighted to be in a position of being able to provide for both his and his wife's parents alongside raising his own family of three girls. He and his wife Song had ample homes, took wonderful vacations, and enjoyed a great lifestyle together. As the health of all the grandparents began to diminish, Dr. Byun's medical background enabled him to have an active voice in their care and provide for any medical needs that came along.

Years later, Dr. Byun left a large, reputable clinic to start a smaller clinic with two partners. One spring, his neurosurgery colleagues pointed

out some minor memory errors they noticed in his work. Dr. Byun didn't hesitate to line up a series of tests, subsequently being diagnosed with early-stage Alzheimer's.

The risk of continuing to practice with this diagnosis was too great. All at once, Dr. Byun had to stop caring for patients, and the financial drain of future bills to support his own care became very real.

The early plan

When they formed the small clinic, the partners decided to protect themselves with individual insurance policies rather than a group plan. So, with both extended families relying on his earning power for support, Dr. Byun decided to protect his income. He secured an independent disability policy that offered tax-free benefits. Then, he eventually layered a lump sum disability policy into the mix to further protect his long-term earning and equity in his practice.

Additionally, when Dr. Byun moved his parents into an assisted care facility, he decided it was a good idea to purchase a long-term-care policy for himself.

The outcome

As a result of his inability to work, Dr. Byun received maximum benefits on the individual disability policy (in this case, a tax-free \$16,000/month until age 67), and the lump sum disability policy provided him \$1 million after 12 months, which went a long way to meeting the financial needs for his extended family.

Moreover, his long-term-care policy would provide for the care he would eventually need in a specialized care facility as his condition progressed. Dr. Byun's thoughtfulness about his family's unique needs reduced the chances that his family would lose everything he had worked so hard for, and all that his parents had sacrificed decades before.



So Close to Retirement I Can Taste It

What happened

At 62, Dr. Ross was at the final stages of a very successful career. Early on, she had paid her own way through school, launched her career in anesthesia, and started a family. Now, even with three kids in private colleges, she and her husband were on track for a comfortable retirement.

Then she learned she had stage three cancer, and the diagnosis left them emotionally devastated. This had never been part of their plans.

The early plan

After medical school, once Dr. Ross started to earn at a high level, she focused on paying off her school bills and determined to never take her strong income for granted. As her family grew, her income grew, and her family's financial goals came into sharper focus. She decided to use insurance as a tool to protect her earning power. Though her clinic offered disability, the group policy only paid at 60% of her income with a cap of \$10,000/month—which would only amount to \$120,000 annually before taxes. Her annual salary was substantially more and she wanted a higher level of coverage, so she took on an additional individual disability policy with a benefit amount of \$15,000/month that was portable, so she could carry it with her should she change employers. Unlike the group policy, these benefits were nontaxable, further enhancing her direct benefit.

The outcome

As a result of planning ahead, after her cancer diagnosis Dr. Ross received the monthly maximum payout from her group disability for the nine months she was unable to work (a taxable \$60,000

after the three-month waiting period), as well as a payout from her individual disability (a tax-free \$90,000 after the three-month waiting period). In time, she recovered from her cancer surgeries and treatments, her personal finance goals stayed on track, and the kids' tuition bills continued to get paid. In fact, Dr. Ross and her husband decided life was too short and made arrangements to retire earlier than expected.

Now that's a plan.

What to look for when considering various types of personal insurance:

Portability: Some policies can be carried with you when you change employers, and some terminate when you leave—which leaves you at risk of being denied when you reapply. Find out if the policy is portable from employer to employer.

Caps on coverage: Most disability policies are capped at 60% of your income. In addition, many have a monthly cap of \$5K, \$10K, or more. Know what the caps are to better understand the income shortfall you'll suffer if you are unable to work—and which products you might consider to help make up for it.

Taxability: The disability benefits provided by most large groups are taxable, but individual disability plans are often nontaxable.

Guaranteed premiums: An additional advantage of many individual policies is an option to lock in premium rates so they never increase for the life of the policy. 

For more information about any of the policies discussed above, contact Janet Jay at Physicians Insurance Agency, at (800) 962-1399 or janet@phyins.com.





New Live Seminar

The Coach Approach: Transforming Health Care through Patient Engagement

Studies show that half the patients who leave their primary care visits don't understand what their doctor told them. And the average adherence rates for prescribed medications are about 50%; for lifestyle changes, they're less than 10%.

Improve your ability to communicate, listen, and affect your patients' lives. Learn the fundamentals of behavior change and how to bring out the best in your patients. Coaching skills help you increase trust, provide better quality care, improve patient compliance, and reduce risk.

This is an interactive, 2½-day seminar, offering **18.75 AMA PRA Category 1 credits™**, designed to introduce health care professionals to the spirit and practice of coaching. The training merges evidence-based behavior change methods with simple, yet powerful tools to help patients overcome ambivalence and take ownership of their well-being. At course conclusion, participants will be able to

- Display mindfulness while demonstrating the five Core Coaching Skills for patient interaction
- Classify a patient's stage of change according to the Transtheoretical Model
- Use Appreciative Inquiry to discover what motivates your patients to change
- Navigate ambivalence using the skills of Motivational Interviewing
- Develop methods to manage progress and accountability to support a patient's desired outcome

Developed by Vera University, a division of Vera Whole Health, The Coach Approach is offered in partnership with Experix, a wholly owned subsidiary of Physicians Insurance that provides continuing medical education and comprehensive risk management content.

Registration Information

WHO SHOULD ENROLL

Physicians involved in direct patient care with a desire to:

- Improve the quality of patient care and satisfaction
- Increase patient compliance and outcomes
- Create dynamic provider/patient relationships that inspire and motivate change
- Connect more meaningfully with patients, coworkers and peers

UPCOMING SESSIONS IN SEATTLE

- July 28-30
- September 8-10
- November 6-8

COST

This CME is included with a Physicians Insurance policy. Nonmembers can enroll for \$995.

HOW TO ENROLL

To register and get full course details, dates, and accreditation information, call or visit our Web site.



www.phyins.com/CME



(800) 962-1399



Specialty-specific Online Courses

Teamwork, Communication, and Patient Safety in the Emergency Department: Case Studies

As an emergency physician, you operate under great time pressure within a high-risk, high-volume environment. This self-study course will help you mitigate the risk by using evidence-based communication tools. The course demonstrates through case examples how to put the tools into practice, facilitate team effectiveness, and enhance patient safety. An interactive quiz at the end of each case reinforces key topics discussed throughout the course.

WHO SHOULD ENROLL

Physicians of all specialties, clinical practitioners, medical staff, health educators, and health administrators will benefit from this course.



FACULTY Dr. William Hurley is currently medical director of the Washington Poison Center, chief medical officer of Summit Pacific Medical Center, attending physician in the emergency department at Harborview Medical Center, and assistant clinical professor with the University of Washington School of Medicine. He helped to

found and develop the University of Washington TeamSTEPPS National Training Program and has been active in the study and teaching of teamwork skills to improve patient safety since 1993.

Managing Category II Fetal Heart Rate Patterns: A Standardized Approach

As an obstetrical practitioner, you know the challenges inherent in managing Category II fetal heart rate patterns during labor. Interpreting these tracings remains one of the most critical issues in obstetrics. We are pleased to announce a new tool that can help! A simple, rational, evidence-based algorithm will be presented by obstetrical patient safety leader Steven L. Clark, MD.

This webinar will explain and demonstrate the algorithm, which reflects a synthesis of medical evidence and current scientific thought. You will learn through examples of challenging fetal strips how to achieve compliance with the current standard of care in managing this difficult clinical situation.

Developed in conjunction with other leading experts, Dr. Clark highlights his article published in the August 2013 American Journal of Obstetrics and Gynecology.

WHO SHOULD ENROLL

Obstetric physicians, general practice physicians, nurses and mid-level providers caring for pregnant patients will benefit from this course



FACULTY Dr. Steven L. Clark is a maternal-fetal medicine specialist and is medical director of Women's and Children's Clinical Services for the Hospital Corporation of America. He has served as president of the Society for Maternal Fetal Medicine, chair of the ACOG Technical Bulletin Committee, and a board examiner. He has served on several ACOG task forces and committees, and as patient safety consultant to the U.S. Air Force Surgeon General. He currently serves on the Scientific Advisory Board for United Health Care and on the Joint Commission Perinatal Advisory Panel. He has published over 200

scientific articles and chapters, has edited several textbooks, including *Critical Care Obstetrics*, and serves as a peer reviewer for 23 national and international scientific journals.



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with the Executive Director of the Washington Health Alliance

MARY MCWILLIAMS

was appointed Executive Director of Puget Sound Health Alliance in June 2008, after serving three years as a founding member of its board of directors. Prior to the Alliance, Mary was president and CEO of Regence BlueShield in Washington, CEO of both PacifiCare of Washington and Providence Health Plans in Oregon, project director at the American Health Management and Consulting Corporation outside of Philadelphia, and marketing director for the Rocky Mountain HMO in Grand Junction, Colorado. She is a board member of the Greater Seattle Chamber of Commerce, Puget Sound Energy, and the Seattle Branch of the Federal Reserve Bank of San Francisco.



The Washington Health Alliance (WHA) has been monitoring and reporting on health care in Washington State for 10 years, with a goal of reducing costs and increasing quality. We recently spoke with retiring executive director Mary McWilliams to hear her views about cost and quality.

Q In recent years, reducing costs has become more and more important to the work the Alliance is doing, and is stated as the organization's highest goal. What trends are you seeing?

A The group purchasers of health care, employers, and labor trusts have historically focused on premiums and service levels of health plans to drive their purchase decisions. But those major purchasers — due to the Cadillac Tax*

coming in 2018 — are incentivized to moderate costs below a certain level or face an excise tax. Therefore, employers are increasingly interested in looking beyond the premium to the cost and quality of doctors and hospitals. They're making decisions on benefit programs that favor high-value delivery systems in order to affect their trend line. For instance, some local employers like King County and Washington State are now considering offering an accountable care organization (ACO) as a health care option to their employees.

Q What has been and will continue to be critical to reducing costs?

A Several factors contribute to lowering cost—and data is at the center of them. First off, there needs to be transparency of information

on price and quality of care, in the form of tools for the consumer. In the best cases, this kind of data is integrated at the specific health plan benefits level, with a cost calculator on the plan's Web site for consumers to evaluate costs and quality as a part of their own choices.

Second, purchasers need access to data so that they can evaluate new models for networks and benefit design, like ACOs, and understand the variation in provider performance based on where employees seek care. This community-level view of cost and quality is important context for their benefits strategy.

Lastly, neutral organizations like the Alliance, which brings parties together in solving the challenge of cost and quality, can help moderate costs. Our primary effort is to provide insights through measurement and reporting of data on cost and quality, so market participants can identify what improvements are needed at a community level.

Q What can you tell us about underutilization of effective care?

A Some diagnostic and preventive services that have been shown to be effective are underutilized. Examples are regular blood sugar monitoring for diabetes and cholesterol testing for heart disease. The Alliance uses claims data on three million lives to measure and report on the frequency in which patients are receiving these services from their medical group.

*The Cadillac Tax refers to a provision in the Affordable Care Act that will levy an excise tax on employers whose health coverage exceeds a certain cost.

BLOG: TAKING CARE

Your peers speak up on difficult topics

Visit the Physicians Insurance blog to read more about the following topics, written by our members.



www.phyins.com/taking-care

We focus on the prevalence of evidence-based practices with our Community Checkup Report, having just printed our seventh edition. This work has shown that protocols for effective care should be used and reported publicly.

Q Before you retire this summer, what is your focus in these final months?

A We're on the verge of major expansion work, both in developing an All-Payer Claims Database for the state, and expanding Alliance reporting statewide. I'll be busy, keeping momentum up to the last minute so these projects are up, running, and poised for the next executive director to lead through execution. 

TREATING JOINT INFECTIONS IN OBESE PATIENTS

by *Edward E. Leonard II, MD*

Obesity, now affecting more than 30% of the U.S. adult population, is associated with a wide range of increased medical risks and studies have shown that obese patients are at a disadvantage when they develop pancreatitis or H1N1 infection. Read cases studies on how treatments can differ for obese patients, especially related to infection.

DELIRIUM IN A HOSPITALIZED ELDERLY PATIENT

by *Viral Shah, MD*

Delirium is not uncommon among elderly patients in hospitals. Read cases about situations that could happen to your parent or grandparent.

WHEN A PHYSICIAN IS DEVASTATED BY THE LOSS OF A PATIENT

by *Ron Hofeldt, MD*

A primary care physician sees a longtime patient for her annual physical, and all lab results are

normal. Two weeks later, she sees him for what she thinks is the flu, presenting with symptoms of neck

stiffness, nausea, vomiting, light sensitivity, and confusion. It turns out to be bacterial meningitis. Read how physicians are helping themselves and their peers when things go wrong.

TAKING A ONE-MINUTE TIMEOUT TO IMPROVE MEDICAL SKILL AND HELP PATIENTS

by *Mary M. Mitchell and James K. Weber, MD*

It's impossible not to notice the extreme stress so many physicians endure every day. It's hard to know how many challenges to expect in a given day. When a patient has a lot of questions, and there's a full load of patients in the waiting room, the anxiety can mount. Read about creating moments of respite to improve skill.

HELPING A SICK PASSENGER ON A PLANE

by *David McClellan, MD*

What do you do when you hear a flight attendant ask over the intercom, "Is there a doctor on the plane?" Read how this emergency physician has helped passengers with minor as well

as life-threatening conditions, and his advice for physicians whose skills are in need during flight.





GreenField Health

Remember Who You Work For

FAST FACTS

ESTABLISHED: 2001

LOCATION: PORTLAND, OR

TOTAL STAFF: 40

CLINICS: 2

PHYSICIANS INSURANCE MEMBER:
SINCE 2013

A phone call with the leadership at GreenField Health of Portland, Oregon, can leave you excited and optimistic about the future of primary care medicine, and your mind racing with possibilities. When we caught Steve Rallison, GreenField Health's administrator, and Dr. David Shute, the medical director, on the phone to hear about their model of delivery, it was clear they have a mission to make a difference. *USA Today* must have noticed this as well when it featured them in a 2010 cover story as one of three innovative health programs demonstrating the future of primary care.*

Established in 2001, GreenField has never known paper records, having only used EMR. And while they are always looking for efficiencies in their use of EMR, that's just the tip of their efficiency iceberg: They also use a "lean

coach"—someone who works with them to get the waste out of everything they do. But their commitment to improvement doesn't stop with the seemingly mundane (or not so mundane) efficiencies of clinic processes and protocols. It is much broader than that.

For GreenField Health, they believe that health care today is broken, but that they are precisely where the biggest impact can be made. "Our purpose of existence is to care for people and to inspire them towards health," says Rallison. "We believe that the biggest area to make an impact is the delivery of primary care. Health care can be improved greatly if primary care physicians are allowed to do what they are trained to do."

Enter the membership model of care

The membership model and its various cousins have been known as the subscription model, concierge model, boutique medicine, direct care, or even "cash only." GreenField charges an annual membership fee that is based on age, with discount

* Rita Rubin, "Innovative Health Programs Counter Primary Care Shortage," *USA Today*, August 6, 2010, accessed May 12, 2014, http://usatoday30.usatoday.com/news/health/2010-08-16-1Primarycare16_CV_N.htm?csp=obinsite.



NEW PHYSICIANS INSURANCE MEMBERS: WELCOME!

.....

Eugene Emergency Physicians
Eugene, OR

Medical Imaging Northwest
Tacoma, WA

Member Plus Family Health
Bainbridge Island, WA

Sound Interventional Pain Management
Auburn, WA

Valley Urology Center
Renton, WA

rates for families or corporate groups, ranging from \$12/month for youth, up to \$65/month for those aged 70+. The membership fee helps pay for the customer-oriented parts of medicine that are not covered by patients' insurance — same-day appointments, relatively no waiting, non-rushed appointments, attentive follow-up, phone and secure e-mail contact with a provider, and access to care 24/7/365.

seeing up to 30 patients a day. GreenField Health has 30-50% fewer patient visits overall than most primary care clinics. Due to their delivery model and lower daily patient churn, Steve says they need approximately 1.4 exam rooms per full-time clinician, compared to 2-3 exam rooms that other primary care clinics require. "We need 25% less space than a traditional clinic, further reducing costs."

“Who do you work for?” At GreenField Health, no doubt everyone on that team has the same answer: The Patient.

“In essence, the fee covers the customer service and coordination of care that is critical to quality outcomes,” Shute explains. Specifically, these are the elements that enhance patient-physician relationships and patient health, while helping patients avoid unnecessary visits and costs. According to Rallison, these are the elements that enable GreenField to deliver on their core values — relationship, service, and reliability.

“Our clinicians spend 50% of their time seeing patients and the other 50% of their time doing non-visit-based care — on the phone and through secure e-mail — that builds engaged relationships and coordination of care,” says Rallison. A busy day for their physicians is seeing 9-10 patients, which is not much by today's standards; many other practitioners report

GreenField also has a very egalitarian culture. Notes Rallison, “There are no white coats, our doctors go by first name — unless the patient prefers to call them ‘Doctor.’ Every team member here is valued and respected, regardless of their role, and involved in creating results—including patients.” It's not lost on him that in a traditional, hierarchical structure, the system works to make the physician's day efficient, so that there is no downtime in the machine—sometimes at great expense to staff and patient convenience. But GreenField finds there are greater efficiencies overall with an underlying foundation of respect and trust that comes in a less hierarchical culture. “It facilitates communication and is easier to share information, especially with a problem or an opportunity for improvement. It increases patient activation. Oh, and by the way,” he adds, “it's more enjoyable this way.”

(Continued on page 29)

Trial Results

The following summaries are Physicians Insurance cases that have gone to trial and are public record. In reporting these legal results, it is our goal to inform members about issues that impact health care professionals. While we share information we think may be informative, we choose not to disclose the names of participants when reporting these results.



Alleged Failure to Diagnose

SPECIALTY: Emergency Medicine

ALLEGATION: A 53-year-old male presented to the ER with complaints of chest pain. A cardiac evaluation demonstrated a normal EKG and normal cardiac enzymes. It was felt the patient had reflux disease. The ER physician called the physician covering for the patient's primary care physician, and also told the patient to make a follow-up appointment with his primary care physician in two days. The patient did not follow up and had a myocardial infarction 27 days later. The patient alleged that if he had been hospitalized, timely treatment would have prevented the cardiac injury.

PLAINTIFF ATTORNEY: Mark Kamitomo, The Markam Group, Spokane, WA

PLAINTIFF EXPERTS: Richard Cummins, MD, Emergency Medicine, Seattle, WA; John Olson, MD, Cardiology, Seattle, WA

DEFENSE ATTORNEYS: Dan Keefe, Keefe Bowman & Bruya, Spokane, WA; Mike McMahon, Etter, McMahon, Lamberson, Clary & Oreskovich, Spokane, WA

DEFENSE ATTORNEYS: Dan Keefe, Edward Bruya, Keefe, King & Bruya, Spokane, WA

DEFENSE EXPERTS: James Nania, MD, Emergency Medicine, Spokane, WA; Russell Roundy, MD, Emergency Medicine, Spokane, WA; Gust Bardy, MD, Cardiology, Seattle, WA; William Bennett, MD, Cardiology, Spokane, WA

RESULT: Defense verdict, Spokane County Superior Court, Judge Price

COST TO DEFEND: \$334,844

Alleged Misdiagnosis

SPECIALTY: Radiology and Neurology

ALLEGATION: Misdiagnosis of spinal lesion resulting in unnecessary spinal surgery followed by post-surgical paraplegia secondary to cord compression in a diabetic 36-year-old single male. Plaintiff alleged lesion was AVM and surgery was contraindicated. Defendants diagnosed epidural lipoma at T1-T8. Lipoma confirmed by pathologist. Neuropathy justified surgical removal of the lesion.

PLAINTIFF ATTORNEY: Matt O'Meara, Tacoma, WA

PLAINTIFF EXPERTS: Robert Rand, MD, Neurosurgery, Santa Monica, CA; Daniel Rovner, MD, Neurology, Los Angeles, CA; Donald Reay, MD, Pathology, Seattle, WA; Mariann Drucker, MD, Radiology, Seattle, WA

DEFENSE ATTORNEY: Steven Fitzer, Burgess-Fitzer, Tacoma, WA

DEFENSE EXPERTS: Robert Aigner, MD, Neurology, Seattle; Michael Peters, MD, Neuroradiology, Seattle, WA

RESULT: Defense Verdict, Superior Court for Thurston County, Judge Berschauer

COST TO DEFEND: \$139,751

Alleged Negligent Prenatal Care and Delivery

SPECIALTY: Obstetrics

ALLEGATION: The plaintiffs were parents along with their fourth child. The mother's pregnancy was remarkable only for fundal height measurement and ultrasound findings consistent with a large fetus. Labor was induced and a spontaneous vaginal delivery accomplished. The mother alleged she should have been scheduled for a C-section, which would

have prevented an alleged brief shoulder dystocia. The baby has mild Erb's palsy and no cognitive deficits.

PLAINTIFF ATTORNEY: Richard Rogers, Portland, OR

PLAINTIFF EXPERTS: Thomas Thornton, MD, Obstetrics, Portland, OR; Larry Shields, MD, Maternal Fetal Medicine, San Luis, CA; Thomas Benedetti, MD, Maternal Fetal Medicine, Seattle, WA; Brien Vlcek, MD, Pediatric Neurology, Seattle, WA

DEFENSE ATTORNEY: John Hart, Hoffman, Hart & Wagner, Portland, OR

DEFENSE EXPERTS: Mark Tomlinson, MD, Obstetrics, Portland, OR; Mark Nichols, MD, Obstetrics, Portland, OR; Sean Blackwell, MD, Maternal Fetal Medicine, Houston, TX; Cristin Babcock,

MD, Obstetrics, Eugene, OR; Frank Manning, Maternal Fetal Medicine, New York, NY

RESULT: Plaintiff verdict of \$1,932,881, on appeal, Lane County Superior Court, Judge Rasmussen

COST TO DEFEND: \$837,990

Alleged Failure to Diagnose Infection

SPECIALTY: Internal Medicine/ Emergency Medicine

ALLEGATION: Failure to diagnose shoulder joint space infection resulting in permanent loss of function in left arm in a 29-year-old female.

PLAINTIFF ATTORNEY: Dennis Clayton

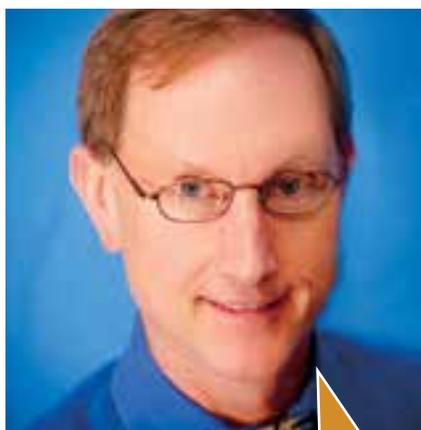
PLAINTIFF EXPERTS: Ray Bracis, MD, Infectious Disease, Portland; Peggy Goldman, MD, Emergency Medicine, Seattle, WA; Tim Lovell, Orthopedic Surgery

DEFENSE ATTORNEY: Brian Rekofke, Witherspoon, Kelly, Davenport & Toole, Spokane, WA

DEFENSE EXPERTS: John Staeheli, MD, Orthopedic Surgery, Richland; Craig Olson, MD, Emergency Medicine, Spokane, WA

RESULT: Defense Verdict, Superior Court for Spokane County, Judge Austin

COST TO DEFEND: \$138,359



“This frees up the physician to do the job as they think it should be done. Rather than seeing as many patients as possible, they can focus on providing care in the best way possible for each patient, putting the patient’s needs first.”

Dr. David Shute, Medical Director, GreenField Health

(Member Spotlight, Continued from page 27)

Another key difference for GreenField is that there are no incentives for physician productivity, and the clinicians are paid a flat salary. Says Rallison, “People put their time where you put the incentive — such as making the physician’s day efficient. If you remove perverse incentives around volume, the physicians can more easily focus on their patients’ needs.” Shute agrees, “This frees up the physician to do the job as they think it should be done. Rather than seeing as many patients as possible, they can focus on providing care in the best way possible for each patient, putting the patient’s needs first.”

Recalling a previous leadership role in risk management training, David notes the importance of asking health care professionals the pivotal question, “Who do you work for?” At GreenField Health, no doubt everyone on that team has the same answer: The Patient.

Shute says this model is not necessarily easier on the physician, as they might spend just as much time — if not more — on e-mail and phone contact as they would at a face-to-face appointment. They are just as time-pressed as high-volume physicians, but devote their time to different processes to deliver care. The key point here is that GreenField’s delivery process is geared to be easier and more convenient for the patient.

GreenField has long believed that delivering quality service and reliable care is efficient for the system as a whole. “We’ve always been focused on comprehensive, convenient care. With our service-oriented approach, we’re saving time for our patients, which saves them money — and, in turn, saves money for employers and insurance companies. At the same time, our model allows for high engagement, so we’re improving health overall — further avoiding unnecessary procedures or use of expensive technology, and general system abuse,” says Rallison.



IS THERE A DOCTOR IN THE HOUSE?

Government Relations Update

Physicians Insurance believes in working within the legislative and regulatory environment and is committed to physician advocacy at the state and national levels. As the only medical professional liability carrier based in the Northwest with an in-house lobbyist registered in Washington and Oregon, we work to defeat legislative initiatives that

- create new causes of action against physicians
- alter the standard of care against physicians
- create strict liability
- create onerous and unnecessary duties

In addition, Physicians Insurance monitors changes in leadership in all three branches of government and seeks opportunities to support candidates who advocate for quality health care and a balanced, fair approach to our members' medical professional liability exposure.



For more information on Physicians Insurance's Government Relations and Community Outreach Program, contact



Anne E. Bryant,
Senior Director of
Government Relations
Anne@phyins.com

OREGON'S EARLY DISCUSSION AND RESOLUTION UPDATE

The Oregon Patient Safety Commission sought public comment on the draft administrative rules required by Oregon Laws 2013, Chapter 5 (SB 483) to implement Early Discussion and Resolution.

Physicians Insurance offered oral and written public comment to address our concerns on behalf of physicians and their defense. We continue to work with the commission as we move forward to the July 1 implementation. If you have questions or comments you would like to share with Physicians Insurance, please contact Anne Bryant (anne@phyins.com) or Catherine Walberg (catherine@phyins.com).

As a reminder, the most important step you can take is to call your professional liability insurance carrier as soon as you receive a Notice of Adverse Health Care Incident, even if you are not sure it falls within the scope of the new law.

WASHINGTON ELECTION UPDATE

Washington State's primary election will take place August 5th, and the general election will be November 4th. Washington's "Top Two" primary election means that the two candidates who receive the most votes in the primary election advance to the general election, regardless of their party preference.

- **Senate:** This year, 25 Senate seats — half the Senate — will be up for four-year term elections. Media attention will focus primarily on the races that affect members of the Senate Majority Coalition, which is the historical move of two Democrats crossing over to caucus with the Republicans to form a new majority controlling the Senate. One of those Democrats, Senator Rodney Tom, is not seeking reelection.
- **House of Representatives:** All 98 House of Representatives seats will be up for two-year term elections. Dr. Nathan Schlicher, Gig Harbor emergency room physician, announced his candidacy to return to the Washington State Legislature. Dr. Schlicher, who won appointment to the Senate after Derek Kilmer left for Congress, was defeated by Republican Jan Angel in last November's special election. He will seek Angel's

former House seat this election, challenging Republican Jesse Young, who was appointed to the seat in January. Dr. Schlicher graduated from Pacific Lutheran University in Tacoma before going to the University of Washington School of Law and School of Medicine in Seattle. As a physician and attorney, he brings a promising skill set to the Washington Legislature.



Learn more about
Dr. Nathan Schlicher at
<http://nathanforhouse.com>.

- **Supreme Court:** Governor Jay Inslee recently appointed King County Superior Court Judge Mary Yu to the Washington State Supreme Court. Justice Yu replaced Justice James Johnson, who had been the lone conservative voice on the nine-member high court before his retirement. 



**FOR MORE INFORMATION
ABOUT YOUR STATE ELECTIONS,
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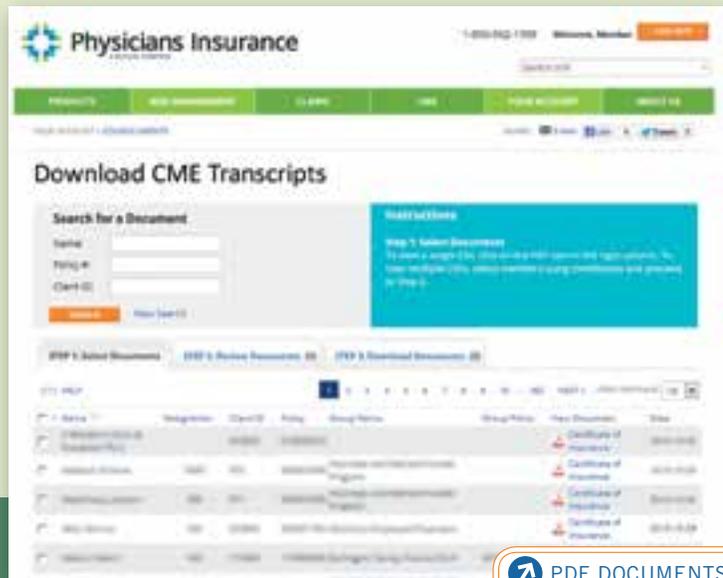
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www.phyins.com/transcripts