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May 2022

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Quote of the Month

"The rise in U.S. medicine spending was largely driven by the increased availability of pandemic vaccines, boosters, and treatments....However, the $4 billion increase in OOP costs for patients matched the historical high previously seen in 2018, which is a trend we will need to continue to watch."

Murray Aitken, Senior Vice President and Executive Director, IQVIA Institute for Human Data Science

Healthsprocket

5 States with the Highest Average Mileage for Emergency Ground Ambulance Transport in 2020

1. 26.5% of hospital nurses reported being "floated" or reassigned to care for patients in a clinical care area that required new skills or was outside of their competency.
2. 46% of these reported that they did not receive any education or preparation before being floated to units outside of their expertise.

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Source: National Nurses United, April 14, 2022

Factoid

Amount of Physicians in The U.S. in 2019

- Emergency medicine physicians: 13,741

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Source: U.S. Census Bureau, March 2022

In This Issue

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Delivering Transparency to Health Insurance Enrollees

By Angie Fedderson, MBA, CPC, SelectHealth

A common healthcare frustration is getting the medical bill with surprising costs after receiving the care, procedure, or treatment. Out of fear of expensive care costs, it is not uncommon for people to either postpone medical treatment until their illness worsens to a dangerous, sometimes life-threatening state; forgo treatment altogether; or cut back on other essential expenses like food and housing to afford their healthcare costs. Medical care has become often unaffordable, and the decline in health is the regrettable outcome.

There are additional steps insurers can take to provide not only better cost transparency but medical clarity to enrollees that will help them make more informed health decisions.

Here are three ways SelectHealth, a nonprofit health insurer, works toward this goal.

Cost estimator tool. Providing simple health tools to enrollees helps them become active participants, alongside their healthcare provider, in their health journey. This tool gives enrollees the ability to search and review approximate medical costs associated with a variety of care and services. For example, before having a procedure or more expensive service, enrollees can navigate through their member portal to the Cost Estimator Tool. There, they can review the cost of the particular procedure or service at various facilities and with different healthcare providers.

Provider locator tool and provider reviews. Choosing the right provider can be difficult and stressful, and this decision-making often may delay care. After every visit with their healthcare provider, enrollees are allowed to review and offer feedback through comments about their experience. Providers are scored on a five-star rating system. When determining which provider to use through the Find a Doctor tool, enrollees easily see the associated star rating and can read positive and negative comments from real patients.

Value-based care focus. The traditional approach of fee-for-service, where healthcare providers are compensated based on the number of services provided, is an underlying reason for higher and more frequent medical bills hitting enrollees' accounts. The more recent shift to the fee-for-value model restructures this outdated model and pays healthcare providers based on the quality of service provided, patient satisfaction scores, and then total costs of care. This new model emphasizes healthcare providers delivering the right care at the right time, which reduces the use of costly services and prescriptions that may not be needed. SelectHealth partners with like-minded healthcare providers who see the importance of value-based care. These collaborations help keep care and services affordable (and accessible) for enrollees.

Transparency across the healthcare and health insurance industries is an important step in improving healthcare and adding to the value-based care initiative. Medical costs are often unexpected even with thoughtful planning. However, insurers and healthcare systems can become an advocate for their enrollees and patients by providing tools and adapting processes that drive medical cost transparency.

Angie Fedderson is SelectHealth's Director of Medical Review and Coding and has been with the company for 30 years. In her role, she ensures accurate billing and coding and that services are medically necessary.

@monthly | news round the web

Feature stories making news as reported from key web sites, and compiled by MCOL

Boston Children's Hospital trials AI to predict no-shows
A research team from Boston Children's Hospital has created an artificial intelligence model that can successfully predict the likelihood of a patient to miss appointments, according to an April 20 Nature study.
Becker's Hospital Review
April 28, 2022

CMS finalizes rule that calls for standardized plan options, network adequacy reviews for ACA exchanges
Insurers on the Affordable Care Act will have to develop standardized plan options and prepare for network adequacy audits on the law's insurance exchanges starting next year, according to a final rule.
FierceHealthcare
April 28, 2022

Probe finds Medicare Advantage plans deny needed care to tens of thousands
Medicare Advantage Organizations (MAOs) delayed or denied payments and services to patients, even when these requests met Medicare coverage rules, according to a report released by federal investigators on Thursday.
The Hill
April 28, 2022

Why focusing on behavioral health could give insurers a leg up on the competition
Mental and behavioral health conditions account for a growing segment of healthcare costs, and insurers have a significant opportunity to address these expenses and drive costs down overall, according to a new report.
FierceHealthcare
April 27, 2022

Permanent telehealth expansion could cost Medicare $25B over 1 decade
Permanent expansion of telehealth coverage could cost Medicare $25 billion over 10 years, even without increased use, according to a report released April 21 by the Committee for a Responsible Federal Budget.
Becker's Hospital Review
April 27, 2022

Employers are reevaluating health benefits amid tight labor market, survey finds
Facing worker recruitment and retention challenges in a tight labor market, almost two-thirds of U.S. organizations (64%) plan to boost efforts to address employee healthcare affordability over the next two years, a survey from Willis Towers Watson found.
Healthcare Dive
April 27, 2022

Healthcare M&A slowed in Q1 amid economic concerns, omicron impact
The healthcare sector turned cautious in the first three months of 2022, completing 34% fewer deals than in the fourth quarter of 2021, according to a report from KPMG.
Healthcare Dive
April 26, 2022

Majority of physicians say telehealth enables more comprehensive quality care
A survey conducted by the American Medical Association found that the vast majority of physician respondents say they're currently using telehealth – and many of those reporting a decrease say they're providing a mix of virtual and in-person care.
Healthcare IT News
April 25, 2022

Taxing hospitals for high prices could curb costs, study suggests
A study published April 25 in Health Affairs suggests taxing as a tool for policymakers to address high healthcare prices.
Becker's Hospital Review
April 25, 2022

Covid was third-leading cause of death in U.S. once again in 2021
For the second year in a row, Covid was the third-leading cause of death in the U.S., according to a Centers for Disease Control and Prevention report released Friday. Covid was the underlying cause of more than 415,000 deaths in 2021, or 13 percent of the national total, the report found.
NBC News
April 22, 2022

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Entry from MCOLBlog.com, appeared in last month's MCOL Weekend e-newsletter

Strategic Prioritization and Deselection: Being transformative in the beginning stages of an endemic

By Dr. Seleem R. Choudhury, March 31, 2022

On the cusp of entering an endemic state, organizations are deciding what to turn their attention to "after COVID." Wise leaders will recognize that this is not as simple as carrying on with their pre-COVID strategies. No organization has been immune to the shockwave of disruption that the pandemic has caused (Lagasse, 2020). This is especially true in the healthcare field. Hospital staff and resources are strained from bearing the weight of pandemic changes and regulations as well as the loss of skilled staff in the Great Resignation. You simply cannot "pick up where you left off" strategically when your workforce—the essential piece to actually accomplishing any strategy—is burned out and struggling. Something has to give.

Traditionally, at the beginning of a strategic planning activity, the organization establishes a vision focusing on the desired future state. This future state is usually based upon understanding the current state, forecasting, and looking for opportunities to excel among a playing field that is familiar. Yet today, the healthcare, business, chain supply, workforce, economic, governmental, state, and regulatory landscape is far from familiar. The past two years have been an extended "strategic resilience test" of sorts (Diedrich, Northcote, Röder, & Sauer-Sidor, 2021). While all organizations understand the importance of strategic planning and implementation, only those with high levels of situational awareness will thrive post-COVID. Put simply, situational awareness is "knowing exactly who you are, where you are, where you are going, and how you will get there, within your rapidly changing environment" (Afterburner Team, 2022).

Situational awareness requires a dynamic review not just of your strengths as an organization, but your limitations within the current environment. In healthcare, a years-long pandemic and a decimated and tired workforce presents organizational limitations that demand organizations to rethink their old, all-ambitious strategic plan that requires numerous detailed sub-plans, resources, funding, and metrics. Instead, the strategic plan needs to be narrowed, unifying, well-paced, and focused. Today, the biggest strategic decision for healthcare institutions will require boldness, but it isn't about doing something *new*. Rather, it is about doing something *less.*

"Strategic deselection"

The landscape we find ourselves in is unfamiliar. While healthcare organizations could push through and aim to succeed in their myriad pre-pandemic priorities, this transition period from pandemic to endemic is an opportunity to consider what would be most advantageous to focus on, what needs to be done and what does not. This is an opportunity to *prioritize* and *deselect*, rather than to add.

Sg2, a healthcare consultancy company that focuses on healthcare trends and unique solutions, states:

"The ability to prioritize the most impactful initiatives the organization is positioned to execute over the short-term, while simultaneously deselecting those that could derail it, will be essential to ensure sustainability" (Sg2, 2018).

Often organizations do not have the ability to or see the benefit of pausing existing initiatives. A lack of "sunset" processes in many organizations make it difficult to determine when to retire a strategic plan (Hollister & Watkins, 2018)ollH. Deselection is about triaging the strategic plan, understanding that all tasks cannot possibly be saved based on existing capacity. This requires leadership willing to make difficult decisions about what needs to be discarded or paused to give only the top priority their full attention. A focus on only one to three key priorities will allow the organization to use limited resources well, and will give staff a chance to recharge by being attentive to and report on only a small number of priorities.

Define criteria for selection and deselection

It is normal behavior for organizations to focus more on what they need to do than the things they have already accomplished. This is called the "Zeigarnik effect." Psychologists describe it as a "psychological phenomenon describing a tendency to remember interrupted or incomplete tasks or events more easily than

(continued on next page)

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Strategic Prioritization and Deselection...continued

tasks that have been completed" (Good Therapy, 2016).

There are multiple tools and strategies that can help organizations overcome this tendency in order to have laser-like focus on only their most essential goals. A simple tool to aid strategic prioritization and deselection is a matrix. This tool can help an organization narrow their options "by systematically comparing choices through the selection, weighing, and application of criteria" (Public Health Foundation, 2022).

A prioritization matrix is often used with Six Sigma, and the above prioritization matrix breaks tasks out into two dimensions: "Do Now" and "Do Later," and "Crucial" and "Not Crucial." The matrix, once completed, can help illuminate what should be done, delayed, and deselected. Though simple in form, using the prioritization matrix effectively is hard work, requiring organizations to make difficult trade-offs and stop initiatives that were once enthusiastic about.

Stephen Covey is celebrated for his famous business quote: "The main thing is to keep the main thing the main thing" (Kruse, 2012). The concept sounds simple, but any leader knows that it is easier said than done. For an organization and its leaders, keeping in mind what strategies are primary, secondary, and which priorities rank lowest will help promote unity and confidence in decision-making (Rodenhizer, 2016).

Successful strategic implementation processes require the work and attention of employees and managers at all levels within a healthcare organization. The workforce is the main driver for implementation of strategy. Common business wisdom states that the more projects you do the less effective you become. "Staggering or postponing strategic imperatives" will reduce the number of projects handled at once, which effectively reduces the "number of projects per person" (Steyn, & Schnetler, 2015). Today, as healthcare organizations revisit their strategies, initiatives that include unlimited projects, ambitious milestones, and metrics success should be used judiciously, especially in the context of a distressed workforce.

Overload can result in "costly productivity and quality problems and employee burnout" (Hollister, & Watkins, 2018). Waves of healthcare and hospital workers have quit their jobs (or their entire profession) because of moral distress, exhaustion, compensation, poor treatment by their hospitals or patients, or some combination of these. These losses leave the remaining healthcare workers with "fewer trusted colleagues who speak in the same shorthand, less expertise to draw from, and more work" (Yong, 2022). It is critical for the health of our employees, and thereby the health of our organizations, that more strategies are minimized or deselected, and only the absolute necessities receive prioritization to move the organization forward.

Read more from Dr. Seleem Choudhury at seleemchoudhury.com

Resources:

Afterburner Team (2022). Three Ways to Improve Your Situational Awareness. Afterburner.

Diedrich, D., Northcote, N., Röder, T., & Sauer-Sidor, K. (2021). Strategic resilience during the COVID-19 crisis. McKinsey and Co.

Good Therapy (2016). Zeigarnik Effect. Good Therapy.

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Kruse, K. (2012). Stephen Covey: 10 Quotes That Can Change Your Life. Forbes.

Lagasse, J. (2020). COVID-19 is forcing rural hospitals to rethink their business models. Healthcare Finance News.

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Sg2 (2018). Transformative Planning: Strategic Prioritization and Deselection. Sg2.

Steyn, H., & Schnetler, R. (2015). Concurrent projects: How many can you handle?. *South African Journal of Industrial Engineering*, *26*(3), 96-109.

Yong, E. (2022). Hospitals Are in Serious Trouble. The Atlantic.

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Spring is Here and Medicare Advantage is in Full Bloom

MCOL Staff, April 7, 2022

Mark Farrah Associates has released their assessment of Medicare Advantage and Prescription Drug Plan performance, market share and market penetration as of March, 2022. They report that total MA membership exceeded 29.4 million and Medicare stand-alone PDPs covered over 23.4 million members. Year-over-year MA plan enrollment grew by 8.5%, and PDPs experienced a membership decrease of -3.4%.

MFA tells us that:

- Texas experienced the most sizeable year-over-year increase of over 172,000 MA members.
- Stand-alone PDPs continued to see a significant decrease of approximately 824,000 enrollees between March 1, 2021 and March 1, 2022.
- CVS, Centene, UnitedHealth, Humana and Cigna were the top five companies that dominate 88.5% of the PDP market.

  MFA reports that In the MA world, UnitedHealth in March 2022 holds the top position with 27.1% marketshare, followed by Humana with 17.4%, CVS Health with 10.7%, Anthem with 6.5% and Kaiser with 6.1%.

Also, here's the March 2022 MA/PDP Snapshot recently released by MCOL in HealthExecSnapshot:

Medicare Advantage / PDP Snapshot March 2022

	March 2022	February 2022	March 2021
Medicare Advantage	28,745,929	28,692,477	26,468,857
Other Prepaid	730,943	731,262	690,082
Total Prepaid Enrollees	29,476,872	29,423,739	27,158,939
Special Needs Plan Enrollees	4,662,136	4,611,124	3,876,679
% of Medicare Advantage	16.2%	16.1%	14.6%
Prepaid Plan with PDP	26,562,655	26,504,186	24,291,931
PDP Only	23,444,389	23,426,153	24,268,611
Prescription Drug Plan Enrollees	50,007,044	49,930,339	48,560,542
Prepaid with PDP / Total Prepaid	90.1%	90.1%	89.4%
PDP Only / Total PDP	46.9%	46.9%	50.0%
Employer Plan Prepaid Enrollees	5,195,637	5,196,274	5,022,682
% of Prepaid	17.6%	17.7%	18.5%
Employer Plan PDP Only	4,394,846	4,398,381	4,549,829
% of PDP Only	18.7%	18.8%	18.7%

	Change Prev Month	Change Prev Year
Total Prepaid Enrollees	53,133	2,264,800
Special Needs Plan Enrollees	51,012	734,445
Prescription Drug Plan Enrollees	76,705	1,369,797
Employer Plan Prepaid Enrollees	(637)	173,592
Employer Plan PDP Only	(3,535)	(151,448)

Source:

Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report

https://go.cms.gov/37fxz8L

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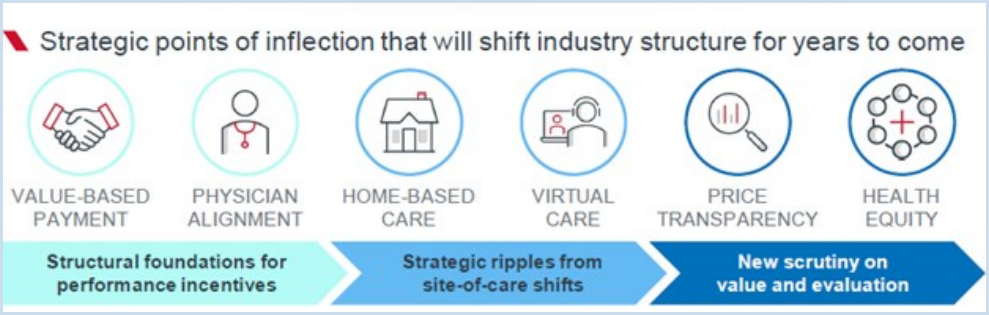
Catching up with Advisory Board's Ken Leonczyk on the State of the Health Plan Industry and what health plan leaders need to know for 2022

By Claire Thayer, April 11, 2022

The pandemic has had a significant impact on health plans and in many ways has been a catalyst for change across the healthcare industry. Recently, Ken Leonczyk, Executive Partner, Advisory joined us for a lively discussion on what health plans need to know about key structural shifts of the peri-pandemic period. Ken identifies these six strategic points of inflection that will shift industry structure in the years ahead.



Value-Based Payment

Risk-based payment models will continue to grow, but who participates is an open question. The pandemic has done little to shift long-standing barriers in hospital financial needs, but plans have made headway with independent physician groups. Plans must now think about how the growing array of models fit together in a complex ecosystem.

Physician Alignment

An array of non-hospital suitors—plans, private equity firms, service partners, and national groups—are aligning more closely with physicians through a variety of partnership models. While hospitals may lose power, plans need to prepare to navigate relationships with all manner of new stakeholders throughout physician networks.

Home-Based Care

The wave of investment in home-based care today, centered around start-up financing or grants, does not guarantee long-term, systemic change. The industry may exacerbate existing challenges around staffing supply, care fragmentation, and health inequities. Plans must weigh how their policies will impact network access and marginalized patients.

Virtual Care

Most of the pandemic's spike in virtual care came from traditional providers, but vendors are angling to transform their offerings to steal patient relationships— not just visits. As plans explore virtual-first products, they must ensure incentives are enough to influence consumers—and brace for fallout with local providers.

Price Transparency

The market will soon be inundated with an unprecedented level of pricing information, but disruption to historic practices will depend on the usability of the data. New vendors are emerging to parse and package the data for end users, so plans must prepare to clarify the broader context of their rates to members, purchasers, and providers.

Health Equity

The past few years brought health equity into stark focus, but to make true progress, leaders must cement equity as a business goal. As plans build equity goals into provider payments and care management actions, they must standardize data collection and analysis to generate evidence for sustainable interventions.

If you missed this informative webinar presentation, *State of the Health Plan Industry: Unpacking the potential impact for 2022 planning,* we invite you to watch this short webinar recap video here.

You can access the complimentary presentation slides presentation slides here and webinar video here. To continue the conversation with Ken Leonczyk and learn more about how Advisory Board is working with other health care organizations, drop him an email at healthplan@advisory.com.

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Value-Based Care and Care Coordination: Five Key Takeaways from WakeMed Key Community Care and UC San Diego Health

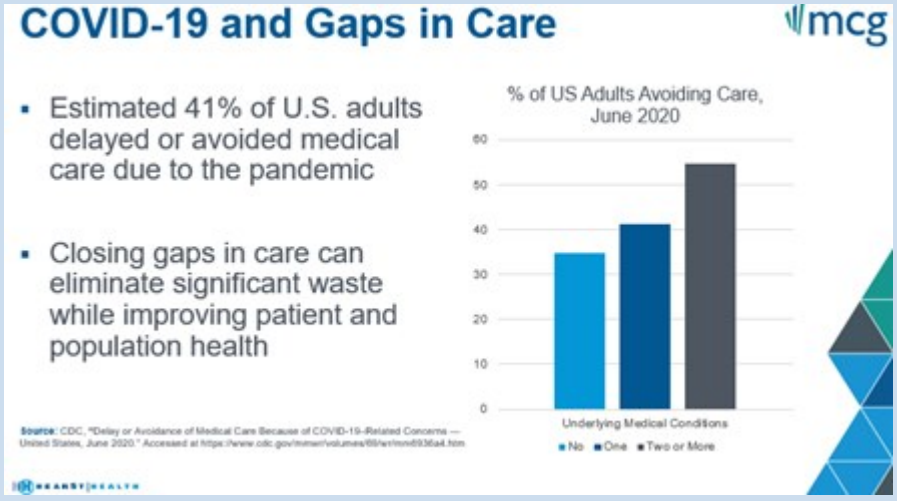
By Claire Thayer, April 12, 2022

Healthcare organizations face increasing pressures to meet demands of population health and effective care management. Recently, we hosted a panel discussion webinar, co-sponsored by MCG Health, that identified some of the challenges to delivering value-based care and how providers are leveraging MCG Health solutions for care coordination to develop high-quality care programs.

We caught up with speakers Lindsey Pierce, MSN, RN, CCN, Assistant Director, Population Health UC San Diego Health and Kathryn Tarquini, PhD, RN, CCM, Director, Clinical Services, WakeMed Key Community Care on five key takeaways:

1. How did COVID-19 impact your organizations?

According to the CDC, an estimated 41% of US adults with one underlying medical condition avoided seeking care in 2020. This number jumps to over 50% for people with two of more underlying medical conditions. The COVID-19 pandemic is at least partly to blame for these gaps.



Lindsey Pierce: During the pandemic, we saw that patients were either delaying care or switching over to telehealth visits, and they weren't being screened as adequately. Patients were also very scared and often socially isolated, so there was a further need to use MCG psychosocial assessments to address these new gaps. Like so many organizations, we also had issues with staffing. Nursing students were unable to graduate at a time when we needed nurses, so we took a twofold approach, and we started a nursing student clinical program with our population health team who contacted patients during this time.

Amid the pandemic, we were also starting new programs and making changes to better serve our patients, and it was difficult to get everyone aligned around the needed cultural change. This is something that takes time and it's important to remember to communicate the 'why' behind value-based care and make sure that your team understands it. Starting out, it took a little bit of time even for providers to understand that our care managers are part of the care team and we're here to help them. Using physician champions and patient advocates helped to break down those barriers, build rapport across the teams, and now every provider wants

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Value-Based Care and Care Coordination...continued

our team involved in the patient's care.

Kathryn Tarquini: One of the challenges we faced was launching a renewed service line - new teams, models, platforms, and tools - in early 2020, alongside the start of a pandemic. We learned to leverage our strong foundation built on the mission and vision of the ACO and the care management model. This meant we had to learn to engage virtually and build and strengthen relationships that way, using multimodal messaging to educate partners and providers about our service lines.

We also listened to what providers and practices were experiencing and needed, especially around the pandemic with things like vaccinations and other care interventions so we could provide solutions to address them when possible. Our technology platform and tools allow for transparency of our care management work, which also helped.

2. How is the transition to value-based care affecting your organization?

Lindsey Pierce: Overall the transition to value-based care has been a tremendously positive impact for UC San Diego Health (UCSD). It's allowed us to help drive some cultural changes that really benefit our patients, and it also gives us the opportunity to generate some revenue or share savings. We found that population health services have been at the forefront for helping to drive cultural change in strategy for value-based care, and we see that for interdisciplinary teams risk stratification and utilization oversight are essential to the success of the care program.

We began in 2016 as the organization started to shift towards growing our value-based contracts. We started in Medicare Shared Savings about three years ago and it helped us to expand and grow our network within San Diego, and we now have around 60% of insured lives under a value-based care arrangement. Before this shift, UCSD was performing significantly higher than the national average on hospital admissions per thousand. Over our three-year journey of aligning workflows, integrating technology, and improving processes, we've really been able to bring down avoidable hospital admissions to considerably below the national average.

For organizations who are starting out on this journey, it can seem like a difficult transition going from fee-for-service to value-based care. But at its core value-based care is simple, it's quality divided by cost, and this helps support high quality and cost effective care delivery. Through our population health services, we're able to provide wrap around services to our patients and that helps us to support high quality of care. I do think we'll see this more in the future in healthcare in the coming years and it's something that I'm excited to be a part of.

Kathryn Tarquini: WakeMed Key Community Care is an ACO formed in 2014 as a joint venture between WakeMed Health and Hospitals and the Key Physicians Group of independent physicians in the Raleigh, North Carolina area. These organizations came together because they realized the importance of delivering high quality care in a value-based care model. Since the ACO was formed eight years ago, our primary care physicians have come to understand the value of value-based care. They're now highly experienced and have become strong advocates for this model. In 2020, we brought all population health services in-house and this resulted in the formation of new centralized teams for care management – which is when we began using MCG and Arcadia for our care management needs. This has also helped us to provide higher quality care. The overall effect on the organization is based on the results that we've seen in quality, achieving and exceeding quality measures, being able to provide coordinated care, and using tools to proactively care for patients. Currently, there are also a variety of population health and quality initiatives within many departments of the hospital system that are value-based, such as hospital or home and navigator programs. We're working together to align some of these initiatives and connect the leaders to more formally collaborate and create some synergy for greater success.

3. What role have your technology partners played in supporting your transition to value-based care?

Kathryn Tarquini: Our primary partners that have made our program successful are MCG and Arcadia. These two partners have been critical to creating a strong foundation, and there's a lot of synergy that comes from the alignment and integration of these two. We use MCG guidelines for clinical decision support integrated into Arcadia's Care management platform to document, track, and manage the care management work and the care managers' workload – this is at the core of what we do with care management.

Arcadia also provides for our data analytics and management system and allows for data exchange with each

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Value-Based Care and Care Coordination...continued

other. We have close to 20 different EMRs in our ACO and so it collects and exchanges data with the EMRs to provide proactive tools. For example, a pre-visit planning tool to proactively manage risk and a predictive analytics tool using data from claims, the EMR and census data to identify those patients who are most likely to benefit from care management. The Arcadia platform also provides a way to see the status of quality measures – specifically which quality measures are completed and which ones have a gap – so that the practices can proactively address those by reaching out to patients. It promotes care coordination with the providers and the practice partners by allowing all members of the health care team to view all aspects of the care management process in real time.

The partnership with MCG supports the team with accurate and efficient assessment tools that are easy to read and follow, written in a conversational tone, and with many evidence-based assessment options to choose from. Using MCG also allows us to have standard work at the point of care, and this is especially helpful for our team with diverse experience and expertise. We have a multidisciplinary team of RNs and LCSWs, and what we call case management representatives. Using MCG ensures that everyone is deploying the evidence-based guidelines consistently, which leads to an efficient workflow and positive work experience.

Lindsey Pierce: It's important to have partners that understand your organization's vision and provide tools that allow the team to be organized, efficient and perform at the top of their clinical license. In 2021, we integrated MCG care guidelines into Epic Healthy Planet, and our team was involved from the very beginning. We had super users to make sure that the product worked efficiently. We also have health coaching through text message and remote blood pressure monitoring, so we've created really nice wrap around service for our patients.

With MCG's partnership, we refined and made sure the workflows were seamless, and it was great from a patient perspective as well. It was an absolute journey, but one of the things we always look for, whether it's the community partner and affiliated provider or vendor, it's making sure that you have a partner who's willing to work with you and reach the ultimate goal and is willing to adapt and change - in healthcare you have to be adaptable and willing to adjust as needed. We found that really great partnership with MCG. We got help and support every step of the way with our Epic super users and from our team who were working on integrating the assessments. In 2024, we're hoping to get population health accredited through NCQA, and I think that will be very well supported based upon the integration of MCG's assessments. Our text-based health coaching platform also uses MCG's education materials, so that's fantastic because the patients are hearing the same information consistently whether it's through the text messaging program or if we mail our educational materials. Building strategic partnerships with community organizations, network-affiliated providers, or vendors, it's really important that all are aligned to avoid duplication of services, waste, and coordinate a really seamless experience for our patients. That's something that we've certainly found through the relationships that we've developed with MCG and our other partners.

4. In what ways has predictive analytics helped your organization to improve patient outcomes?

Lindsey Pierce: It's important to have data analytics that identifies gaps in care opportunities, performs risk stratification and identifies patients most likely to benefit from the program, and turns patient clinical data into actionable information. I think oftentimes as we enter into more value-based care contracts, each will have nuances of the data analytics they're looking for. If you can synthesize down to one overarching goal, this can help to simplify a target for your care team, and that way your team members and providers aren't feeling confused about what they're working towards. We've done that with UC San Diego Health - simplified to just a few simple goals - and we apply them to all of our value-based care agreements and our team is really clear on what we're working towards. They're easy to measure, and it gives us a good place to work on process improvement. We focus primarily on one goal that's lowering all costs: hospital admissions per thousand. We do this because it's very well-defined, easy to measure, and is a metric where our team can make a direct impact. There might be some goals that you maybe don't have great data analytics on; even though it might be a good goal, if you can't share the outcomes, that can make that goal really difficult to work towards.

Kathryn Tarquini: We use data analytics in real-time and just-in-time opportunities to optimize care and proactively manage risk to drive population health management, and predict which patients are most likely to benefit from care management services. One tool that our practices use is the 'pre-visit planning tool,' which helps the care team identify quality care gaps and risk coding opportunities just before an office visit. So far,

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Value-Based Care and Care Coordination...continued

this has helped us achieve exceptional quality scores and lower readmission rates across numerous payers, and we've been able to distribute shared savings to participating providers each year. For example, between 2016 and 2019, we distributed nearly $120 million in shared savings from BCBSNC contracts alone.

5. What are some of the major milestones, key players, and successes you've seen implementing enterprise-wide value-based care model?

Lindsey Pierce: Key milestones were the development of our community network (community partnerships), growing our team and getting our workflows to be standards-based, along with integration with telemedicine to extend our reach without adding FTEs. We needed involvement from every level, physician champions, leadership, great vendors that can address gaps, and care managers. We found that having solid relationships with our network is one of the first steps we needed to take, and it was really important for us to regularly meet and facilitate goal alignment with that network. That way we were able to share performance milestones and make sure that every provider within the network understood the benefits and also the potential risk. We really focus on having our care team members work to the top of their licensed scope of practice and we also want to give them the tools to have a direct impact on process improvement for our team. We sent them all to LEAN 6 Sigma training and this just helps the team to understand the tools and resources on how to create change as you work towards standardized work in a new program. We joke all the time on our team that the only thing that's consistent is change because we're continually refining our workflows to be lean and patient-centered.

Kathryn Tarquini: There are two main factors that contribute to our success. The first is our providers, and the fact that we're a physician-led ACO. Our providers are experienced advocates for value-based care – and we have strong relationships with them and their practices. Our model places the patient/PCP relationship at the core of our work. Providers review patients who've been identified for care management by our predictive analytics, and when possible, they alert patients of our pending outreach.

Another factor contributing to our success is the compassionate and highly-skilled care management team we've assembled. We help them have a positive experience, professional fulfillment, and joy through this work by equipping them with MCG and other tools, educating them about strategies, skills and trends, and we problem-solve together. By creating a work environment that focuses on continuous quality improvement, fosters collaboration and innovation, and where it's safe to learn and grow from opportunities, we're able to fulfill our mission and deliver timely, high-quality care to our patients.

We've been seeing upwards of 50-70% engagement with patients through care management, and we have numerous patient stories demonstrating how the team has been able to make a difference in our patients' lives. We decided last year to reinvest shared savings to provide actual solutions to identify social determinants of health (SDOH)-related barriers. We've been excited to launch two initiatives this year, including a rideshare for transportation support, and a meal service for delivering medically-tailored meals to patients' homes. We are really looking forward to seeing some of the specific examples and impact that these and other interventions are having on our patients' health and their health outcomes.

If you missed this informative webinar, we invite you to watch this short recap video here. Additionally, below is a list of webinar supplemental material that may interest you:

MCG White Paper. Populations at Risk: Optimizing Post-Acute Care Management

On-Demand Physician Leader Webinar Series. Populations at Risk: Optimizing Post-Acute Care Management

MCG White Paper. Population Health: Engaging Patients to Improve Healthcare Outcomes

The MCG Guide to Efficient Care Coordination & Patient Throughput

@monthly | Blog

We Love Innovation. Don't We?

By Kim Bellard, April 22, 2022

America loves innovation. We prize creativity. We honor inventors. We are the nation of Thomas Edison, Henry Ford, Jonas Salk, Steve Jobs, and Stephen Spielberg, to name a few luminaries. Our intellectual property protection for all that innovation is the envy of the world.

But, as it turns out, maybe not so much. If there's any doubt, just look at our healthcare system.

Matt Richtel writes in *The New York Times* "We Have a Creativity Problem." He reports on research from Katz, et. alia that analyzes not just what we say about creative people, but our implicit impressions and biases about them. Long story short, we may say people are creative but that doesn't mean we like them or would want to hire them, and how creative we think they are depends on what they are creative about.

"People actually have strong associations between the concept of creativity and other negative associations like vomit and poison," Jack Goncalo, a business professor at the University of Illinois at Urbana-Champaign and the lead author on the new study, told Mr. Richtel.

Vomit and poison?

Well, at least our patent system, which protects intellectual property and helps fosters innovation, works, right? Again, not so much. A *New York Times* editorial charges: "The United States Patent and Trademark Office is in dire need of reform."

If there's any doubt, just look at the price of insulin, which has been propped up by patent "innovations" that keep its price high after a hundred years. "When it comes to protecting a drug monopoly," *The Times* says, not limiting those monopolies to insulin, "it seems no modification is too small."

The U.S. is still, by far, the leader in patents granted, but not in scientific research papers or R&D spending per capita/% of GDP, which makes one wonder what all those patents are for.

Healthcare desperately needs innovation. No one can dispute that; not anyone working in it, not anyone receiving care from it, not anyone who has had any exposure to it. But healthcare also has a lot of middle managers, and middlemen, and, as Professor Mueller said, "Novel ideas have almost no upside for a middle manager."

Even worse, healthcare is always teetering on the edge of uncertainty — where's the funding coming from, how much, what health crisis is coming, what's the government going to do next? The forces causing all that uncertainty should be driving innovation, but, as Professor Morrison's 2012 research also found, "… uncertainty also makes us less able to recognize creativity." We have blind spots about what creativity is, who creative people are, and when and how we should incorporate those into our organizations.

Right now, healthcare thinks that EHRs and digital health — whatever that might actually be — qualify as innovation. That's enough, it believes; those are forcing change in ways and at a pace healthcare is not used to and is not comfortable with.

Too bad.

It has been said that if your company has an innovation department, it's not innovative. If it has middle managers deciding which novel ideas get pursued, don't expect real innovation. If it is ruling out hiring people who worked on unusual projects (think sex toys), it's rejecting creativity.

Your biases against creativity may (not) be showing.

This post is an abridged version of the original posting in Medium. Please follow Kim on Medium and on Twitter (@kimbbellard)

@monthly | Factoids

Selected Factoids from the MCOL Daily Factoids e-newsletter

Amount of Physicians in The U.S. in 2019

- Emergency medicine physicians: 13,741
- Radiologists: 19,421
- Other Physicians: 698,316
- Surgeons: 48,495
- Physician assistants: 107,710
- Podiatrists: 7,568
- Audiologists: 14,517

Source: U.S. Census Bureau, March 2022

AMA: Doctors Committed to Telehealth

- More than 80% said patients have better access to care since using telehealth.
- 62% believe patients have higher satisfaction since offering telehealth.
- 60% agreed telehealth enabled them to provide high-quality care.
- 56% are motivated to increase telehealth use in their practices.
- 44% indicated that telehealth decreased the costs of care.

Source: AMA, April 1, 2022

@monthly | healthsprocket | HealthExecSnapshot

Selected healthsprocket lists from the healthsprocket.com

Fact Based List:

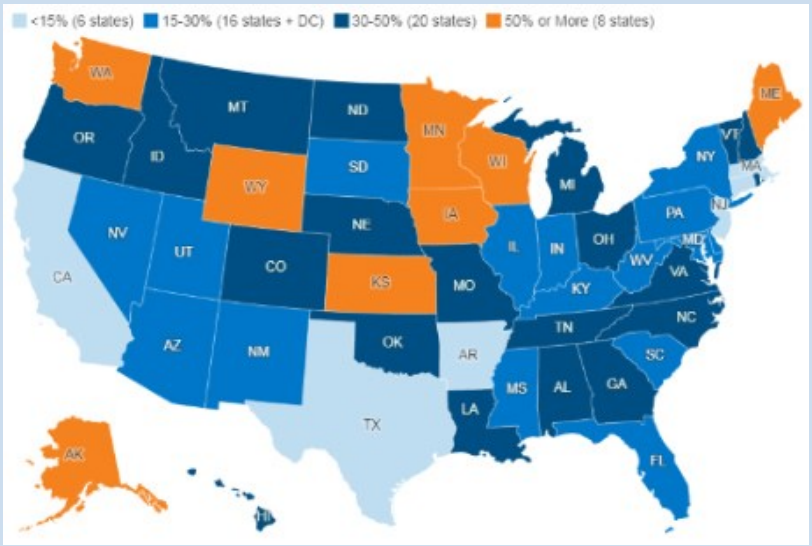
Sprocket: National Nurses United Survey: 7 Findings

1. 26.5% of hospital nurses reported being “floated” or reassigned to care for patients in a clinical care area that required new skills or was outside of their competency.
2. 46% of these reported that they did not receive any education or preparation before being floated to units outside of their expertise.
3. 64.5% reported that their facilities are using excessive overtime to staff units.
4. 72.3% reported an increase in the use of travel nurses in the prior month.
5. 48% reported a small or significant increase in workplace violence.
6. 83.5% feel stressed more often than before the pandemic.
7. 62% reported having to reuse single-use PPE, an unsafe practice.

Notes: Survey responses from 2,575 nurses, gathered from both NNU union nurses and nonunion nurses in all 50 states plus Washington, D.C., covering the period Feb. 2, 2022 to March 20, 2022.

Source: National Nurses United, April 14, 2022

Snapshot: KFF: Nursing Facility Staffing Shortages Vary Widely by State



According to a Kaiser Family Foundation issue brief, 28% of about 14,000 nursing facilities reporting nationwide indicated at least one staffing shortage during the week ending March 20, 2022. 26% of the nursing facilities reported aide shortages, 24% reported nursing shortages, 3% reported clinical staff shortages and 24% reported other staff shortages. In eight states, at least half of nursing facilities reported staffing shortages, including Alaska (80%), Minnesota (64%), Maine (59%), Kansas (58%), Wyoming (56%), Wisconsin (51%) and Iowa (51%). California and Connecticut reported the lowest level of staffing shortages, at 4% each. Texas, Arkansas, Massachusetts and New Jersey also reported staffing shortages below 15%. Nationally, the peak shortage of 34% occurred during the week ending January 23, 2022.

Notes: In Alaska and Arkansas, greater than 20% of nursing facilities did not report data and/or did not pass quality assurance and validation checks performed by the Centers for Medicare & Medicaid Services (CMS).

@monthly | Quoted

From MCOL's Quotes of the Week last month

"Healthcare cost projections are being made under uncertain conditions due to unexpected COVID-19 surges, unknown long-term impacts of the coronavirus on infected individuals, potential downstream effects of delayed and avoided care, and the ongoing labor shortages in the health care sector."

Dr. Janet Young , Lead Clinical Scientist - Data Sciences and Methodologies, Springbuk

"Although considerable uncertainty remains, the COVID-19 pandemic and public health emergency are expected to continue to influence the near-term outlook for national health spending and enrollment. Through 2024 health care use is expected to normalize after the declines observed in 2020, health insurance enrollments are assumed to evolve toward their prepandemic distributions, and the remaining federal supplemental funding is expected to wane. "

John A. Poisal, Deputy Director, National Health Statistics Group, Office of the Actuary, CMS

"Fresh off sharp declines in fee-for-service volumes last year, many clinical executives I work with are revisiting their value-based care strategy. Whether their organization is new to risk or an early adopter, I've been urging these executives to think practically about what these changes in the financing model mean for frontline clinicians."

Eliza Dailey, Research Consultant, Advisory Board

"The rise in U.S. medicine spending was largely driven by the increased availability of pandemic vaccines, boosters, and treatments....However, the $4 billion increase in OOP costs for patients matched the historical high previously seen in 2018, which is a trend we will need to continue to watch."

Murray Aitken, Senior Vice President and Executive Director, IQVIA Institute for Human Data Science

"The pandemic presented a real-life, real-time case study of provider-patient engagement and activation. Despite widespread patient preferences for more, the majority of doctors and health systems have not identified what that looks like or how to deliver it. That leaves Americans wanting their doctors to be their go-to, trusted resource for health information, but, in its absence, turning to less trusted resources, such as the media."

Mike Linnert, Founder and CEO, Actium Health