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Dr. Ami Bera - Physician Representation & Change In American Medicine
Paying for Value
Patient Experience: A Clinical And Business Imperative In An Era Of Accountability
Helping you keep pace with the evolution of health care—it’s in our DNA.

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CAPG Members and Friends:

The CAPG Board of Directors and I would like to wish all of our CAPG Health readers a gratifying and prosperous New Year. 2013 will certainly bring challenges as implementation of the Affordable Care Act (ACA) moves forward, but no one is better equipped to respond successfully to these challenges than the members of CAPG and those who support us. It is your experience in coordinated care and your understanding of its patient-centered, quality-focused concepts that will drive that success.

In the months ahead, CAPG Health will publish a number of articles that focus on helping you understand and comply with the new rules, and increase your ability to leverage new opportunities. In this issue, for example, you’ll find an article on patient satisfaction by Kevin Sullivan of Sullivan/Luallin, Inc, an important success factor for healthcare providers.

For an even more extensive view of the ACA and its effects on physician groups, I urge you to attend the annual CAPG Healthcare Conference scheduled for June 6-9, 2013. The venue this year is the world-class JW Marriott at L.A. Live, the exciting new entertainment complex in downtown Los Angeles.

Our conference speakers have not yet been announced publicly, but I can assure you they are at the very top of the list of national experts on America’s healthcare issues. You will be receiving information about the Conference later this month. I encourage you to make plans early to join us there. Thank you for your continued interest in CAPG Health.

Sincerely,

Donald Crane,
President and CEO

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For information about advertising or special promotions, contact Valerie Okunami at 916-761-1853. For editorial guidelines, email lhawkins@capg.org
Dr. Ami Bera was elected to represent the people of California’s 7th Congressional District in the 113th U.S. Congress. A lifelong Californian and first generation American, Bera attended California’s public schools through medical school, earning both his B.S. and M.D. from the University of California, Irvine. Bera went on to serve Sacramento County as Chief Medical Officer. He then served as clinical professor of medicine and associate dean for admissions and outreach at University of California, Davis. Bera and his wife Janine, also a medical doctor, live in Elk Grove, California with their 15-year-old daughter, Sydra. Dr. Bera sat down with Dianne Glover to discuss his objectives as he heads to Washington.

Dianne: What is the central message that you want to take to Washington?

Bera: It would be the restoration of opportunities for the next generation. I’m a product of giving people a chance. My parents immigrated here. I attended our public schools. I am the byproduct of that opportunity, so a restoration of that central value that represents America.

Dianne: How important is it that physicians are represented in government as Congress deals with health care issues?

Bera: Physician representation is important. Over the next decade, we’ll see a transformation of American medicine, and physicians are uniquely positioned to be patient advocates. We need to articulate our concerns. Physicians need to be sitting at the head of the table and leading the discussion.

Dianne: What is the best way for doctors to become involved in the political process?

Bera: Obviously, it would be great to see more doctors get in the ring and run for office. But also, we can come together and support those that are in elected office. Doctors can get involved by being engaged in professional organizations, such as CAPG. The message is that sitting on the sidelines is not going to work because others are then going to make those decisions.

Dianne: So what motivated you to want to run for Congress?

Bera: I have had a very fortunate professional career. I have practiced medicine, served as the medical director of a hospital system and as chief medical officer for Sacramento...
County. I am always looking for ways to improve efficiency and to create better public-private partnerships. I have had the ability to look at medicine through different perspectives. Now that we find ourselves looking at reshaping health care delivery in America, I felt that call to serve, which led me into medicine originally.

Dianne: That makes sense; they’re both ideally service industries.

Bera: Absolutely. Also as a doctor, we’re trained to care for the patient. As their Congressman, I have the unique privilege and the faith of my constituents to do the best job serving their needs.

Dianne: You have called our health care system “broken” and said that the industry puts profits before patients. How effective do you think the Affordable Care Act will be in fixing what’s broken?

Bera: The Affordable Care Act starts to lay the framework to increase access. It does not necessarily address the inefficiencies in health care or the cost of health care, which for most people is going up every year. At the same time, benefits are getting cut. In California, we obviously are in a unique position, because we’ve been dealing with a managed care environment for years. We’ve been looking for higher quality and more cost-effective ways to deliver services in an environment where resources are tied.

We have been doing for years much of what the Affordable Care Act starts to lay out at the national level. We have been able to address issues of cost and not sacrifice the quality. In fact, while we’ve been lowering costs and becoming more efficient, we have been increasing the quality of care. Now we’ve got to share those lessons. And change in health care is not easy.

Dianne: Do you think ACOs are a part of the solution?

Bera: ACOs are a part of the solution. We’re starting to lay the groundwork for more integrated delivery systems. In our own backyard here in Sacramento, we’re seeing the health plan, hospital system and physician group fully integrated. If the Affordable Care Act is fully implemented, that will probably be the model across the country.

Dianne: You have spoken about how expensive health care is. How do providers lower costs?

Bera: The simplest way is to make sure we align incentives, so that the driving incentive is quality. The goal should be to keep people healthy. But the model in many parts of the country is one of consumption—to consume more pharmaceuticals and more therapies. We should shift that paradigm to delivery throughout the most appropriate locations. ACOs start to lay the framework of aligning those incentives. If we look in our own backyard, Kaiser probably is the most integrated system. Their incentive is to deliver care at the most appropriate and most cost-efficient location.

Dianne: Let me ask about you personally. How would you finish this sentence? People would be surprised to know that I...

Bera: I love to go fishing. One of the biggest sacrifices running for Congress will be not being able to head out to the water like I do here. I’m an avid backpacker and camper. I have caught a 75 pound salmon—which is a big fish.

Dianne: Wow. I guess it will be a different kind of fishing you’ll be doing in Washington.

Bera: Exactly.

Dianne: Any words of wisdom or advice for CAPG members?

Bera: CAPG is an organization that is advocating for the interests of physicians that are practicing in the group model. I look forward to working with CAPG, as we move forward in the Affordable Care Act. I look forward to being a voice for California physicians and physicians across this country.

I also want to add that I’m very appreciative of the CAPG member groups and the individual physicians within CAPG who directly supported my campaign.

Dianne: Congratulations on your successful run, Congressman!
BAY VALLEY MEDICAL GROUP ADDS NEW PHYSICIANS

Bay Valley Medical Group has added three new physicians to their current staff. Houman Sharifi, M.D, Anand Mehta, M.D, and Jeffrey Woldrich, M.D. joined Bay Valley Medical Group, building on the internal medicine and urology departments.

"Bay Valley Medical Group is excited to welcome three new physicians to our group," said Eric S. Kohleriter, M.D, Medical Director of Bay Valley Medical Group. “Each has outstanding credentials and is ready to provide compassionate care to our many patients.”

KAISER PERMANENTE TAPS TYSON FOR CEO POSITION

Kaiser Permanente named President and COO Bernard Tyson to succeed George Halvorson as Chairman and CEO. Tyson, 52, will replace Halvorson as CEO after a six-month transition period, and will take over as Chairman of the Board at the end of 2013 when Halvorson leaves.

CEDARS-SINAI PHYSICIAN NOMINATED BY PRESIDENT OBAMA TO NATIONAL CANCER ADVISORY BOARD

Beth Y. Karlan, MD, director of the Women’s Cancer Program at the Cedars-Sinai Samuel Oschin Comprehensive Cancer Institute, was appointed by President Barack Obama to the National Cancer Advisory Board, a committee that advises the U.S. National Cancer Institute.

She is one of six new appointees joining the 18-member panel, which, with the President’s Cancer Panel, are the federal advisory bodies whose members are appointed by the president. The board counsels the secretary of the U.S. Department of Health and Human Services, the NCI director and the president on issues related to the institute’s activities, including reviewing and recommending grants and cooperative agreements.

“In addition to being a world-renowned scientist and surgeon, Dr. Karlan has been an instrumental voice advocating for greater public awareness, education and resources devoted to fighting cancer and saving lives,” said Steven Piantadosi, MD, PhD, director of the Samuel Oschin Comprehensive Cancer Institute and the Phase One Foundation Chair. “Her impressive knowledge and dedication will be an asset to the National Cancer Advisory Board, and we congratulate her for this well-deserved honor.”

CALOPTIMA NAMES NEW CHIEF EXECUTIVE OFFICER

The CalOptima Board of Directors appointed Michael Schrader as Chief Executive Officer for the agency, which provides Orange County’s low-income families, seniors and people with disabilities quality health care coverage in a cost-effective and compassionate manner. Schrader brings more than 17 years of managed health care experience to CalOptima.

“The Board was committed to bringing in the right person for this important role,” states Mark Refowitz, chair of CalOptima’s Board of Directors. “There were many qualified candidates who we screened and interviewed, but it was important to us that the person selected has health care experience and is familiar with our model. Michael brings all those qualities to CalOptima, and we are confident he will be a great leader for our staff and to our stakeholders.” Schrader will join CalOptima by the beginning of 2013.
California Advanced Primary Care Institute (CAPCI) to Launch January 2013

Statewide Non-Profit Organization Aims to Urgently Revitalize Primary Care

Beginning January 2013, the California Advanced Primary Care Institute (CAPCI) will launch itself as a broadly inclusive organization and multi-pronged effort to improve the appeal of primary care as a career choice, and simultaneously elevate the performance of primary care teams.

CAPCI emerged from a statewide consensus meeting in April, 2012, sponsored by the California Association of Physician Groups (CAPG). CAPCI, a non-profit foundation, convenes its first plenary Steering Council meeting in January 2013.

“Primary Care is the cornerstone for all of California’s healthcare delivery systems and sets the foundation for every goal of healthcare reform,” said Wells Shoemaker, MD, Medical Director of CAPG. “Sadly, California faces a serious erosion of primary care workforce at the same time that our state braces for a daunting bulge in chronic illnesses and the long-awaited opportunity through health reform to serve millions of previously uninsured individuals and families.”

California’s primary care workforce will shrink by 30% in the next 5-8 years as a consequence of two converging misfortunes. “Baby Boomer” primary care physicians, for years the load-bearing stalwarts among the internists, family physicians, and pediatricians, are retiring. Newly trained clinicians have been progressively choosing other medical disciplines, cutting the “reinforcements” down to half what they were 15 years ago.

“Given the time it takes to train doctors, advanced practice nurses, and physician’s assistants, this impending shortfall cannot be entirely avoided. We have to use scarce resources in smarter ways, many of them embedded in the concept of the Medical Home,” stated Dr. Shoemaker.

“If we are going to transform primary care to provide superb, patient-centered care to every Californian, we will need to fundamentally change our approach to training the people who work in primary care,” stated Kevin Grumbach, MD, Professor and Chair, UCSF Department of Family and Community Medicine, and member of the CAPCI executive management committee. “This new coalition represents an unprecedented partnership between practice organizations and training institutions to equip the workforce for the innovative care models that will drive excellence in primary care throughout California.”

While previous efforts in California have fallen short in changing primary care workforce dynamics, CAPCI offers hope for a different outcome by addressing two core principles for success:

1. Inclusivity CAPCI has engaged all four healthcare delivery systems: private sector organizations; community clinics; military and veterans affairs systems; and independent doc...
2. Ambitious Scope of Engagement

Previous efforts have looked at only one or two facets of the challenge, for example, payment disparities or paperwork burden. CAPCI believes that simultaneous efforts need to be made in four distinct areas in order to turn this around. We call these the “Four P’s”

» Pipeline: Change the training environment and the appeal of primary care as a career choice for physicians and other clinical professionals.

» Practice redesign: Practice with greater efficiency, better information, modern communication, and central attention to the patient experience. This is the promise of the Medical Home, but it needs to expand beyond individual offices to community-wide scale. Redesigned practices must also embrace California’s unique cultural diversity.

» Payment: Success requires that payments are aligned with modernized practices to deliver the core of healthcare reform: better health; better care; and better affordability. CAPCI aims to reach a “tipping point” of purchaser strategies that will influence behavior change at the practice level.

» Policy: Current systems rest on a 60-year hodgepodge of assumptions, regulations, and “conventional wisdom.” That chaos has landed the U.S. (and California) lower than 20th in the world in nearly every public health measure. CAPCI will enable intelligent policy informed by a consensus of knowledgeable contributors that is able to keep pace with changing dynamics.

“Never has such a broad platform been established, and none too soon. With the crunch bearing down, every one of the parties involved in CAPCI ‘has a dog in this race.’ Restoring California’s primary care workforce is like repairing a disabled car. You can install a rebuilt engine, but without four good tires, reliable brakes, and bright headlights, you won’t get off the blocks,” stated Wells Shoemaker MD, Medical Director of CAPG.

CAPCI has received start up funding from the California HealthCare Foundation, The California Endowment, CAPG member group contributions, and the California Academy of Family Practice. Membership in CAPCI’s Governance bodies and additional commentary available on www.capci.org.

Contact: Elissa Maas MPH, Executive Director CAPCI, (916) 443-4153 or emaas@capci.org.
CAPG’s members have long been on the forefront of coordinated, accountable, high quality health care delivery. Through consistent advocacy, CAPG members have risen to the challenges facing the health care system and Medicare. CAPG member groups have continued to innovate in order to provide better care through innovative delivery models under the umbrella of a population-based payment. And, in recent years, policymakers in Washington have recognized and encouraged the further development of these models. As the new Congress begins its work in January, important obstacles remain with respect to the future of Medicare and Medicaid and the role that coordinated care plays in a sustainable health care delivery system.

The results of the November 2012 election were largely viewed as a final testing ground for whether or not the Affordable Care Act (ACA) would remain the law of the land. With President Obama securing his second term, full scale repeal of the ACA appears to be off the table. While there may still be piecemeal attempts to repeal or amend some of the more controversial parts of the law, for the most part, the work now turns to implementation.

While the election upheld the viability of the ACA, it brought with it a new class of policymakers who will now continue to develop Medicare and health industry policy. In California a combination of the “jungle” primary and redistricting in the state created a large amount of turnover. In particular, there was significant turn over on the healthcare committees of jurisdiction, including Rep. Pete Stark, the top Democrat on the Ways and Means Health Subcommittee, who lost in the general to Democrat Eric Swalwell and the defeat of two Republicans on the Energy and Commerce Committee, Rep. Mary Bono Mack and Rep. Brian Bilbray, both of whom CAPG has closely worked with in the past. As a result of these and other race shakeups, 14 new members will take their place in the California congressional delegation in 2013, the largest turnover in the delegation in decades. This means that CAPG has important work to do in educating and building relationships with new Members. There are new opportunities to work with physician Members in the California delegation, newcomers Dr. Ami Bera and Dr. Raul Ruiz.

CAPG’s work now focuses on implementation and improvement of the ACA as most of the provisions become fully effective just a short year from now, in 2014. This work includes communicating results of ongoing healthcare delivery innovation, such as accountable care organizations, and protecting existing programs, like Medicare Advantage. Beyond these core initiatives, the insurance market reforms and health benefit Exchange provisions are now being implemented in a flurry of rulemaking activity.

In addition, there are important challenges on the horizon relating to the long-term stability of Medicare and Medicaid. Depending on how Congress approaches issues including the debt ceiling, the fiscal cliff, and the sustainable growth rate, there may be new opportunities to incorporate policies that support coordinated care delivery with a fiscally responsible payment mechanism to replace a broken fee-for-service delivery system. In Washington, D.C., we will continue to look for mechanisms that support the foundation of care delivery that CAPG members practice every day.

Lastly, this important work does not just occur in Washington, D.C. Through my work with CAPG, I have seen that one of our strongest advocacy tools is the CAPG member groups. In California, Members of Congress have witnessed first-hand the difference between coordinated care and non-coordinated care, the importance of health information technology, and how a properly structured payment mechanism can lead to critical improvements for patients. These types of opportunities to bring real world experiences to policymakers are invaluable.

2013 is clearly a critical year for the health industry and the future policies that will govern Medicare, Medicaid and the health industry as a whole. I encourage CAPG’s members to continue to educate key Members of Congress from across the nation, particularly those who sit on healthcare committees, in a coordinated, thoughtful manner. By working together at the local level and in Washington, D.C., we can continue to change the health care delivery system and to build on the foundation that CAPG’s members have worked so hard to achieve.
10TH ANNUAL

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JUNE 6–9, 2013
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Registration Is Now Open!
WWW.CAPG.ORG/CONFERENCE2013

Presented by the California Association of Physician Groups
The Patient Experience – Where Old Problems Meet New Politics

Along with HEDIS metrics, assuring a satisfactory patient experience has moved to the top of short-term agendas, led (as always) by hospitals. In a recent Health Leaders survey of hospital executives, 84% ranked the patient experience among their top three priorities; 28% have assigned responsibility to the Chief Executive (not a mid-level Quality committee), and a surging 40% are tying executive compensation to patient surveys and related metrics.(1)

What starts in hospitals comes eventually to physician groups and provider networks. But the concept isn’t new: As far back as 1836, Dr. Wendell Holmes (Harvard Medical School) listened to his mentor at the Paris École de Medicine insist that “as essential as was the study of specific diseases through scientific investigation, there had to be...concern for, and some understanding of, the patient.”(2)

It’s taken our industry nearly two centuries to get the message. Unwilling to see the light, we’ve waited to feel the heat of Accountable Care, Medical Home, and other regulatory mountains to climb in search of payer Incentives; it’s not lost on revenue-seeking practice leaders that CMS will award “up to 30 percent” of incentives based on the patient experience.(3) Not to mention that public access to consumer-to-consumer web postings.

There’s even a strong correlation between the provider-patient relationship and positive medical outcomes. Since the 1970s, myriad studies have made the connection between “positive affect” between patient and provider and self-reported outcomes.(4)

For physician groups, provider networks and small-practice physicians across California, “new politics” demands workable solutions to the “old problem” of how to treat the person along with the pathology.

Whose responsibility is it?

Without doubt, improving the patient experience starts with leadership. So said James P. Malone, explaining to a 2011 CAPG audience how Kaiser Permanente’s San Diego service area boosted its rating for “caring concern” from 13th to first place in less than two years. “The service message starts with continuous, visible leadership and a willingness to allocate resources for events focused on the patient experience.”

But leaders can’t do much without support from providers. Some years ago, Buenaventura Medical Group achieved the fastest and most dramatic improvement in patient satisfaction in our thirty years of consulting – more than doubling its percentile ranking for “overall satisfaction” in less than nine months. “Every one of our 45 physicians bought into the patient-centered program,” said Jim, then Buenaventura’s administrator. “Seeing the physicians’ commitment, our managers and staff jumped on the bandwagon, too.”

Getting your providers on board

First, let’s talk about “engagement,” and why it’s better to have “engaged” providers instead of merely “satisfied” practitioners.

For years we’ve been surveying physicians to see how satisfied they are with their jobs. Problem is, physician satisfaction surveys usually show fairly high agreement with statements like “Overall, this is a good place to work,” or “I expect to be working here this time next year.” Yet it’s often a major leadership challenge to get physician buy-in for non-clinical initiatives like improving the care experience.

In brief, satisfied people meet standards; “engaged” people exceed them. The gurus tell us that “satisfied” people usually do their jobs well under supervision – which explains why Medical Directors are so intent on defining job specifics, measuring key indicators, and applying collegial arm-twisting, or financial sanctions, to persuade providers to meet service standards.

Engagement is something different: According to no less a source than Wikipedia, it’s “the extent to which employee commitment, both emotional and intellectual, exists relative to accomplishing the work, mission, and vision of the organization.” Translation: “Engaged” physicians do whatever is necessary for the benefit of internal and external customers, and for the success of the business as a whole – without having to be supervised, cajoled or threatened!(5)

Roadmap to physician engagement

If by now you’re sufficiently intrigued with the “engagement” idea to wonder how best to create an internal culture that promotes top-level performance, there’s no better authority than Craig E. Samitt, M.D., M.B.A., President & Chief Executive Office of Dean Health Systems (WI). Dr. Samitt has spent much of his career grappling with the challenges of running a complex medical organization, and the following action plan is lifted (with permission) from his presentation to an industry conference while holding the operational reins at Fallon Clinic (MA).

Viewing engagement from a leadership perspective, Dr. Samitt offers nine strategies based on four premises:

- People in general (and physicians in particular) are change-resistant.
- People in medical groups are savvy, and approaches to motivation that work effectively for others may not be effective with doctors and those who support them.
- Knowledge workers resist top-down approaches and overt efforts to change behavior.
- No one strategy works all the time; we must develop a portfolio of levers, and pull each one.

Here are the nine “lessons” derived from Dr. Samitt’s message, applied to the issue of creating engagement among all members of the care team:

Lesson 1: Set a clear, consistent and unwavering vision of the future

People will follow leaders who have clarity of vision; they need to hear consensus...continued on next page
Lesson 3. People love data, so give it to them

Everyone wants proof; tangible proof is more persuasive than anyone’s opinion, no matter how fervently it’s expressed. Whatever data you use, it must be reliable, consistent, and valid — and given the amount and velocity of current change in healthcare, every medium offers information that should be shared with everyone whose buy-in is necessary for the service initiative to succeed.

Lesson 4. People want to do a good job; in fact, they want to excel

Physicians, in particular, are highly competitive, and they can “infect” their clinical teams with the same enthusiasm for excellence. Leaders can have influence over how physicians communicate with employees by giving them tools that will make them effective when they do. (Side note: un-blinded data is more effective despite the inevitable push-back it generates.)

Lesson 5. Money motivates, but not if it’s over-used

While strategies that reduce the potential for revenue loss can motivate significant change among physicians, money is not intrinsically a motivator — it does not directly persuade people to work harder, or do a better job. Even in a recession economy, money is a “hygiene” factor — it influences whether people might stay or leave, but it doesn’t affect the quality of their work.

Lesson 6. The higher the talent of new recruits, the more the resisters get diluted out

Hiring service-oriented people is an imperative at every level of the practice; doctors, managers and employees who understand the service message are more receptive to training programs, and more likely to deliver patient-responsive service once on the job. Eventually the service-oriented folks will outnumber and offset the carping of the tail-draggers.

Lesson 7. Drive to group decisions, and let the group police itself

There’s a big pay-off if you can summon the trust to put the right people on a task, and then back off to let them achieve the objective, their way. First, people find it easy to blame leadership, but they’ll rarely criticize themselves — if they’re accountable for achieving results, and have authority to pursue them, it’s nigh impossible for them to escape the criticism for failure.

Lesson 8. Different initiatives require different motivational techniques

Getting people to go along sometimes requires mandating — especially when there’s no alternative (as with the EHR transition). But not always. In most instances, allowing others to decide the best way to implement agreed-upon leadership decisions gives people feelings of “being in on things” and having at least some control over their work lives.

Lesson 9. When you’ve motivated, incented and measured, don’t forget to provide the tools

The missing ingredient in many Service Quality initiatives is providing proven tools and techniques for exceeding patients’ expectations. New challenges, like pay-for-performance incentives and achieving Medicare’s Five-Star Quality ratings, need new ways of changing physician behavior.

From our work with CAPG members, the C.L.E.A.R. Service Model is as good as any for simplicity and ease of application. The acronym includes 24 proven techniques:

1. Connect: procedures for greeting and treating patients that make positive first impressions
2. Listen: techniques for making people feel valued and heard
3. Explain: strategies for ensuring that patients understand explanations and
4. Ask: scripts to ensure that people get their questions answered and their needs met
5. Reconnect: techniques for ending patient encounters on a positive note

Conclusion

Leaders in group practice, both in clinical settings and in managerial roles, have both the challenge and the opportunity to maximize their people’s potential to improve performance. It’s timely that someone has raised management science concurrent with raised expectations and new threats to revenue and profitability. No one doubts that, to navigate tomorrow’s choppy waters, highly engaged physicians, managers and employees are needed both at the tiller and in the engine room.

(1) Intelligence Report, HealthLeaders Media Council, 2012
(3) www.cms.gov
(4) Google “Patient Satisfaction and Medical Outcomes” for a list of qualified studies
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Paying for Value

Moving toward a healthcare system in which we pay for care based on value -- not just volume -- and reward physicians for providing the right care -- not just the most care -- is essential to helping all Californians get better care. Catalyst for Payment Reform (CPR), a coalition of large national employers and others who purchase care, including CalPERS, was founded in 2009 to create an urgent platform for payment change. Believing “our health care system needs CPR,” CPR reports on the shortfalls of the current healthcare payment models and has developed a framework and tools for change that empower purchasers, and build alignment between the private sector and Medicare. Now CPR is embarking on a first-of-its-kind effort to track progress on payment reform in California and across the nation, and is looking to California’s health plans and medical groups to participate and be represented in the effort.

With support from the California HealthCare Foundation and The Commonwealth Fund, in late March CPR will launch a National Scorecard on Payment Reform, which shows our nation’s and California’s current methods of payment and progress toward a more value-oriented approach. Health plans are currently providing the data to populate the Scorecard through the eValue8 platform, a national request for information tool, hosted by the National Business Coalition on Health. The Scorecard will not identify health plan performance individually, but rather the nation’s progress on payment reform in the aggregate.

CPR’s goal is to have at least 20% of the nation’s health care spending occur through value-oriented payment methods by 2020. Medicare is already required by law to make almost 10 percent of payments tied to value by 2017, and the private sector already lags way behind.

Along with the National and California Scorecards, this March CPR will also launch a companion tool called the National Compendium on Payment Reform. This will be a searchable, sortable website that catalogues the numerous payment reform activities and pilots underway, both across the nation and in California.

“Payment reform comes in several flavors, and the two most important changes we want to see are that there be a performance-based component to all payment methods and a component to cut waste,” explains Suzanne Delbanco, Executive Director of CPR.

Delbanco goes on to explain: “Innovation and learning works both ways—Medicare also can learn a lot from the private sector, especially in a state like California where so many plans and provider groups are already trying ground-breaking new models of payment.”

Numerous California medical groups have already been payment reform trailblazers, participating in everything from ACOs, to bundled payments, to shared savings models. For example, under a new model called the Intensive Outpatient Care Program, the Pacific Business Group on Health (a founding supporter of CPR) has partnered with medical groups across California and Arizona to improve care for medically complex patients—those with the highest cost of care. Under this model, medically complex patients receive intensive care management to keep them from unneeded hospital admissions. The model is supported by a grant from the Centers for Medicare and Medicaid Innovation and has already proven to yield savings of 20 percent in pilot sites with PBGH member companies.

The first wave of participating California medical groups include: Brown & Toland Physicians; Hill Physicians; John Muir Health; Partnership Health Plan of CA; St. Joseph Heritage; Sharp Community Medical Group; Sharp Rees-Stealy; and Sutter (East Bay, Gould, and Pacific).

Ultimately, 20 medical groups will participate in IOCP. The Intensive Outpatient Care Program is an example of what can be captured in the Compendium website.

Starting in late March, CPR invites California medical groups and health plans to visit www.catalyzepaymentreform.org and share information about their payment reform initiatives by creating an entry on the Compendium website. Plans and providers can update their information and make entries on an ongoing basis, as new programs and pilots get underway.

The 2013 Scorecard will be used to identify baseline information on how the commercial market is moving toward a value-oriented payment system. In 2014 (and, as the Scorecard is released annually thereafter) CPR will identify trends in payment models, and our state and national progress on payment reform.

Those interested in more information can visit www.catalyzepaymentreform.org. To sign up for an information webinar about this work scheduled for late March, contact nperelman@catalyzepaymentreform.org.
Chapter One – 2000-2002

Pioneer Medical Group opened its doors on Monday, October 2, 2000, with five clinics. The sixth opened two days later. I must say, Pioneer was an apt name for the new entity. PMG had—and still has—a frontier spirit, achieving success despite adversity. During our first two years in business, we were borrowing heavily from Downey Regional Hospital, the HMOs were taking their time transferring medical records from KPC, and KPC, of course, sued us. But we got through it all, and, by our 8th quarter, we began to turn a profit.

Chapter Two – 2002-2007

PMG started this period still deep in debt—approximately $7.5 million in startup financing. Nevertheless, we were able to pay it off in full, ahead of schedule, and without sacrificing patient quality. In fact, for several years during this period we were named a “Top Performer” in Los Angeles County by the Integrated Healthcare Association using the criteria of clinical measures, IT development and patient satisfaction. The only other groups with this record are Kaiser Permanente, Healthcare Partners, the two groups associated with Cedars-Sinai and the UCLA Medical Group, all of which are either significantly larger than PMG and/or backed by huge institutions. We were also awarded “Elite” status in the CAPG Standards of Excellence program. I felt just like a proud papa!

Chapter Three – 2008-2009

Like many organizations, the Great Recession hit us rather hard. To make matters worse, it was during this time that PMG began transitioning to a paperless and filmless operation, which negatively affected productivity (but not quality of care). Finally, Downey Regional Medical Center had its own problems and cancelled all of its risk contracts with medical groups; and we just had to weather the storm.

Chapter Four – 2010-2012

Weather the storm we did. Over the past three years, PMG has once again turned the corner to get profitability back on track. Today, PMG has 50 providers operating in eight clinics in Los Angeles and Orange Counties. PMG provides care to over 60,000 patients through capitated enrollment as well as our fee-for-service line of business. Our strength in the marketplace made it possible for us to take advantage of an exciting opportunity, one that opens the book on a new chapter for PMG.

Chapter Five – 2013 and beyond

PMG has engaged in a strategic partnership with MED3000, a national leader in healthcare management, technology products and services, to form a new practice management company called Eagle Medical Management, LLC, a MED3000 Company. Eagle Medical Management provides complete practice management services, including clinical staffing, accounting, billing and collections, human resources management, finance, IT support, contracting and managed care administration.

Initially PMG will be the only medical group supported by Eagle Medical Management. Going forward, we anticipate expanding to provide practice management services to other healthcare organizations, a development that we expect will produce enduring success. From chaotic beginnings to our latest evolution, I believe the story of Pioneer Medical Group is truly inspiring, and I am happy to have had the honor of playing a role.

John M. Kirk serves on the CAPG Board of Directors and is the Vice-Chair of CAPG’s Public Policy Committee.
Introduction: At the 2012 CAPG Conference, the HealthCare Partners Institute for Applied Research and Education (HCPI), supported by California HealthCare Foundation funding, presented the pre-conference workshop, “Changing the Patient Experience at Integrated Care Organizations.” The session included presentations from leading medical groups that have successfully operationalized diverse patient experience strategies. Following an interactive panel moderated by CAPG’s Dr. Wells Shoemaker, health leaders weighed in on the importance, implementation, barriers to, and definition of patient experience. The following conversation with the Institute’s Dr. Jeremy Rich highlights the HCPI-CAPG survey results and Dr. Shoemaker’s perspective on the state of patient experience among California medical groups.

Jeremy Rich: With the national election behind us, the Affordable Care Act’s (ACA) panoply of patient-centered goals and measures will likely forge ahead. Encouragingly, 95 percent of medical group leaders responding to the HCPI-CAPG patient experience survey already agree that patient experience is “very important” to a group’s success. How does this mesh with what you are seeing in the field?

Wells Shoemaker: Acknowledgment of patient experience’s importance is gratifying, but in practice we have yet to see consistent effort reflected in that rating. It’s one thing to talk about it, another to have done something on a community scale. Certainly some exemplary medical groups have made great strides, but often the level of attention and service we expect in other aspects of our personal lives as “consumers” isn’t what we are prepared to offer patients. We need to change this mindset.

Dr. Rich: How does one make a compelling case for investing time and resources to improve patient experience?

Dr. Shoemaker: In today’s business climate, even if one views patient-centric care as the “right thing to do,” moral suasion isn’t sufficient to justify major expenditures. But a patient’s experience is also a significant clinical issue. And it’s a crucial business driver.

Clinically, evidence suggests treatment compliance and self-management are better for patients who have had a positive experience. Health outcomes are better, too. Enhancing patient experience is a tool for improving clinical results.

There is also a potent business case to be made. Providing an exceptional patient experience can attract and retain patients. It’s becoming a discriminator and differentiator in part because social media has had a profound effect on consumers’ ability to share experiences, good or bad. Think Yelp, Facebook. Consumers may not be able to assess comparative clinical quality, but they can judge whether they’ve been treated well.

By Jeremy Rich, DPM, Director of the HealthCare Partners Institute for Applied Research and Education

By Wells Shoemaker, MD, CAPG Medical Director
Dr. Shoemaker: These results aren’t surprising; particularly that 85% have invested in clinical systems improvement. We have spent time and made impressive progress on building the clinical engines of healthcare delivery. What’s critical is that we can use these engines to improve the patient experience, or palliative care, or health disparities. These are intertwined clinical challenges—working on cultural proficiency, for instance, contributes to better care and overall patient experience. It’s awkward to talk about patient experience as disconnected from clinical and business operations. Patient experience is integral to our work; separating it out diminishes its importance.

Dr. Rich: If patient experience is an essential element of clinical and business excellence, then we need to remove any obstacles. Survey respondents said the greatest challenges they face in improving patient experience (Chart 2) is that physicians are too busy or lack knowledge regarding its importance. What advice would you give to overcome these barriers, especially when physician “burn-out” with medical practice often runs high?

Dr. Shoemaker: Improving patient experience entails hard work. If physicians are unhappy, the number one strategy to improve their satisfaction is to improve patient satisfaction. If time and education are real barriers, the group needs to restructure how things are done. Free up time for what leverages patient experience. It doesn’t matter how smart clinical systems are if we don’t organize around the patient as the core. Staffing and culture are critically important—they separate groups that succeed from those that don’t.

Great organizations become so intentionally, not by accident. A number of California medical groups have figured that out. Sharp, for example, has made a huge investment and has seen the turnaround.

Dr. Rich: Being “listened to,” having physicians explain things, spending time, and treating the patient and family with respect outweigh administrative considerations, according to our survey (Chart 3).

Dr. Shoemaker: Absolutely. So saying that physicians are too busy simply doesn’t hold water if a group is serious about its success.

Dr. Rich: We asked about value-added tools to support patient experience (Chart 4). Overwhelmingly, respondents mentioned techniques to improve patient-physician communications; nearly half are interested in educational programs. What advice would you give to those who want to improve patient experience but aren’t certain how to start?

Dr. Shoemaker: There are many excellent resources available. The California Quality Collaborative publication, “A CQC Guide to Improving the Patient Experience” is just one. But let me suggest starting with a few practical action steps:

1. Explore—get knowledge, get help, learn from what others are doing

2. Start working on culture—it’s all about people
3. Begin training—send a few physicians to a course, bring training on-site
4. Regularly feature patient experience in internal and external communications—keep it on the front-burner; give it attention.

If we don’t design patient experience as an outcome of every clinical encounter and enterprise, we’re missing something. Patient experience metrics need to be reported right alongside lab outcomes.

I’ve heard the argument that patient experience measures (e.g., PAS, CG-CAHPS) have limitations, but the data can be used within a group to explore substantial differences among physicians. They are a valuable tool to identify opportunities to improve both clinical and business operations.

As healthcare reform moves ahead and ACOs are implemented, success or failure will not hinge on HEDIS scores or graphic color brochures. It will be decided by whether a family’s visceral experience with healthcare is better. Ultimately, that is the bottom line.

Jeremy Rich, DPM is director of the HealthCare Partners Institute for Applied Research and Education, a non-profit organization in Torrance, CA. He can be reached at jrich@healthcarepartners.com. Wells Shoemaker, MD is CAPG’s medical director and vice-chair of the California Quality Collaborative. HCPI thanks Lois Green, president/principal of The Performance Alliance, for assistance on this article. We also gratefully acknowledge the generous support of the California HealthCare Foundation, Oakland, CA.
Diabetes care is complex and requires that many issues, beyond glycemic control, be addressed.1 One issue is medication adherence.2 Medication adherence may prevent hospitalizations for diabetes complications.2 Another major issue is hypoglycemia. Not only is it a barrier to successful diabetes management,1 but it can also be very costly3:

- ER-to-inpatient costs: $10,3623
- ER plus outpatient costs: $9863
- Hospital admission costs: $7,3173

However, you may not be informed of all your members’ hypoglycemic events. In a multicenter, retrospective medical record review of 3 academic emergency departments, 83% of hypoglycemia visits, often excluded in prior hypoglycemia analyses, were coded as “diabetes with other specified manifestations,” while others may not be reported at all.4

For these reasons, diabetes management costs may be even greater than you know.

References:
Diabetes care is complex and requires that many issues, beyond glycemic control, be addressed. One issue is medication adherence. Medication adherence may prevent hospitalizations for diabetes complications.

Another major issue is hypoglycemia. Not only is it a barrier to successful diabetes management, but it can also be very costly:

- ER-to-inpatient costs: $10,362
- ER plus outpatient costs: $986
- Hospital admission costs: $7,317

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For these reasons, diabetes management costs may be even greater than you know.

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For more information about Brown & Toland’s Medicare ACO initiative, please visit www.brownandtoland.com.