Advisory Board | Health Care Advisory Board

Partnering with Physicians in Enterprise Cost Control

The High-Performing Clinical Enterprise, Part 2

The best practices are the ones that work for you.℠

research technology consulting

1 The New Physician Partnership Mandate

2 Building the High-Performing Clinical Enterprise

3 Toward a New Physician Compact

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The High-Performing Clinical Enterprise

Seven Practices for Partnering with Physicians on Cost Management

1

Enabling Cost-Conscious Care Delivery

Engineer a Reliable and Low-Cost Clinical Product

Establish Expected Clinical Practice

1. Cost-driven care variation agenda
2. Implementation-focused clinical governance model

Translate Standards into Frontline Care Delivery

3. Refined rules-based environment
4. Meaningful accountability for participation and performance

2

Transforming the Clinical Enterprise

Build a Cost-Efficient Clinical Workforce

Redesign the Clinical Engine

5. Principled network curation
6. Stabilized compensation structure
7. Productivity-enabling role redesign

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Source: Health Care Advisory Board interviews and analysis.

Transforming the Clinical Enterprise

Build a Cost Efficient Clinical Workforce

SECTION 2

5. Principled Network Curation
6. Stabilized Compensation Structure
7. Productivity-Enabling Role Redesign

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If We Were Building from Scratch…

Today's Physician Networks Not Engineered for New Market Realities

Characteristics of the Status Quo Physician Enterprise

Designed with physicians at the core

Heavy reliance on procedural, surgical specialists

Defaults to legacy roles and responsibilities

Burdened by low functioning technology

Centered on in-person clinical interactions

Common Shortcomings in Existing Physician Networks

$400K **Expensive**

Expected per physician losses at multi-specialty employed medical group[1]

80% **Roles Operate Below Top Of Impact**

Of adult primary care can be provided by nurse practitioners or other APs

26% **Underproductive**

Reduction in productivity for disengaged physicians

59% **Burned Out**

Highest rate of burnout experienced by physicians[2] in 2017

1) For a bottom quartile performing medical group with 150 or fewer physicians.
2) For emergency medicine physicians.

Source: Anagnostopoulos, F., et al. "Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design," *J Clin Psychol Med Settings*, 2012 Dec; Mundinger, Mary, "Advanced-Practice nursing—good medicine for physicians?," NEJM, 1994 Jan; Peckam, C., "Medscape lifestyle report 2017: Race and Ethnicity, Bias and Burnout," *Medscape*, 2017; Health Care Advisory Board interviews and analysis.

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Envisioning the Cost-Effective Clinical Enterprise

Network Design

Right Size and Composition

Network should be rightsized to reflect emerging supply needs and only include culturally compatible clinicians

Strategy-Aligned Incentives

Physician compensation should reward desired performance while upholding the system's cost goals

Financial Sustainability

Economic alignment models should be financially sustainable and support the interests of both physicians and the system

Care Delivery

Right Roles and Responsibilities

Clinicians should operate at top-of-impact to improve efficiency, productivity, and engagement

Value-Added Technology

Technology should facilitate, not impede, the delivery of high-value and efficient care

Practice Sustainability

Clinicians should be able to deliver high-quality, patient-centered care without feeling burned out

Source: Health Care Advisory Board interviews and analysis.

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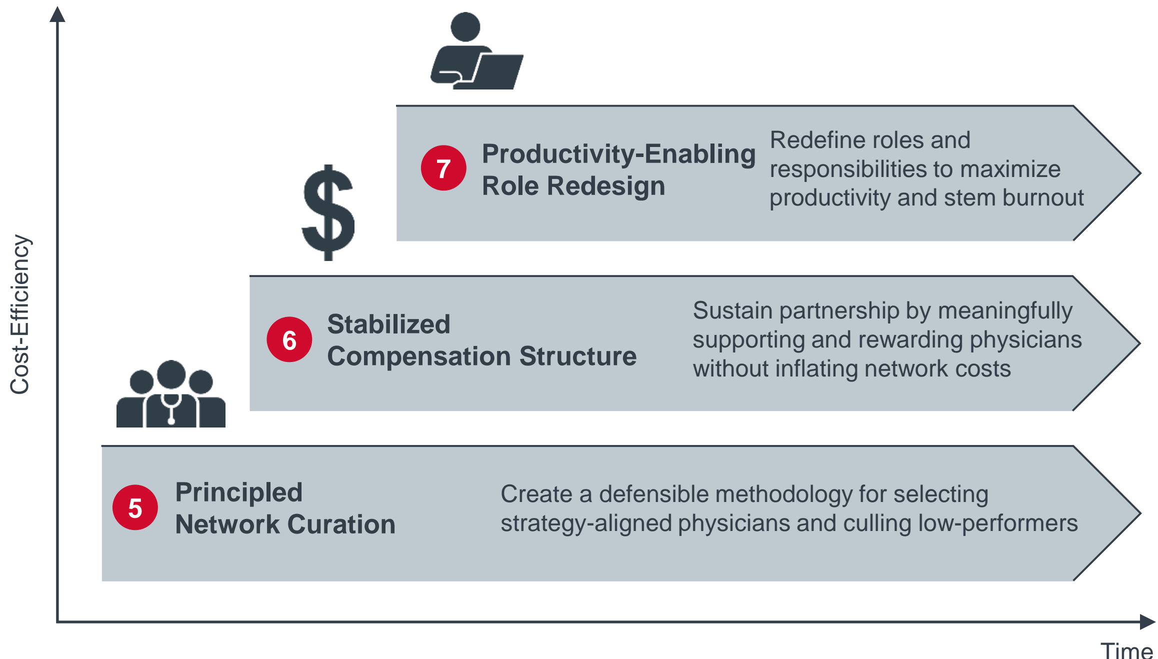
Transforming the Clinical Enterprise

Three Steps to Building a Cost-Efficient Clinical Enterprise



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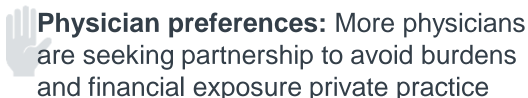
Source: Health Care Advisory Board interviews and analysis.

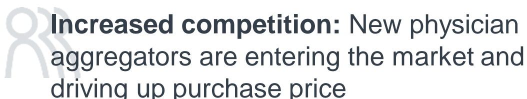
Choosing the Right Partner No Easy Task

Systems Unprepared to Meet Heightened Partnership Activity

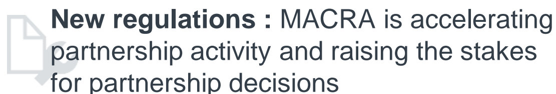
Pressure to Partner Mounting



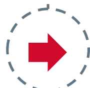
Physician preferences: More physicians are seeking partnership to avoid burdens and financial exposure private practice



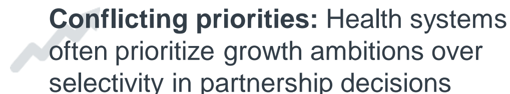
Increased competition: New physician aggregators are entering the market and driving up purchase price



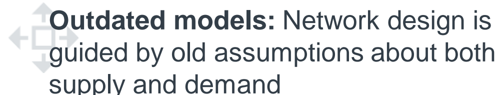
New regulations : MACRA is accelerating partnership activity and raising the stakes for partnership decisions



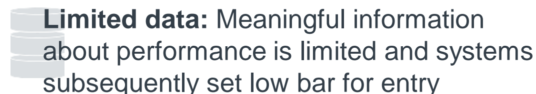
Systems Poorly Positioned to React



Conflicting priorities: Health systems often prioritize growth ambitions over selectivity in partnership decisions



Outdated models: Network design is guided by old assumptions about both supply and demand



Limited data: Meaningful information about performance is limited and systems subsequently set low bar for entry

91% CEOs predict continued growth in employment **due to the requirements of MACRA**

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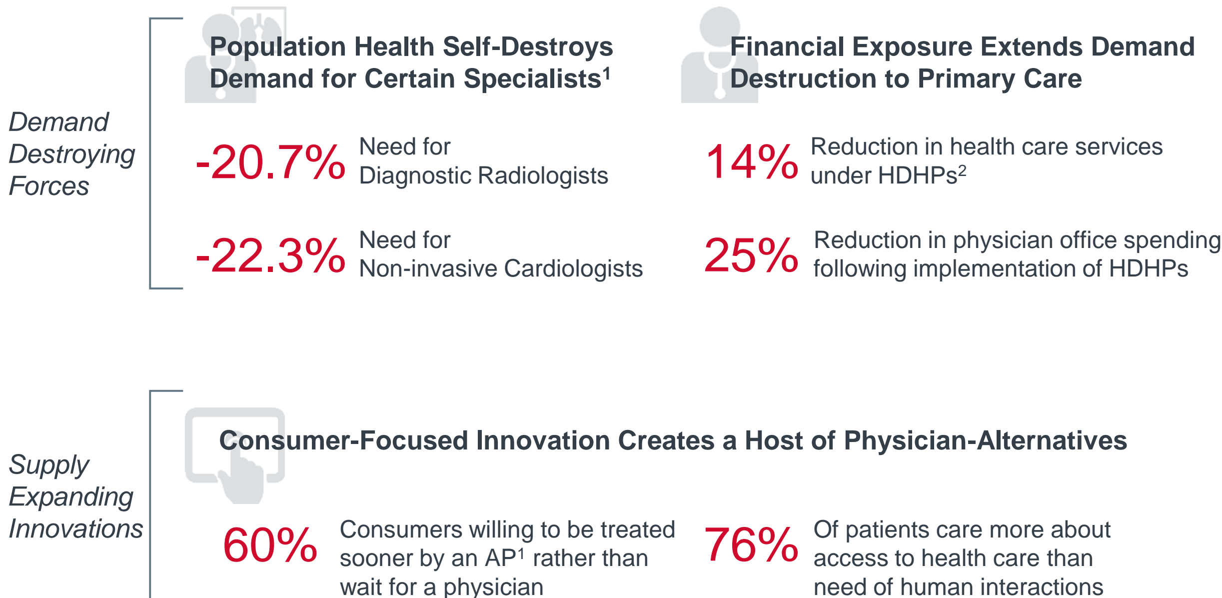
Source: Health Care Advisory Board interviews and analysis.

Debunking the Myth of a Physician Shortage

Population Health and Consumerism Shifting Both Supply and Demand



1) Moderate refers to the shift in the number of physicians needed to manage care for 100,000 lives when utilization shifts from loosely managed care to moderately managed care, as defined by the Milliman benchmarks.
2) High deductible health plans.

Source: Z et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," The National Bureau of Economic Research, October 2015; Sources: PwC, "Healthcare's new entrants: Who will be the industry's Amazon.com?" Health Research Institute, April 2014; Health Care Advisory Board interviews and analysis.

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Debunking the Myth of a Physician Shortage

Continued

Impact of Population Health on Specialist Demand

Specialist	Change in Number of Physicians (Moderate Care Management)[1]	Change in Number of Physicians (Aggressive Care Management)[2]
Ophthalmologists	-22.3%	-44.5%
Non-invasive Cardiologists	-22.3%	-44.6%
Anesthesiologists	-17.3%	-34.5%
Diagnostic Radiologists	-20.7%	-41.4%
Dermatologists	-15.9%	-31.9%

1) Moderate refers to the shift in the number of physicians needed to manage care for 100,000 lives when utilization shifts from loosely managed care to moderately managed care, as defined by the Milliman benchmarks.
2) Aggressive or well managed refers to the shift in the number of physicians needed to manage care for 100,000 lives when utilization shifts from loosely managed care to well managed care, as defined by the Milliman benchmarks.

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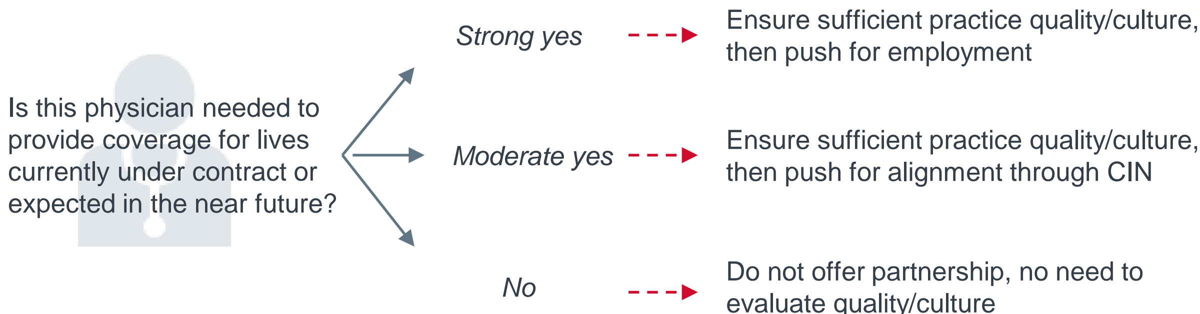
Source: Health Care Advisory Board interviews and analysis.

Shape Mix by Putting the Brakes on Recruitment

Add New Specialists to Network Only if Clear Need Exists

Physician Partnership Decision Tree



Case in Brief: Jacobs Health Care[1]

- Large health system in the Southwest with roughly 2,000 employed physicians and CIN[2] with more than 4,000 providers
- Strict partnership criteria means network virtually closed to new specialists; PCP ranks still growing, but capacity needs evaluated every six months

1) Pseudonym.
2) Clinically Integrated Network.

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Source: Health Care Advisory Board interviews and analysis.

Raise the Bar on Performance Standards

Jacobs[1] Turns Suggestions Into Requirements to Participate in Network

PAST → PRESENT

- Contract risk a goal, but not immediate
- Performance standards for network partners recommended but not required

Representative network participation standards for PCPs

- ✓ Be a certified PCMH[2]
- ✓ Use Jacobs PAC[3] providers
- ✓ Have an EMR
- ✓ Complete patient satisfaction surveys
- ✓ See patients again before renewing home health requests

- Considering MSSP[4] Track 2 or 3 to qualify for MACRA APM[5] track
- Compliance with standards now seen as non-negotiable

Case in Brief: Jacobs Health Care[1]

- Large health system in the Southwest with roughly 2,000 employed physicians and CIN with more than 4,000 providers
- Strict partnership criteria means network virtually closed to new specialists; PCP ranks still growing, but capacity needs evaluated every six months

1) Pseudonym.
2) Patient-centered medical home.
3) Post-acute care.
4) Medicare Shared Savings Program.
5) Alternative Payment Model.

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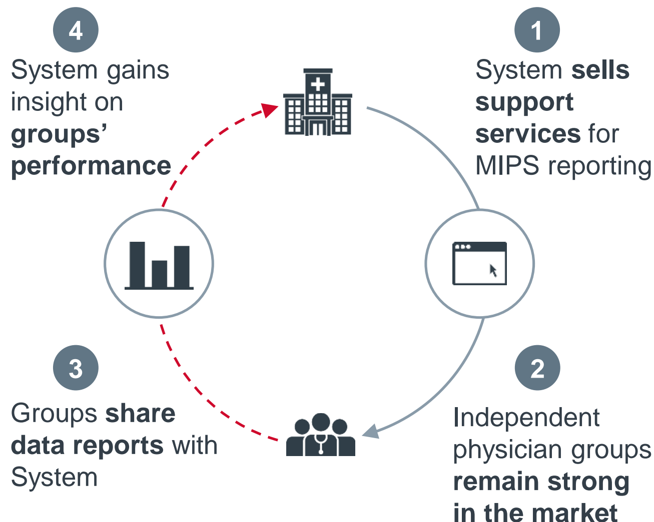
Source: Health Care Advisory Board interviews and analysis.

A Window into Comprehensive Performance

MACRA Support Allows for Market-Leading Insight into Clinical Practice

Steps to Retrieving Meaningful Cost and Performance Data



Data Provides Prediction of Performance in MIPS

Metric	*Indication*
Resource utilization	Cost-consciousness
Quality Scores	Outcomes, patient experience
ACI Score	EMR utilization

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Source: Health Care Advisory Board interviews and analysis.

A Window into Comprehensive Performance

Continued

Case in Brief: Astin[1] Health

- 10-hospital integrated delivery system located in the South
- Operates a physician services organization (PSO) offering analytics and reporting products
- Purchasers of PSO services agree to share physician-level cost and quality data
- Uses data to determine which physicians to bring into their employed medical group or CIN

1) Pseudonym.

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Source: Health Care Advisory Board interviews and analysis.

Embracing Millennial Talent

New Physicians Offer Opportunity to Mold Strategy-Aligned Partners

Millennials in the Physician Workforce

15% Of physicians in the US workforce **are under 35**

52% Of millennials working in health care say good **opportunities for career progression** made an employer attractive

52% Of millennials working in health care would deliberately seek out employers whose **corporate social responsibility values matched their own**

Working with Millennial Physicians

Advantages

- Technology proficient
- Highly teachable
- Loyal

Disadvantages

- Greater work-life balance expectations
- Significant investment to train

Case in Brief: New West Physicians

- Physician-owned primary care medical group network of 120 providers based in Denver, CO
- Focused on recruiting young physicians willing to learn and open to new models of care delivery

Source: PwC, "Millennials at work: Reshaping the workplace", *Millennials Survey*, 2017, http://www.pwc.com/gx/en/issues/talent/future-of-work/millennials-survey.html; Health Care Advisory Board interviews and analysis.

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Drawing a Line in the Sand

Formal Process Expedites Exit of a Few Bad Apples

University Hospital Holds Physicians to Productivity Standards

Identify Low Performers

Physicians below 50th percentile of productivity are identified; system leaders alert them of their status

Formalize Expectations

Physicians who have not improved are placed on three-month performance improvement plans (PIPs)

Reward Improvements

Physicians who complete their performance improvement plans remain in the network

Hold to Set Standards

Physicians are culled if they do not achieve the goals of their performance plan

Physician Performance in Year One of Program

84	Physicians warned about performance status
34	Physicians self-improved after being warned
50	Physicians put on performance improvement plans (PIP)
6	Physicians failed to improve

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Source: Health Care Advisory Board interviews and analysis.

Drawing a Line in the Sand

Continued

Case in Brief: University Hospitals

- 1,032-bed health system located in Northeast Ohio
- Physicians performing at or below MGMA's[1] 50th percentile of productivity are put on a three-month performance improvement plan (PIP)
- In the first year of the program, 84 of the 2,000 physicians were given a warning, 34 self-improved, and the remaining 50 were given a PIP
- Six physicians failed to right their performance and were let go

1) Medical Group Management Association.

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Source: Health Care Advisory Board interviews and analysis.

Principles of Network Curation

Takeaways for Health System Leaders

Slow Recruitment Efforts

When right-sizing network, rely on attrition to achieve desired size with minimal disruption

Identify Opportunities to Mold Partners

Recruit physicians who have a foundation of cultural alignment and can be taught over time

Establish Clear Expectations for Inclusion

Codify standards for physicians to join the network and remain in good standing

Capture Data Ahead of the Market

Capitalize on existing relationships to collect meaningful performance data before competitors

Create a Defensible Process for Culling

Communicate expectations and deploy a clearly defined plan for culling low-performers

Reevaluate Network Regularly

Don’t make network curation a one-time event; reassess size and composition over time

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Source: Health Care Advisory Board interviews and analysis.

No End in Sight

Physician Compensation Continues to Climb

Employment Remains Expensive

$400K

Expected per physician losses at multi-specialty employed medical group[1]

Trends Point to Continued Growth

49%

increase in the number of hospital-employed physicians, 2012-2015

And Physicians are Driving Most of the Costs

85% Medical group costs attributed to human capital

50% Medical group human capital costs attributed to physician labor

"Physician compensation is like college tuition: We all realize the rising costs are not sustainable, but no one knows what to do…. Nobody else in our health system gets the year-over-year wage growth that our physicians do. But on the other hand, everything else that costs that much is bricks and mortar, and you can't fill those beds without providers."

Medical Group CEO of a 8-Hospital System

1) For a bottom quartile performing medical group with 150 or fewer physicians.

Source: Physicians Advocacy Institute, "Physician Practice Acquisition Study: National and Regional Employment Changes," 2016, http://www.physiciansadvocacyinstitute.org/Portals/0/PAI-Physician-Employment-Study.pdf; AHA, Trendwatch 2015; Health Care Advisory Board interviews and analysis.

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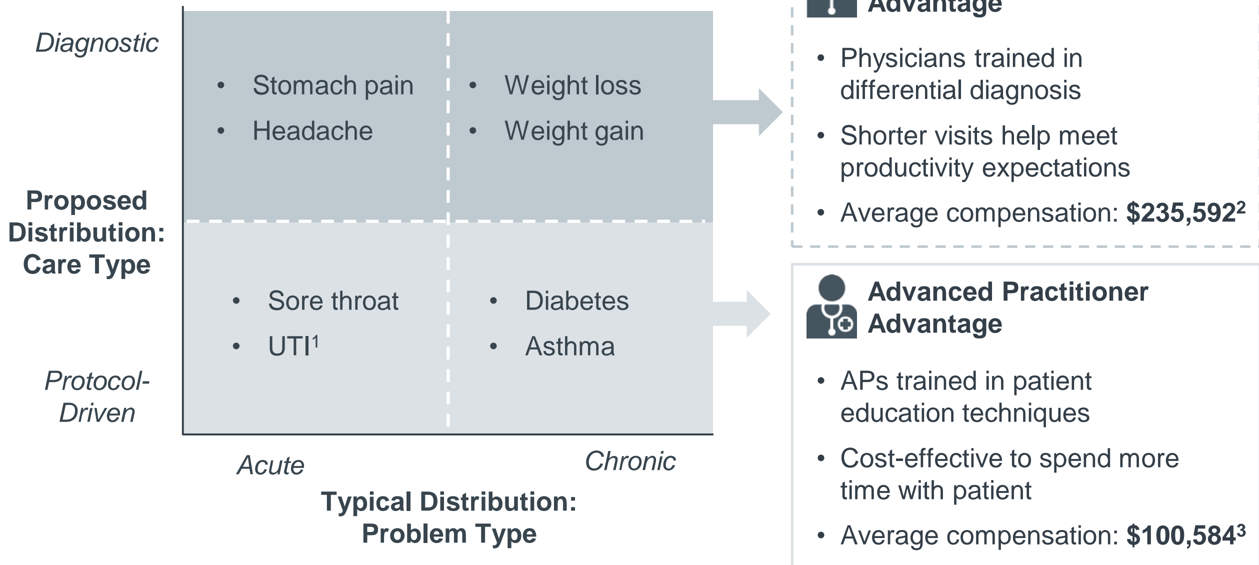
Improving Clinician Labor-Cost Efficiency

Provider Skills Map to Care Type, Not Problem Type



1) Urinary tract infection.
2) Average annual compensation for Internal Medicine MD.
3) Average annual compensation for Internal Medicine NP.

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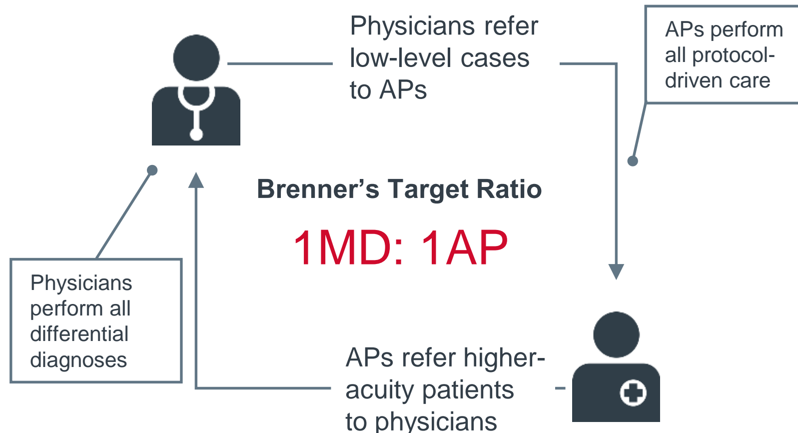
Source: Health Care Advisory Board interviews and analysis.

Rebalancing Network Composition

Most Systems Underutilize Advanced Practitioners

Reimagining Physicians' Role with Team-Based Care



2x

Average investment per employed physician compared to the average investment per AP[3]

Case in Brief: Brenner Health Network[1]

- 1,000+ physician IPA based in the Northeast
- Striving to reach a ratio of one advanced practitioner[2] for every one physician

1) Pseudonym.
2) Advanced practitioner, including Nurse Practitioners (NPs) and Physician Assistants (PAs).
3) Based on Advisory Board analysis.

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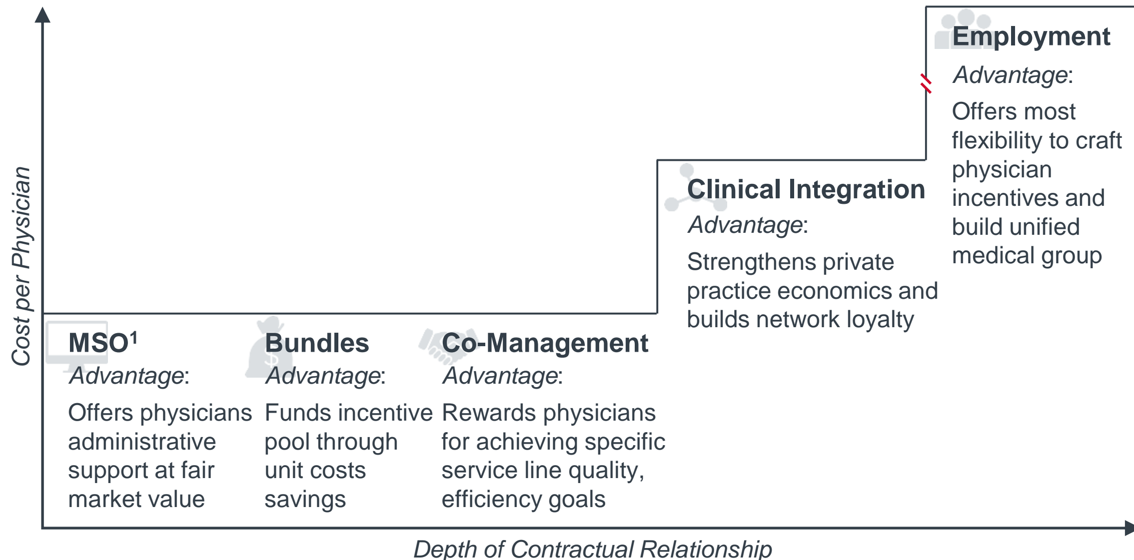
Source: Health Care Advisory Board interviews and analysis.

Employment Far From the Only Option

Multiple Avenues to Defer Employment—Especially for Specialists

Select Hospital-Physician Partnership Models



Questions Guiding Model Selection:

What do physicians need from a system relationship?

What do health systems want from their physician partners?

What is the most cost-effective way of achieving these goals?

1) Management services organization.

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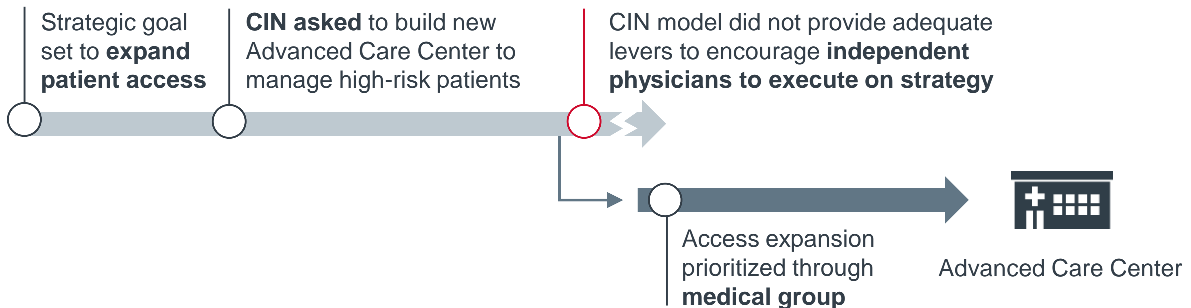
Source: Health Care Advisory Board interviews and analysis.

However, Employment Sometimes the Right Choice

Even Advocate Expands Access Through Its Employed Physicians First

Advocate Medical Group Provides Accessibility



Case in Brief: Advocate Physician Partners

- 5,000+ provider CIN affiliated with 12-hospital Advocate Health Care in Chicago; includes both independent practices and system's 1,500+ provider employed network
- Advanced CIN with strong track record of achievement on risk-based contracts
- Prioritized access expansion through Advocate Medical Group after efforts with clinically integrated independent physicians fell short of expectations

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Source: Health Care Advisory Board interviews and analysis.

Incremental Innovation in Compensation Models

More Talk than Action in Major Compensation Overhaul

Renewed Interest in Salary-Based Pay

Respond to Consumer Market Forces

Allows for work that is not directly reimbursed but increasingly important for consumer loyalty

Enhance Medical Group Growth

Encourages patient sharing within a particular specialty area in order to maximize access

Prevent Physician (and Administrator) Burnout

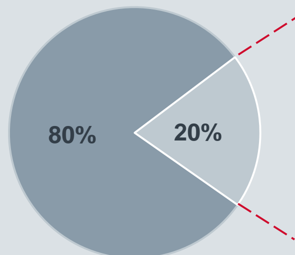
Foster more collaborative group culture in which physicians need not be paid piecemeal for every initiative

New Applications of Production Base + Bonus Model

New Definitions of Productivity

Primary Care: Care team productivity, panel size

Specialists: Practice or group level productivity



Non-Production Metrics

Clinical Quality

Patient Experience

Access to Care

Group Citizenship

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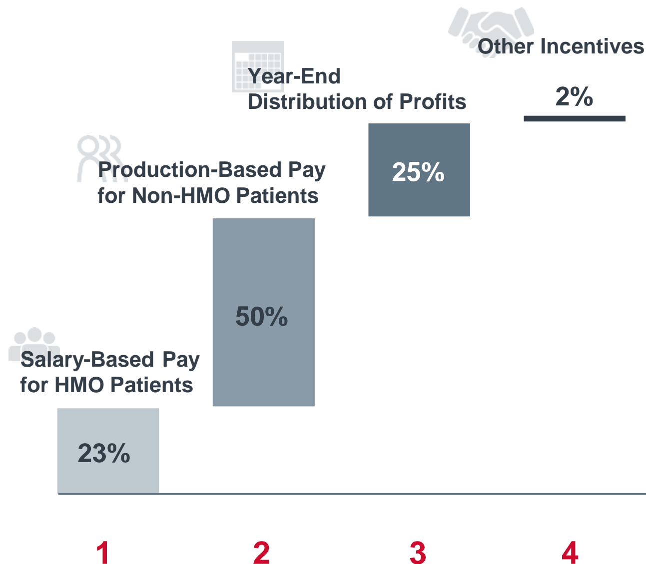
Source: Health Care Advisory Board interviews and analysis.

Blending Incentives to Match Contract Economics

Sharp Rees-Stealy Finding Balance Between Risk and Fee-for-Service

Compensation Formula for Foundation Physicians[1]



1 Salary-Based Pay for HMO Patients

- PCPs paid variable salary based on size of attributed age- and sex-adjusted panel
- Specialists paid fixed salary based on expected care for entire HMO population

2 Production-Based Pay for Non-HMO Patients

- Includes all patients with non-HMO insurance
- All physicians paid a percent of charges submitted for these patients

3 Year-End Distribution of Profits

- Split based on equal draw for all seniority, patient satisfaction, peer reviews, and citizenship

4 Other Incentives

- Small bonuses paid for performance against other initiatives deemed important by group

1) Group average, individual formula based on patient panel mix.

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Source: Health Care Advisory Board interviews and analysis.

Blending Incentives to Match Contract Economics

Continued

Case in Brief: Sharp Rees-Stealy Medical Group

- 500+-physician medical foundation based in San Diego; affiliated with four-hospital Sharp Healthcare
- Compensation model includes a large component based on a salary guarantee, as well as several other pay structures and added incentives over time
- Conflicting priorities for physicians, from having a charges-based pool for non-HMO patients and a salary-based pool for HMO patients, is mitigated by the group's revenue tipping far enough toward capitation

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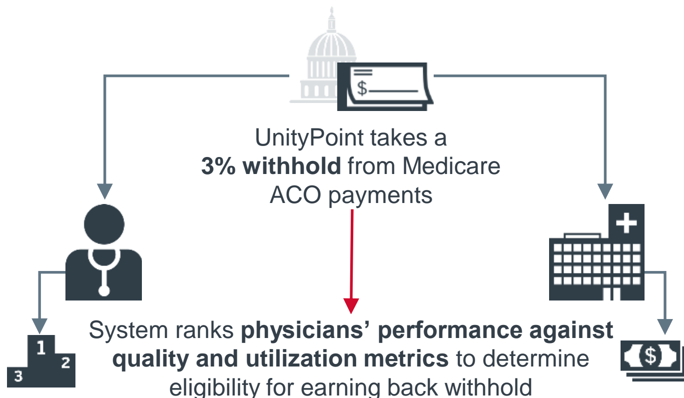
Source: Health Care Advisory Board interviews and analysis.

Designing Budget-Neutral Bonuses

Establish a Physician Funded Pay-for-Performance Pool



Physician Rank	% of Withhold Earned Back
Platinum	110%
Gold	105%
Silver	95%
Bronze	75%

Case in Brief: UnityPoint Health

- 33-hospital health system with locations across Iowa, Wisconsin and Illinois
- NGACO[1] participants are subject to a 3% withhold from their ACO FFS reimbursements
- Providers will be categorized as platinum, gold, silver or bronze based on their performance on 13 metrics, including both quality and utilization

1) Next Generation Accountable Care Organization.

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Source: Health Care Advisory Board interviews and analysis.

Designing Budget-Neutral Bonuses

Continued

Case in Brief: UnityPoint Health

- 33-hospital health system with locations across Iowa, Wisconsin and Illinois
- NGACO participants are subject to a 3% withhold from their ACO FFS reimbursements
- The withhold is based on quality and utilization metrics, divided into five buckets:
  - **Hospital metrics:** Patient safety and adverse events composite, pneumococcal vaccine, influenza vaccine, follow-up after hospital discharge, and risk-adjusted all-condition unplanned readmissions
  - **Primary care metrics:** Pneumococcal vaccine, influenza vaccine, follow-up after hospital discharge, risk-adjusted all-condition unplanned readmissions, acute admission rates for patients with diabetes, and annual wellness visits
  - **Specialists metrics:** Pneumococcal vaccine, influenza vaccine, risk-adjusted all-condition unplanned readmissions, admissions for COPD or asthma in older adults, admissions for heart failure, and acute admission rates for patients with diabetes
  - **SNF metrics:** Pneumococcal vaccine, influenza vaccine, risk-adjusted SNF 30-day unplanned readmissions, and risk-adjusted SNF average LOS
  - **Home health metrics:** Pneumococcal vaccine, influenza vaccine, risk-adjusted 60-day acute care hospitalization during home health episode, and risk-adjusted ED use during home health episode

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Source: Health Care Advisory Board interviews and analysis.

Key Questions for the Health System Executive Team

Discussion Guide: Provider Compensation Strategy

- How long can we sustain current compensation levels, especially if we expand our employed medical group? How can we actively work to control compensation growth over time?
- Is our current approach to provider compensation inflating fair market value? How can we effectively reward providers without driving up compensation benchmarks?
- Can we craft a compelling value-proposition for providers through desirable non-financial features such as geography or culture instead of market-leading compensation?
- How will we compete with non-traditional competitors who might not be bound to the same fair market value restrictions? Given a growing set of partnership options, why should providers choose to work with our organization?
- Do we consider the returns on our investment in the medical group holistically? How are we accounting for the downstream value of the group?
- Have we dedicated sufficient time and energy to structuring APP compensation? Should we incorporate the performance-based incentives we design for employed physicians?
- Are we facing other major changes, such as an EMR implementation, that might discourage disruption to provider compensation at this time?

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Source: Health Care Advisory Board interviews and analysis.

Key Questions for the Health System Executive Team

Discussion Guide: Performance-Based Incentive Design

- How effectively does our compensation model translate our organization's market incentives to frontline providers? Does MACRA require us to accelerate risk-sharing with providers?
- What are the right metrics to motivate desired performance? How will we balance breadth and focus when selecting the number of metrics?
- Does our current model lead to patient "hoarding" among individual physicians or reward network access and growth through collaboration?
- As we expand non-reimbursed care management and access to prepare for population health and consumerism, does our compensation model encourage or inhibit provider participation?
- Is our compensation model contributing to physician burnout? How can we eliminate the "hamster wheel" feeling without overly compromising productivity?
- Is shifting to a salary model right for our organization? How much could physician productivity fall with such a change? Can we design a compensation model that continues to motivate our physicians on productivity while ensuring sustainability?
- How frequently should we update our compensation model and the performance metrics contained within it? Should we "shadow" any changes to compensation design before the new model goes into effect?

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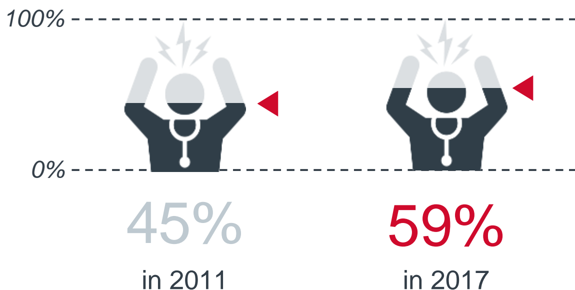
Source: Health Care Advisory Board interviews and analysis.

Confronting Physician Burnout

Understanding and Identifying Burnout Among Clinicians

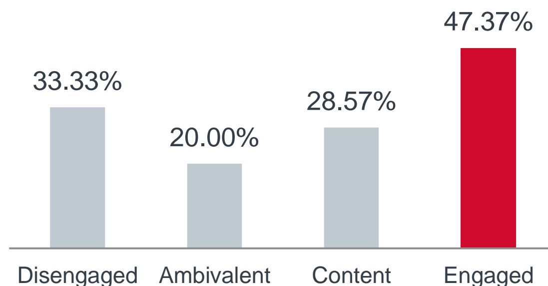
Physician Burnout on the Rise…



45%
in 2011

59%
in 2017

…Even Among the Most Engaged[1]



Multiple Consequences of Physician Burnout

16%
Patient Experience
Decrease in patient satisfaction scores for burned-out physicians

11%
Quality of Care
Percent increase in medical errors in burned-out surgeons

$150k-300k
Recruitment & Retention
Turnover cost of replacing a single physician

1) Percentage of Respondents Agreeing or Strongly Agreeing With the Statement *"I am experiencing more work-related stress and burnout than I did 3 years ago".*

Source: Advisory Board Survey Solutions Physician Engagement National Database; Peckam, C., "Medscape lifestyle report 2017: Race and Ethnicity, Bias and Burnout," *Medscape*, 2017; Anagnostopoulos, F., et al. "Physician burnout and patient satisfaction with consultation in primary health care settings: evidence of relationships from a one-with-many design," *J Clin Psychol Med Settings*, 2012 Dec; Shanafelt TD, et al., "Burnout and medical errors among American surgeons," *Ann Surg*, 2010 Jun; Health Care Advisory Board interviews and analysis.

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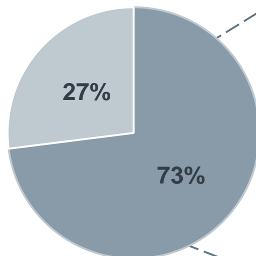
Ultimately, a Productivity Problem

Physicians Overburdened, Underproductive, and Burned Out

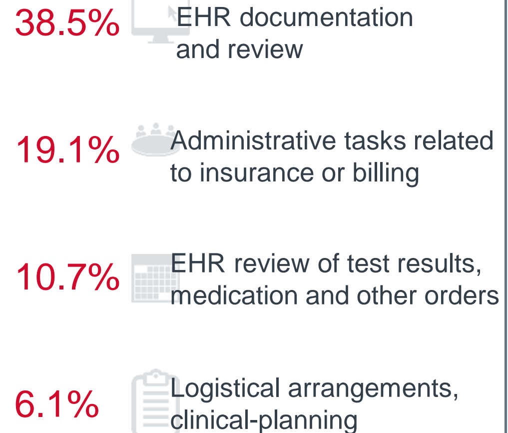
Physicians' Growing To-Do Lists Limits Their Most Important Work

Allocation of Physician Time in Ambulatory Practice

Time physicians spend on **direct clinical face time** with patients



Time spent on **administrative, non-clinical tasks**



Source: Sinsky C, et al., "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties.," *Annals of Internal Medicine,* December 2016, available at http://annals.org/aim/article/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties; Health Care Advisory Board interviews and analysis.

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Beyond Temporary Solutions

Long-Term Strategy Requires Enterprise Change

Instilling top-of-impact care

Ensure the use of every health team member is optimized, beyond just care management

Including physicians in strategic decisions

Empower the clinical workforce to ensure commitment for business strategies

Rethinking technology in our workflow

Streamline the use of technology to prevent interruptions in the provision of care

Freeing physicians of operational burdens

Eliminate tasks that overly burden physician interactions, taking time away from patients

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Source: Health Care Advisory Board interviews and analysis.

Designing for Top-of-Impact Care

Role Redesign Improves Productivity and Reduces Burnout

Barriers to Network Productivity

Clinicians overburdened with below-license administrative tasks

Clinicians inundated with low-acuity visits that crowd out high-impact interactions

Clinicians constrained to treating local patients due to in-person delivery model

Designing the Efficient Clinician Enterprise

1. **Sustainably offload non-clinical tasks to support team**
2. **Redirect low-acuity visits to low-cost solutions**
3. **Extend clinician reach through telehealth tools**

Network productivity

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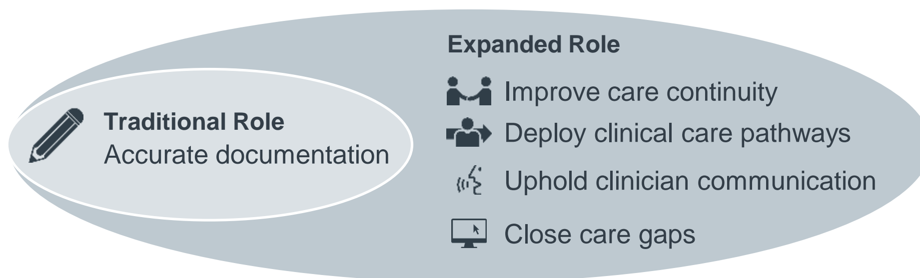
Source: Health Care Advisory Board interviews and analysis.

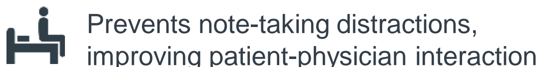
Remove Physicians' Number One Frustration

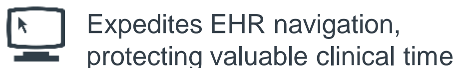
Non-Clinical Roles Shift from Note-Taker to a Bi-Directional Partner

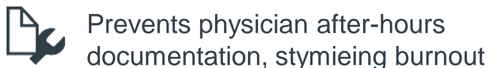
Technology-Enabled Scribes Take on a More Proactive Role

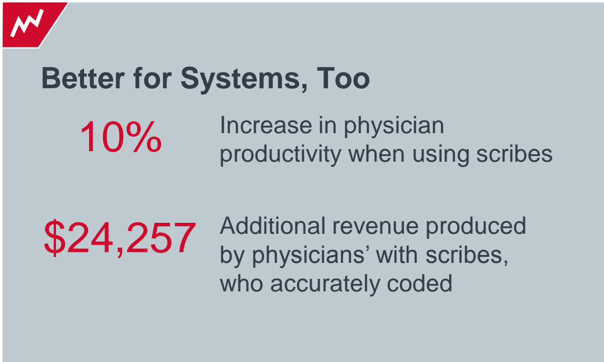


Scribes Eliminate Physician Frustrations









Source: Bank, AJ., Gage, RM, "Annual impact of scribes on physician productivity and revenue in a cardiology clinic", *Clinical Outcomes Research,* 2015; Health Care Advisory Board interviews and analysis.

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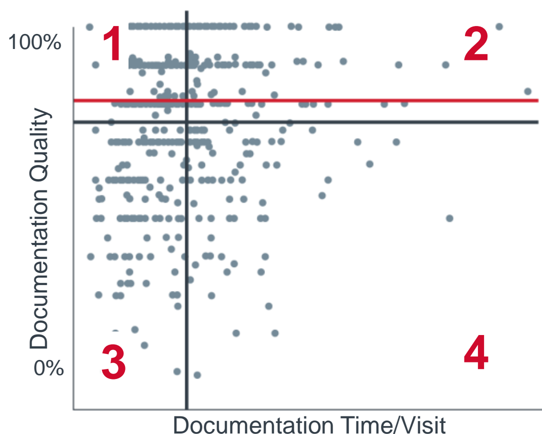
Providing the Right Support to the Right Physician

Privia Considers Specific Physician Needs Before Rolling Out Scribes

Segmentation of Physician Performance



1 "Doing a good job"

2 "Needs his life back"

3 "Rushing through work"

4 "Overwhelmed"

Structuring Differentiated EHR Support

Assess physician performance

Evaluate physicians on both quality of documentation and time spent on documentation

Segment physicians

Clearly define groups of physicians to determine how to best improve the value of their documentation

Roll out pilot

Provide a pilot groups with remote scribes from one of two vendors

Decide on program structure

Privia will evaluate the performance of the pilot groups[1], decide on supports

1) Privia's EHR tracks the time of documentation, after hours saved by remote scribes.

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Source: Health Care Advisory Board interviews and analysis.

Providing the Right Support to the Right Physician

Continued

Case in Brief: Privia

- National physician practice management company based in Arlington, VA
- Piloting remote scribes to physicians to alleviate the time burden of documentation and improve the value of documentation
- Segmented physician group by evaluating physician quality of documentation and time spent on documentation
- Rolling out two remote scribe vendors, Augmedix and Physicians Angels, to select physicians in each of the segmented cohorts
- Scribe pilot is part of a larger initiative to automate routine functions to other staff members, such as pre- and post-visit planning, HCC coding support, and delegated low-level clinical tasks

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Source: Health Care Advisory Board interviews and analysis.

Avoiding a Hiring Spree

Technology and Outsourcing Facilitate Long-Term Sustainability

Case in Brief: Augmedix

- Health care start-up company based in San Francisco, California
- Developed a platform powered by Google Glass to streamline physician data entry, alert delivery, and electronic health record (EHR) interactions at the point of care

3.2	Hours saved in daily charting time
10%	Increase in patients seen each day
33%	Reduction in chronic care gaps

Google glass uses point-of-view video streaming to connect physician to a remote scribe

Scribe performs remote documentation in the EHR[1] while physician performs care delivery

Real-time Alerts delivered directly into the physicians vision at the precise moment of need

Physician responds to each alert in real time, closing care gaps with minimal workflow disruption

1) Electronic Health Records.

Source: Health Care Advisory Board interviews and analysis.

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Building Triage into Primary Care

MetroHealth Redesigns the Practice to Improve Productivity

Nurse-Led Practice Redesign

Nurses
Deployed as **flow coordinators** for the entire clinic, organizing high-acuity patients and providing care in tandem with the physician

Medical Assistants
Positioned in the middle of the hierarchy, assisting physicians and **taking low-acuity cases**

Physicians
Practice at **top-of-license**, at a sustainably **more-productive rate**

Case in Brief: MetroHealth, University of Michigan Health

- 208-bed hospital and integrated health system in Michigan
- Increasing its physicians productivity from the 60th to the 75th percentile of MGMA productivity in order to take on more covered lives
- Transformed practice staffing so that RNs and MAs control the flow of patients, leaving physicians to focus on patient care
- For every 5,000 lives, practices on average have 1 RN, 5 providers[1], and 6-7 MAs[2]

1) Includes on average 2 physicians and 2-3 advanced practitioners.
2) On average a practice has 2 medical assistants for every physician.

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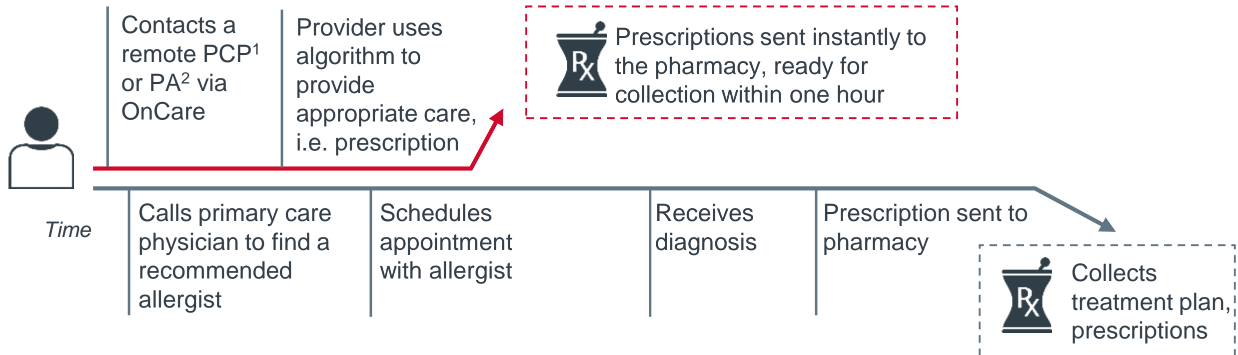
Source: Health Care Advisory Board interviews and analysis.

Striving for Automation

Platform Virtually Eliminates Provider Interactions

Fairview Dramatically Reduces Time to Treatment



Fairview Health Services

- 7-hospital system, based in Minneapolis, MN
- Partnered with Zipnosis to create OnCare, an online virtual care platform to provide 24/7 online diagnoses and treatment for low-acuity health needs
- Offers prescriptions for common ailments, such allergies, strep throat, and UTIs[3], as needed

1) Primary care physician.
2) Physician assistant.
3) Urinary tract infection.

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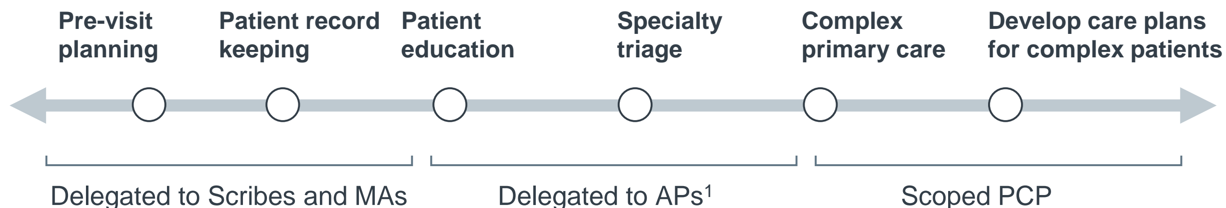
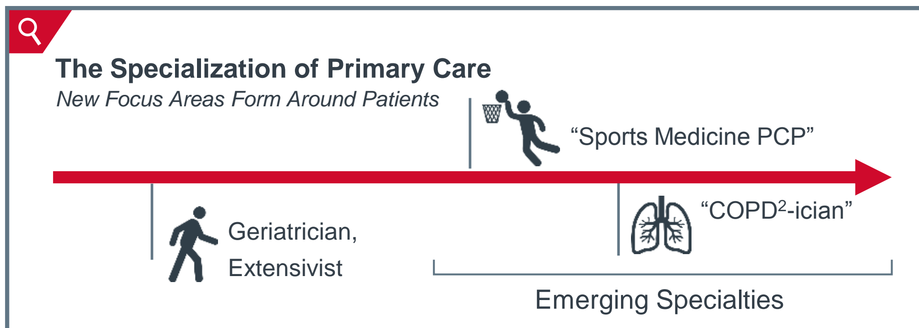
Source: Health Care Advisory Board interviews and analysis.

Rewriting the PCP Role

Targeted Focus Drives Top-of-Impact Care

Spectrum of PCP Responsibilities





1) Advanced practitioner.
2) Chronic obstructive pulmonary disorder.

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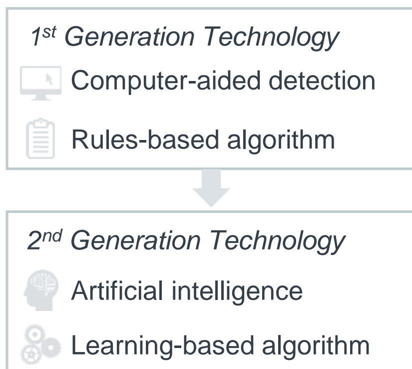
Source: Health Care Advisory Board interviews and analysis.

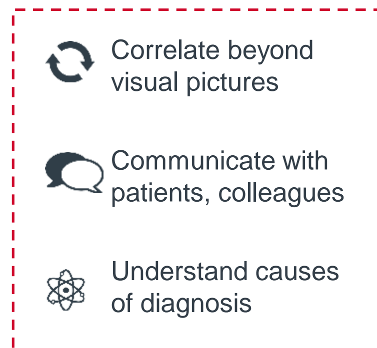
Technology Evolves from Detection to Deep Learning

Artificial Intelligence Provides Glimpse Into Future of Diagnosis

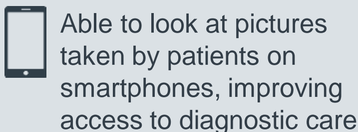
Existing Technology

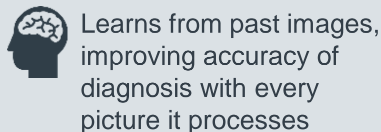


Future Technology



Deep Learning Improves Detection of Melanomas





96% Rate of accurate malignant samples diagnosis[1], outperforming dermatologists

1) In the same study, dermatologists were found to be 95% accurate.

Source: Andre et al, “Deep learning technology outperforms dermatologists at skin cancer classification .” *Nature* 542 (2017); Mukherjee, Siddhartha, “A.I. Versus .D.”, *New Yorker,* 017; Health Care Advisory Board interviews and analysis.

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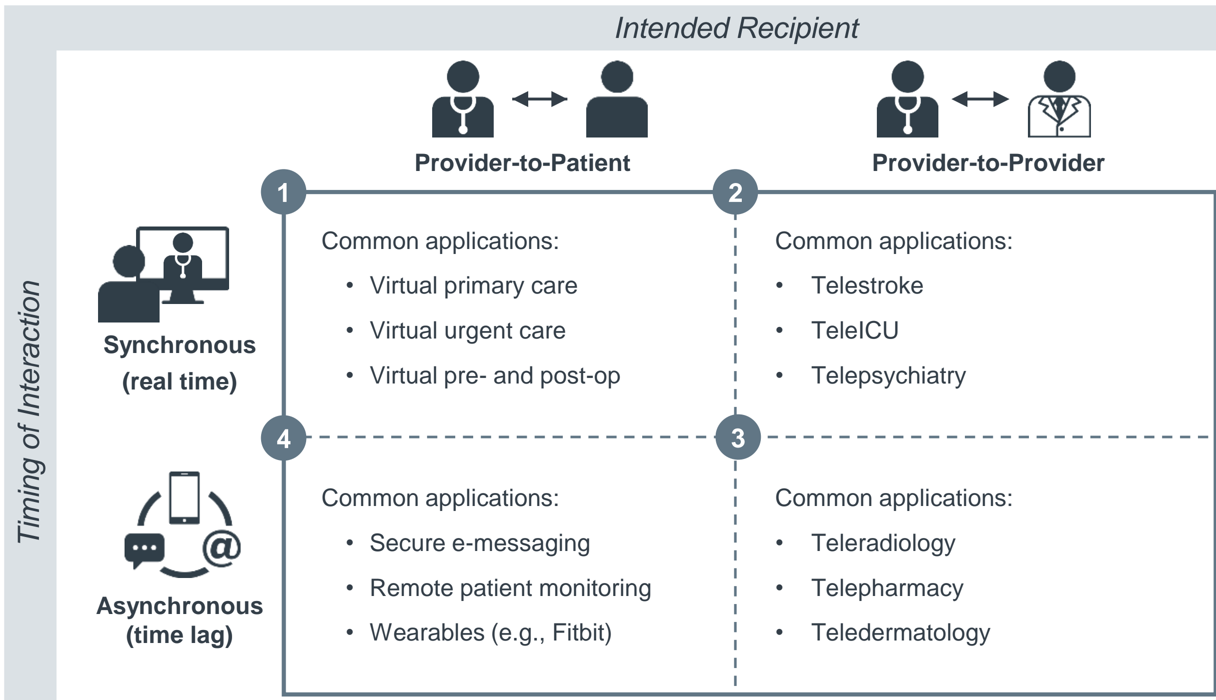
Telehealth is a Tool, Not a Strategy

Modalities Differ by Recipient and Timing of Service



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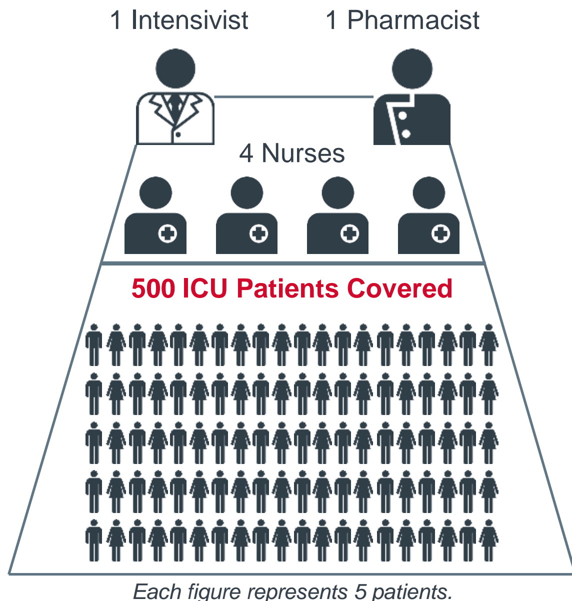
Source: Health Care Advisory Board interviews and analysis.

Virtually Distributing Intensivist Expertise

CHI Health Trims ICU Cost, Length of Stay With TeleICU

The Scalability of TeleICU Programs[1]



Each figure represents 5 patients.

"eFocus" Extends Reach, Delivers Results[2]

300,000	50%	$3M
Total ICU patients remotely managed	Decrease in ICU LOS	Total system savings

Case in Brief: CHI Health

- 15-hospital regional health network in Nebraska and Southern Iowa
- The teleICU program ("eFocus") was implemented after increased system-wide demand for intensivist staffing
- eFocus can cover up to 150 ICU beds in 12 hospitals, staffed around the clock by a multidisciplinary critical care team including physicians and nurses

1) King, N.. (2010).
2) Results since 2007.

Source: King, N., "Critical Care, Critical Choices: The Case for TeleICUs," *New England Healthcare Institute,* December 2010, Accessed 4 Dec 2015. Available at: http://www.nehi.net/writable/publication_files/file/teleicu_critical_care_critical_choices.pdf; Health Care Advisory Board interviews and analysis.

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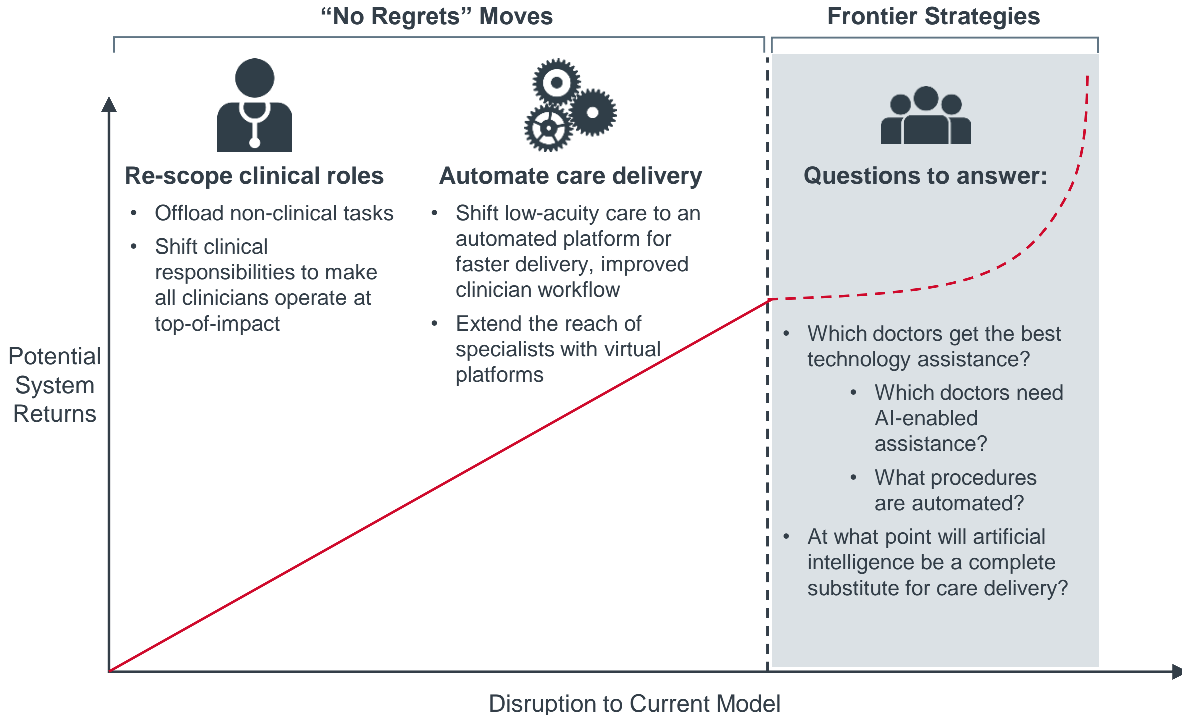
The Playbook for Maximizing Productivity

Prioritizing Investments Needed for True Organizational Change



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Source: Health Care Advisory Board interviews and analysis.

Key Takeaways

Transforming the Clinical Enterprise

1 **Actively curate and cultivate the clinical workforce; health systems can't assume the providers they have are the providers they need**

Health systems must regularly examine the composition of their physician networks and develop principled standards and processes for both adding and subtracting physicians. Market disruptions—especially MACRA—are enabling a rare moment of network reconfiguration.

2 **Strive for sustainable economic relationships with physicians; defer employment where possible and stabilize comp growth over time**

While health systems should attempt to partner with physicians without defaulting to employment, system-sponsored medical groups will continue to grow in size. Health systems must align compensation models with system strategy and actively work to manage long-term compensation growth.

3 **Improving physician productivity and eliminating burnout aren't mutually exclusive goals; the same tactics help advance both critical objectives**

Health systems often fear that productivity-focused initiatives will accelerate physician burnout. However, redesigning roles through labor and technology substitutions both maximizes productivity and addresses the root causes of physician burnout by letting doctors be doctors.

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Source: Health Care Advisory Board interviews and analysis.

1. The New Physician Partnership Mandate

2. Building the High-Performing Clinical Enterprise

3. Toward a New Physician Compact

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The High-Performing Clinical Enterprise

Designing the Efficient Clinical Engine

1 Enabling Cost-Conscious Care Delivery

Establish Expected Clinical Behaviors

1. Cost-driven care variation agenda
2. Implementation-focused clinical governance model

Translate Standards into Daily Practice

3. Refined rules-based environment
4. Meaningful accountability for participation and performance

Engineer a Reliable and Low-Cost Clinical Product

2 Transforming the Clinical Enterprise

Redesign the Clinical Engine

5. Principled network curation
6. Stabilized compensation structure
7. Productivity-enabling role redesign

Build a Cost-Efficient Clinical Workforce

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Source: Health Care Advisory Board interviews and analysis.

Rethinking Our Approach to Doctors

A New Physician Compact…

Old Compact				*New Compact*
Siloed knowledge				Collective wisdom
Complete autonomy				Group adherence
Individual contributors				High-performing teams
Financially privileged				Economically sustained
Subject of strategy				Instrument of success

…In Need of a New Physician

FLICKR

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Source: Health Care Advisory Board interviews and analysis.

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