Can a Leakage Strategy Work for You?

Angela Wayne
Jeremy Tarr

Alex Ellsworth
Susan Boydell
# Agenda

## Getting Started
- Why focus on leakage

Samantha Boydell

## Building a Leakage Strategy into a New Program
- Where to start
- Measuring results

Alex Ellsworth
UHS, Inc.

## How a Large Physician Group Looks at Leakage
- How to look at and use data differently
- Preparing for the future of referral management
- Care Coordination strategies to consider

Angela Wayne
Jeremy Tarr
Beth Israel Deaconess HealthCare

## BREAK (10 minutes)

## Lessons Learn and What’s Next
- Challenges encountered
- Future strategies in development

Alex Ellsworth
Angela Wayne
Jeremy Tarr

## Wrap-Up and Questions

Everyone
Why a leakage strategy

Leakage or keepage?
Leakage or “keepage” or both?

- **LEAKAGE**
  - Volume you should have but don’t

- **Keepage**
  - Volume you currently have and want to keep

**Growth Opportunities**
How big is the problem?

only 35% to 45% of patient referrals ever reach the referred-to-clinic or hospital

Massachusetts Attorney General 2011 Study: Examination of Health Care Cost Trends and Cost Drivers
What Are the Most Important Criteria to Doctors in the Selection of Other Specialists That See Their Patients?

- Clinical expertise/quality: 92%
- How well they communicate with me: 84%
- Patient reports about their care delivery: 68%
- Easy access for my patients: 59%
- How quickly I can get my patients seen: 57%
- Recommendation from peers: 48%
- Hospital affiliation: 21%
- Training: 17%
- Years of experience: 14%

Where to look

1. Referral funnel
2. Ease of use
3. Lack of knowledge
Treatment options are expanding

Growth of specialties are growing rapidly between 1970 and today and when primary care doctors are overwhelmed with patient care, the time they have to learn about new sub-specialties is extremely limited.
A PCP Refers to a Specialist...

- 656 referrals per year
- 55 per month
- 3 per day
## PCP Referral Patterns

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Average Annual Referrals</th>
<th>Average Monthly Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>107</td>
<td>9</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>69</td>
<td>6</td>
</tr>
<tr>
<td>Cardiology</td>
<td>51</td>
<td>4</td>
</tr>
<tr>
<td>Urology</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>General Surgery</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>Neurology</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>Pain Management</td>
<td>29</td>
<td>2</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Oncology</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>252</td>
<td>21</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>656</strong></td>
<td><strong>55</strong></td>
</tr>
</tbody>
</table>
The downstream opportunity

37 referrals from primary care to orthopedics

- 74 office visits (initial and subsequent)
- 59 in-office diagnostics
- 21 office procedures
- 9.9 outpatient procedures/surgeries
- 3.3 inpatient procedures/surgeries
- 12 referrals out for diagnostics
- 7 referrals to other specialists (e.g., physical therapy, pain management)
Understanding the Referral Funnel

Secondary referrals are key in controlling leakage

PCP ➔ GI ➔ Colon Rectal Surgeon ➔ Oncologist

Where is it leaking?
Leakage: Understanding the Mammography Funnel

**National Average**

- **Screening Mammograms**
  - Ex. 12,000
- **Diagnostic Mammograms**
  - Ex. 3,000
  - 25%
- **Biopsies**
  - Ex. 600
  - 5%
- **Surgeries**
  - Ex. 210
  - 1.75%

**Hospital A**

- **Screening Mammograms**
  - 5,301
- **Diagnostic Mammograms**
  - 1,540
  - 29%
- **Biopsies**
  - 79
  - 1.5%
- **Surgeries**
  - 25
  - 0.47%

- 186 additional biopsies need to meet national average
- 68 additional surgeries need to meet national average
Where’s it leaking?

- Employed Physicians
  - Surgeons
  - PCP primary referrals
  - Secondary referrals
  - PCP’s
  - Specialists
  - Newly credentialed physicians
  - Office staff

- Care Continuum
  - Secondary referrals
  - ER/IP discharges
  - On-call surgeons
  - Transfer patients
  - High-aligned surgeons
  - Mid-aligned surgeons
  - Low and zero-aligned physicians

- Awareness
- Capacity
- Ease of Use

Leakage
Leakage Fundamentals

• **Access:** Timely appointments in convenient locations are a requirement

• **Service:** Patient’s make decision based on experience. Referring physicians want happy patients

• **Quality:** is expected and is an opportunity for differentiation

• **Awareness:** There’s no excuse for referring physicians not knowing what you have

“Fundamentally, referral leakage is a failure to be perceived as the best provider in a competitive environment” Dr. William K. Faber, CMO for Health Directions
Case Studies:
Leakage Strategies in a New Program

Alex Ellsworth
Director of Growth, Physician Relationship Management
UHS
Building a Leakage-Focused Culture in a New PRM Program

• Figure out how to identify leakage
• Motivate people to look for it on a regular basis
• Provide tools/resources to act on it
• Create measurement system to “prove” what we did
• Establish a self-sustaining process
UHS PRM Program

- Launched late 2013 (new!)
- Director hired Feb 2014
- CMA launched May 2014
- 20 PRMs: 1 per acute care facility (mostly)
- Direct report to local Bus Dev
- Dotted line to PRM Director at HQ

Mandate: Growth
UHS 2014 Results: Where Did Growth Come From?

Contribution

- Us!
- Other

PRM Works: The Right People, Process, and Tools

Chart metrics are not specific: for illustrative purposes only.
Three Starting Points For Leakage

• Macro
  – All PCPs in a geographical area – all service lines

• Mid-Level
  – Specific competitor, specific service lines

• Micro
  – Individual physicians
All Leakage In That Zip Code

All physician names, facilities, and dollar amounts are fictitious – courtesy of ABC
Macro:

- PRM National Meeting assignment: Each PRM create leakage report for their market
- Help drive PCP targeting
- Raised awareness
- Not specific enough to drive action

PCP leakage: PSA
288.7M – 88 PCP’s
Mid-Level: All Leakage In That Zip Code Going to Competitor X

TOTAL PCP LEAKAGE
$27.5M

OPPORTUNITY BREAKDOWN
1 Areas
1 Zip Codes
96 Physicians
3 Competitors

Top Primary Care Physicians
These are the top PCPs in your selected areas who are connected to your competitors.

- Johnna Silver $2.8M
- Curt Norby $1.5M
- Lonna Brautigam $1.5M
- Remaining Primary Care Physicians $21.5M

Primary Care Physicians
These are all the PCPs in your selected areas.

<table>
<thead>
<tr>
<th>PHYSICIAN</th>
<th>ADDRESS</th>
<th>EMPLOYMENT STATUS</th>
<th>PRIMARY COMPETITOR</th>
<th>SPECIALTY</th>
<th>PCP LEAKAGE</th>
<th>PCP MARKET SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnna Silver</td>
<td>Austin, TX, 78704</td>
<td>Not employ... us - Other</td>
<td>National St... Clinic East Hospital</td>
<td>Internal Medicine</td>
<td>$2.8M</td>
<td>41%</td>
</tr>
<tr>
<td>Curt Norby</td>
<td>Austin, TX, 78704</td>
<td>Not employ... JPMC West</td>
<td>National St... Clinic East Hospital</td>
<td>Internal Medicine</td>
<td>$1.6M</td>
<td>2%</td>
</tr>
<tr>
<td>Lonna Brautigam</td>
<td>Austin, TX, 78704</td>
<td>Not employ... dependent</td>
<td>Washington... Southeast Hospital</td>
<td>General &amp;... Family Practice</td>
<td>$1.5M</td>
<td>0%</td>
</tr>
<tr>
<td>Marcelino Moment</td>
<td>Austin, TX, 78704</td>
<td>Not employ... us - Other</td>
<td>National St... Clinic East Hospital</td>
<td>Internal Medicine</td>
<td>$1.2M</td>
<td>14%</td>
</tr>
</tbody>
</table>
All Cardiology Leakage Going To Competitor X

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**Top Primary Care Physicians**

These are the top PCPs in your selected areas who are connected to your competitors.

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Primary Competitor</th>
<th>POP Leakage</th>
<th>POP Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arlyne Santillippo</td>
<td>Internal Medicine</td>
<td>National St., Clinic East Hospital</td>
<td>$842K</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Johanna Silver</td>
<td>Internal Medicine</td>
<td>National St., Clinic East Hospital</td>
<td>$641K</td>
<td>20%</td>
</tr>
</tbody>
</table>

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**TOTAL PCP LEAKAGE**

$6.6M

**OPPORTUNITY BREAKDOWN**

- Areas: 1
- Zip Codes: 1
- Physicians: 88
- Competitors: 3
Data Filtering Process

• PCP leakage is just a list
• Manually remove:
  – Hospitalists
  – Employed by competitor
  – No opportunity at this time
  – Retired
• Best done in a group setting, real-time, while reviewing dataset
Leakage by Service Line, Going to Our Largest Competitor

- Broke out physician list by service line
- Focused on service lines contained within PRM Initiatives: GI, Onc, NS, Ortho
- Picked 15 PCPs/PRM (Jan 2015)
- Tracked quarterly
  - Visit volume and frequency
  - Patient volume of target specialty physicians
  - Leakage change (6 month lag in CMA)

### Table: Main Street Hospital vs. Competitor

<table>
<thead>
<tr>
<th>Competitor</th>
<th>Practice City</th>
<th>Sub Service Line</th>
<th>Main Street Hospital</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td></td>
<td>GI</td>
<td>$1,823,000</td>
<td></td>
</tr>
<tr>
<td>Jones</td>
<td></td>
<td>GI</td>
<td>$1,604,000</td>
<td></td>
</tr>
<tr>
<td>Anderson</td>
<td></td>
<td>GI</td>
<td>$1,400,007</td>
<td></td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Challenge: Data Is Directional

- CMA asserts 70%+ visibility based on patient claims
- Incomplete view of the market
- Time lag of 6 months makes it tough to evaluate real-time
- Imperfect, but actionable

Example: PCP in FL: $8MM of Leakage. Is it precise? Who care?
Micro-Strategy: Individual Physicians

• 2 PRMs uncover cardiology and GI opportunities
• Reviewing list of physicians who do not send us anything, or haven’t in a while
• Data sources used:
  – CMA list
  – OR/admit schedule
  – Physician practice website

Create a culture that reinforces this behavior. Hire people who instinctively know how to do this. It’s not just data, it’s attitude and skill set.
Example 1 - Dr. Smith: All-American Cardiology Partners

• Cardiologist in Main Street, USA
• Member of large multi-physician group
  Attracted attention because no attending activity with UHS
• Does not perform procedures – clinic based
• Directs referrals to facilities/physicians that he prefers
• Results: approximately 30+ elective cath procedures and ~5 heart surgeries – all incremental
Example 2 - Employed Physician
Dr. Jones: GI Specialist

- The best PRMs operate with a slight sense of paranoia:
  - Who else are our referral sources sending business to, besides us?
- Review CMA connections data
- Look at all physicians who share
  - At least 2 patients in a six month window
  - (somewhat) common diagnoses between those patients
- Disrupt someone else’s referral stream
A Peek Into GI Referral Sources

PCP  Smith, John  Refers to:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Physician Name</th>
<th>Connection Strength</th>
<th>Activity Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>Jones, Sara</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>GI</td>
<td>Bigstuff, Bob</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>GI</td>
<td>Happy, Heather</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>GI</td>
<td>...(7 other GI docs)</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>GI</td>
<td>Our Employed GI Doc</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

• This is like showing someone a blueprint of their house
  – The data might be public, but we should still be discreet
• Practice Manager contacted 3 PCPs later that week
• Received 10 additional referrals within a month

“Hey, they said they were sending us everything!”
What If We Don’t Have Tools To Estimate Market Activity?

• Block time
  – Utilization
  – Days/times at competitive facilities*

• Procedure trends
  – Vs. same qtr. prior year
  – Employed docs

• Dr. Smith’s referral coordinator
  – Ask them where the volume is going!
Who Can Go Out And Do This?

- Physician-based health care sales experience
- Can handle hospital service line complexity
- Interested in variable compensation
- UHS quarterly incentive plan:

<table>
<thead>
<tr>
<th>Category</th>
<th>Weighting</th>
<th>Why</th>
</tr>
</thead>
<tbody>
<tr>
<td>I/P and O/P Incremental Volume</td>
<td>&gt;50%</td>
<td>Fits with career profile</td>
</tr>
<tr>
<td>Visit Volume</td>
<td>&lt;25%</td>
<td>Reward activity, especially for new PRM</td>
</tr>
<tr>
<td>Overall Hospital Performance</td>
<td>&lt;25%</td>
<td>Tie to larger goal</td>
</tr>
</tbody>
</table>

Quarterly Bonus
PRM Profile of Success (so far)

• Delivers high visit volume (4+ per day)
• Conducts variety of visits
  – Physician -- Physician Staff
  – M.D.-M.D. -- Admin to M.D.
• Consistently pulls people out of the hospital to help drive business
• Effectively drives a process in the physician practice

Hire What You Know You Can’t Train For
Questions
Case Studies:
Care Coordination Strategies

Angela Wayne, Chief Operating Officer
Jeremy Tarr, Care Coordination Manager
Beth Israel Deaconess HealthCare
BIDHC Agenda

I. Introduction to healthcare in Boston, BIDHC and care coordination

II. Qualitative and quantitative data

III. Developing strategies

IV. Network built to support care coordination

V. Strategies to consider (afternoon session)
I. Introduction to Healthcare in Boston, BIDHC and Care Coordination

1928: Beth Israel Hospital

1922: Deaconess Hospital

1996: Beth Israel Deaconess Merger to form BIDMC
Boston’s Competitive Hospital Market

Selection of Harvard Medical School affiliated hospitals

• **Beth Israel Deaconess Network**
  – Beth Israel Deaconess Medical Center
  – Three community hospitals

• **Partners HealthCare**
  – Massachusetts General Hospital
  – Brigham and Women’s Hospital
  – Seven other hospitals

• **Specialty hospital competition in local area**
  – **BID clinical affiliates**
    • New England Baptist Hospital
    • Joslin Diabetes Center
  – **Other specialty hospitals**
    • Children’s Hospital Boston
    • Dana Farber Cancer Institute
Beth Israel Deaconess HealthCare

- 150 primary care providers (PCPs)
  - Over 100 employed Physicians
  - Over 40 employed Advanced Level Practitioners

- 40 practices
  - Broad geography: Located between New Hampshire and Cape Cod, divided into five regions

Image credit: http://wwp.greenwichmeantime.com
Care Coordination Guiding Principles

Image credit: www.ihi.org/

I. Intro to healthcare in Boston, BIDHC and care coordination
Care Coordination Talking Points

• When discussing the benefits of care coordination with a patient, the following points have been effective
  – Best care for our patients is coordinated within one network
  – Excellence of care provided by in-network specialists
  – Enhanced communication between PCP and BIDCO specialist
  – Patient satisfaction increases when care is well coordinated
  – PCPs and in-network specialists have a shared EMR
  – Increases our ability to “close the loop” on patients
  – Cost savings to patients when duplicate (out of network (OON) and then in-network) tests and scans are required
Care Coordination Meaning

• Synonyms: Care Retention, Network Utilization
• Antonyms: Leakage, Outmigration
Establishing Baseline Performance and Long-Term Stretch Goals

• Average retention for an employed group of PCPs is 60%
  – Varies depending on local market competition and service gaps within network
• Affiliated (not-employed) PCPs tend to have lower retention
• Determine a reasonable goal for your organization once baseline performance is established
Establishing SMART Short-Term Goals

• The “ask” needs to be reasonable
• Review performance by category of care
  – Inpatient admissions, outpatient procedures, radiology, ED visits and specialist consults
• Individual PCP performance goals
  – Challenge high opportunity PCPs with lower retention rates to increase to average rate by end of year

Image credit: http://studentsuccess.unc.edu
II. Qualitative and Quantitative Data

**Q:** Where to start?

**A:** Data should point you in the right direction

Image credit: [http://walkinginsunlight.com](http://walkinginsunlight.com)
Quantitative and Qualitative Data

• Claims data from risk contracts (ACO, AQC)
  – Same store comparisons
  – Exclude certain categories of care
  – PCP concerns of “misallocated” patients

• Referrals data
  – Real-time tracking

• Hospital reported data

• Interviews
  – PCPs
  – Practice Managers
  – Staff
  – Patients

Image credit: http://www.analyticshero.com
Maintaining Trust and Credibility

• Data helps start the conversation but is not the complete picture

• Data needs to be accurate and actionable

Image credit: http://credibility.weebly.com
Quantitative and Actionable Claims Data

• Three commercial insurers and Medicare ACO
• Dataset is a representative sample of a PCP’s panel
  – Most accurate data available
  – Determine what portion of your PCPs panel this represents
• Tracking PCP performance in three to five categories of care
  – Admissions, outpatient procedures, consult visits, ED visits and radiology
• Limitations
  – Rearview mirror (three month lag)
  – Does not include referring provider

Image credit: http://medcitynews.com
Sharing Data to Drive Change

- Un-blinding PCP reports provides transparency
- Sharing information leads to shared learning
  - Variation within practice and region
- Progression of un-blinding data
  - PCP only
  - Practice only
  - Hospital market
  - Entire network

Each dot represents a PCPs Retention Score

II. Qualitative and quantitative data
### Reporting Actionable Data

<table>
<thead>
<tr>
<th>PCP Group Name</th>
<th>Retention Score by Market and PCP</th>
<th>Legend</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS; HPHC; TUFTS; MEDICARE ACO; July 2013 - June 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PCP Information

<table>
<thead>
<tr>
<th>Home Hospital</th>
<th>PCP Name</th>
<th>Outpatient Procedures</th>
<th>Inpatient Elect. Med/Surg.</th>
<th>Specialist Visits</th>
<th>Retention Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IN OON Total % Retained</td>
<td>IN OON Total % Retained</td>
<td>IN OON Total % Retained</td>
<td></td>
</tr>
<tr>
<td>Boston</td>
<td>PCP1</td>
<td>88 16 104 85%</td>
<td>7 1 8 88%</td>
<td>754 223 977 77%</td>
<td>83%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP2</td>
<td>72 6 78 92%</td>
<td>9 1 10 90%</td>
<td>300 149 449 67%</td>
<td>83%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP3</td>
<td>71 3 74 96%</td>
<td>10 4 14 71%</td>
<td>395 89 484 82%</td>
<td>83%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP4</td>
<td>99 15 114 87%</td>
<td>10 2 12 83%</td>
<td>934 285 1219 77%</td>
<td>82%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP5</td>
<td>141 14 155 91%</td>
<td>13 4 17 76%</td>
<td>572 218 790 72%</td>
<td>80%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP6</td>
<td>139 22 161 86%</td>
<td>13 4 17 76%</td>
<td>603 193 796 76%</td>
<td>80%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP7</td>
<td>60 8 68 88%</td>
<td>9 3 12 75%</td>
<td>363 143 506 72%</td>
<td>78%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP8</td>
<td>182 21 203 90%</td>
<td>22 10 32 69%</td>
<td>1133 370 1503 75%</td>
<td>78%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP9</td>
<td>5 2 7 71%</td>
<td>1 0 1 69%</td>
<td>34 4 38 89%</td>
<td>77%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP10</td>
<td>30 4 34 88%</td>
<td>2 1 3 59%</td>
<td>133 29 162 82%</td>
<td>76%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP11</td>
<td>138 22 160 86%</td>
<td>10 3 13 77%</td>
<td>607 354 961 63%</td>
<td>75%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP12</td>
<td>104 21 125 83%</td>
<td>11 5 16 69%</td>
<td>725 263 988 73%</td>
<td>75%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP13</td>
<td>69 10 79 87%</td>
<td>9 4 13 69%</td>
<td>290 143 433 67%</td>
<td>75%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP14</td>
<td>188 51 239 79%</td>
<td>24 9 33 73%</td>
<td>813 327 1140 71%</td>
<td>74%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP15</td>
<td>31 12 43 72%</td>
<td>7 2 9 78%</td>
<td>202 85 287 70%</td>
<td>73%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP16</td>
<td>27 8 35 77%</td>
<td>1 0 1 69%</td>
<td>189 68 257 74%</td>
<td>73%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP17</td>
<td>133 25 158 84%</td>
<td>13 6 19 68%</td>
<td>651 327 978 67%</td>
<td>73%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP18</td>
<td>70 8 78 90%</td>
<td>4 3 7 57%</td>
<td>376 154 530 71%</td>
<td>73%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP19</td>
<td>35 9 44 80%</td>
<td>1 1 2 59%</td>
<td>161 43 204 79%</td>
<td>72%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP20</td>
<td>47 11 58 81%</td>
<td>4 2 6 67%</td>
<td>205 91 296 69%</td>
<td>72%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP21</td>
<td>64 19 83 77%</td>
<td>4 2 6 67%</td>
<td>450 179 629 72%</td>
<td>72%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP22</td>
<td>5 1 6 83%</td>
<td>0 0 0 59%</td>
<td>40 17 57 70%</td>
<td>71%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP23</td>
<td>38 14 52 73%</td>
<td>7 3 10 70%</td>
<td>195 88 283 69%</td>
<td>71%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP24</td>
<td>33 9 42 79%</td>
<td>3 2 5 60%</td>
<td>281 113 394 71%</td>
<td>70%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP25</td>
<td>130 23 153 85%</td>
<td>16 8 24 67%</td>
<td>553 420 973 57%</td>
<td>69%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP26</td>
<td>26 6 32 81%</td>
<td>2 2 4 50%</td>
<td>124 50 174 71%</td>
<td>68%</td>
</tr>
<tr>
<td>Boston</td>
<td>PCP27</td>
<td>30 7 37 81%</td>
<td>1 1 2 59%</td>
<td>206 127 333 62%</td>
<td>67%</td>
</tr>
</tbody>
</table>
Qualitative Data

• Obtain feedback from PCPs and staff

• Very useful information is gleaned from having conversations about individual patients and trends from the quantitative reporting

Image credit: http://free-power-point-templates.com
Access

• Measuring lead time to appointment by specialty
  – Urgent versus non-urgent appointments

• In-network hospital reported data
  – Identify opportunities to keep care in community
  – Add specialists to improve access
Care Transition Management

• Obtain out of network (OON) hospital inpatient discharge information to reduce readmission rates
• Obtain ED discharge information to schedule follow up appointments
• Review OON volume by provider and compare to claims data
III. Developing Strategies

Image credit: www.forbes.com
Strategy #1
Appointment Scheduling

• Qualitative data led us to focus on ease of access
  – Making in-network appointment scheduling easier as a means to improve care coordination
• No significant impact to specialist visit care coordination rates
  – Low patient usage (10-20%) of phones in the practice
  – Patients who utilized service would have stayed in-network regardless of program
• Data clearly highlighted patient frustrations and access challenges
• within our hospital scheduling process

Image credit: http://blog.revation.com
Strategy #2: Redirection

- Central insurance referral team must understand the benefits of care coordination
- Managed care coordinators educate patients on insurance product and networks
- Patients calling in after appointment are tracked and referral requirements letter sent to patient
- Care coordination advocates processing referrals (influence not control)
  - Benefits to patient (next slide)
  - Specialty-specific talking points

Up to 40% of patients request referral after appointment

Image credit: http://www.cardiocom.com
When Should a Patient be Engaged in a Care Coordination Conversation?

• Appropriate Out of Network (OON) Utilization
  – Prior relationship when disrupting the OON relationship could compromise the patient’s welfare
  – Service not offered in-network
  – PCP approved prior to patient calling central team
  – Second opinion (in certain instances)

• Opportunities to Redirect
  – Prior relationship does not mean active management
  – In-network access challenges
  – Patient preference
  – Referred by specialist
Initial Results of Centralized Referrals

Care Transitions (redirection) Rate

All Specialties (Goal – 10%)

- Depending on the services offered in your network, you may want to exclude specialties from your calculation
- Average Redirection Rate – 6%

---

III. Developing strategies
Initial Results of Centralized Referrals

Care Transitions (redirection) Rate

Focus Specialties (Goal 25%)

Note: Includes Cardiology/Cardiothoracic, GI, Hem/Onc and Orthopedics

- Average Focus Specialty Redirection Rate - 11%
Excel Based Referral Tracking Tool

### CARE COORDINATION - PATIENT REFERRAL AND REDIRECTION TRACKING TOOL

<table>
<thead>
<tr>
<th>Employee</th>
<th>#</th>
<th>REFERRAL REQUEST TYPE</th>
<th>DATE OF REFERRAL REQUEST</th>
<th>MRN</th>
<th>INSURANCE</th>
<th>PCP</th>
<th>SPECIALTY AREA</th>
<th>SPECIALIST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Emp. Name</td>
<td>1</td>
<td>FRONT DESK REQUEST</td>
<td>12/17/2014</td>
<td>000-00-00</td>
<td>Aetna</td>
<td>Enter PCP Name</td>
<td>Orthopedics</td>
<td>Arun Rammapa</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
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<td></td>
</tr>
</tbody>
</table>

### PT. REQ. IN OR OON?

<table>
<thead>
<tr>
<th>PT. ENDS IN OR OON?</th>
<th>WAS PATIENT REDIRECTED?</th>
<th>APPT. DATE</th>
<th>IF PATIENT WAS NOT REDIRECTED, REASON</th>
<th>NOTES</th>
<th>Days Before (After) Appointment [AUTO-CALCULATED]</th>
</tr>
</thead>
<tbody>
<tr>
<td>OON</td>
<td>Yes</td>
<td>9/15/2014</td>
<td>N/A, In-Network</td>
<td>SAMPLE</td>
<td>(89)</td>
</tr>
</tbody>
</table>

---

III. Developing strategies
IV. Network Built to Support Care Coordination
Setting Patient Expectations

• Care coordination letter provided to patient at first visit

• Insurance referral requests are submitted at least three business days prior to specialty appointment (if appointment is scheduled)

• Care coordination letter is sent to patient when practice receives notification that patient went OON for care
System Expectations

• Service gaps in the community are identified and transparent

• Specific action plans are developed to address service gaps
  – Specialists are actively recruited
  – Detailed care plans are developed for patients to go to neighboring communities or tertiary medical center

• Access and quality concerns are taken seriously and addressed timely
“Splitters”

- Identifying and addressing “splitters” who perform procedures at in-network and OON facilities
- Affiliated specialists with high OON volume: Conversation between PCP organization administration and “splitter” to discuss specific instances, overall referral volume and expectations
PCP Expectations

• If a PCP is not comfortable with care coordination conversations, PCP will attend relevant trainings
• Include care coordination in new provider orientation
• One-on-one meetings to discuss care coordination challenges and strategies
Supporting PCPs Efforts

- Promote in-network services
- Provide whitepapers and evidence of care coordination benefits to PCPs in doubt
- Survey PCPs about their care coordination challenges and make changes based on feedback
Simplifying In-Network Referrals

• Providers and staff are busy!
Make in-network referrals easy
  – Implement a pre-visit workflow whereby a list of all specialists a patient is seeing is provided to the PCP
  – Imbed in-network specialists within the same facility as the PCP practices
  – Specialist listing and information integrated into EMR
  – Direct booking of in-network specialty appointments
  – Access and quality feedback will be followed up on with hospital and specialty leadership before reporting back to PCP community on expected improvements
  – Keep all internal care coordination resources current and posted on intranet
Lessons Learned and What’s Next

Alex Ellsworth
Angela Wayne
Jeremy Tarr
Challenges

• How do we prove that business went up?
• ....and how do we know our team had something to do with it?
1: Proof of Volume Increase

- Compare Cerner quarterly I/P + O/P volume, YOY
- Isolate by facility
- Turn off admits/volume originating in ER
- Only include those physicians logged in CMA at 100% by PRM
- Identify PRM responsible for the region

Volume Went Up!
What Does “100%” Mean?

- Create a definition for each part of the sales cycle
- Introduction → Win logged
- Win logged = verification of incremental volume
- UHS has 7 stages between 10-100%
- Each PRM MUST attach a % to EVERY visit, in order for it to count
2: CMA Documentation Indicates Attention To Detail by PRM With the Physician

<table>
<thead>
<tr>
<th>Visit Notes in CMA</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had an extensive conversation with Dr. Smith at his office in X today...cardiologist with All-American and lives in X. He sees patients there M, T, Th and F and sees holds clinic in the X office in City Y on Wednesdays... - he is very conservative when it comes to invasive testing modalities... He <strong>does not perform any procedures</strong> (cath or interventions) anymore. He <strong>refers them to his partners</strong> and <strong>which specific cardiologist he refers to depends upon the patient's problem and the physician's expertise</strong>: he uses Jones 1, Jones2, and Jones 3 a lot. In terms of who he refers to for CVT surgery - for managed care patients with straightforward surgeries, he uses Dr. K at UHS, <strong>more complex cases go to Dr. B. All of his private insurance referrals for CVT go to Dr. L at Competitor X.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital preferences <strong>he does not send any patients to Competitor Y</strong> because of a) location b) it is dirty c) the nurses are grouchy. Outside of their insurance, the main factor in what hospital he directs his patients to is location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had dinner with Dr. Smith We <strong>discussed directing cardiology referrals to UHS from City X</strong> as well as the <strong>new ER group that is in place at competitor Z effective 8/15.</strong> He relayed he sent five patients to us last week as a result of our meetings, and will get me more detail to verify. Will meet with Dr. Smith again in one month.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>date 10/13/14 <strong>Lots of detail on preferences, history, how the referral decision is made</strong></td>
<td>11/20/14</td>
<td>Details that affect the physician decision</td>
</tr>
</tbody>
</table>

**Growth. Alignment.**

PRM Worked With Physician During That Time Period
We Had Something To Do With It!
Proof That PRM Contributed

Visit Volume By PRM: Pipeline Status for Time Period X

PRM marked this physician at 100%
During the quarter in question

100% Activity Logged - Won
10% Introduction
More Challenges

• Physicians who increase volume, but I/P are admitted via hospitalist
• Referral chain is complex
  – PCP → Specialist → Hospitalist
• Example:
  – PRM works with Dr. Smith PCP to redirect referrals to Neurologist Dr. Jones
  – Dr. Jones sends some candidates to Dr. K for Neurosurgery
  – Patient is admitted by hospitalist Dr. L

Now What?
How Good Is Your EMR Data Entry?

- Physician categories in Cerner
  - Admitting -- Attending -- Referring
  - Consulting -- Responsible Party

- Which one should the registrar capture?
- Which one tracks the leakage that PRM or hospital team reduced?

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Admit Physician</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q4 2014 Cases</td>
</tr>
<tr>
<td>Grand Total</td>
<td>Dr. Smith – hospitalist</td>
<td>400</td>
</tr>
</tbody>
</table>

How much of that 400 was incremental?
Micro Example

- Direct Admit program promotion in FL
- PCPs sent new incremental patients
- Admitted by one of 20 hospitalists….uh-oh…
- Check Cerner volume by MD category
  - Attending - no increase
  - Consulting – blank
  - Referring – incremental change!
    - From 3 physicians with most PRM visits
Two Ways To Improve Attribution Accuracy in Plugging Leakage

• Measure it more
• Make your team better
UHS 2015

- Assignment of top PCPs by leakage by service line
- Mandatory for all markets
- Integrate monthly surgical volume*
  - by facility, physician, I/P and O/P
- Skill set training 2x/month
  - Overcome objections
  - Referral coordinator: delivering value
  - Visit strategy and execution
  - Patient experience (quality)
  - Service line referral chain

Create a data-driven, skill set-building culture

*surgical volume being used by PRM locally, but not in a standardized, methodical way
Conclusion

• Hire the right field team who knows how to do this
• Compensate them for it: clearly, fairly, and quickly
• Use top down and bottom up strategies to identify leakage – pursue both
• Data: “don’t let the perfect be the enemy of the good
V. Strategies to Consider
Breaking Down Silos

• Impact of hospitalist movement
  – New provider orientation to include hospital orientation and tours
  – Specialist fairs
  – Bringing specialists to PCPs practice

• Collaborating with hospital leadership
  – Provide actionable data to hospital CEOs

Image credit: http://www.outstand.org
Local Specialist Listing

• If an online specialist directory is not available for your PCPs, manual listings will need to be created and should be available online.

• Listings should include relevant information to help the patient make the appointment and staff process the insurance referral.

• Listings should be reviewed and updated periodically to stay relevant.
Coaching Videos

• Transitioning a patient's care from an out-of-network provider to an in-network provider can be a difficult conversation.

• Consider developing a role play video with one of your care coordination champions and a patient in the exam room.

Image credit: [http://healthpromosolutions.com](http://healthpromosolutions.com)
Real-time Referral Tracking in the Practice

• Focus on high opportunity PCPs
  – Weekly reporting to executive leadership
Care Coordination Takeaways

1. Use quantitative data to start the discussion and qualitative information to direct your efforts

2. Select the strategies that will work well with your organization’s available resources and culture

3. A successful program requires engagement from everyone and is dependent upon working collaboratively across your network
Key Takeaways

Seek to Understand

Identify Opportunities

Quantify

Track and Report
5 steps to get you started

1. **Identify an area of potential leakage:** employed physicians, secondary referrals, ease of use barriers, care coordination...

2. **Gather data to establish a baseline and measure results:** use what you have and determine what additional data is needed

3. **Develop an action plan:** what activity needs to be done to learn more and reduce leakage

4. **Assign accountability:** who owns what and will be required to report results

5. **Measure:** celebrate wins! And continue to make improvements

Don’t take on the entire world of leakage!
People’s deep confidence in their judgments and abilities is often at odds with reality. Most people, for example, regard themselves as better-than-average drivers. The tendency toward overconfidence readily extends to business.

Harvard Business Review, The True Measures of Success, Michael J. Mauboussin
October 2012 Issue
Cost of referral leakage

What is it for your health system?

Every 1% of “KEEPAGE” = $1,000,000 in additional revenue for a health system

Data from Mission Point Health Systems
Questions?
Thank you!

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