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Can a Leakage Strategy Work for You?

Angela Wayne
Jeremy Tarr
Alex Ellsworth
Susan Boydell

Agenda

Getting Started • Why focus on leakage	Susan 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

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Why a leakage strategy

Leakage or keepage?

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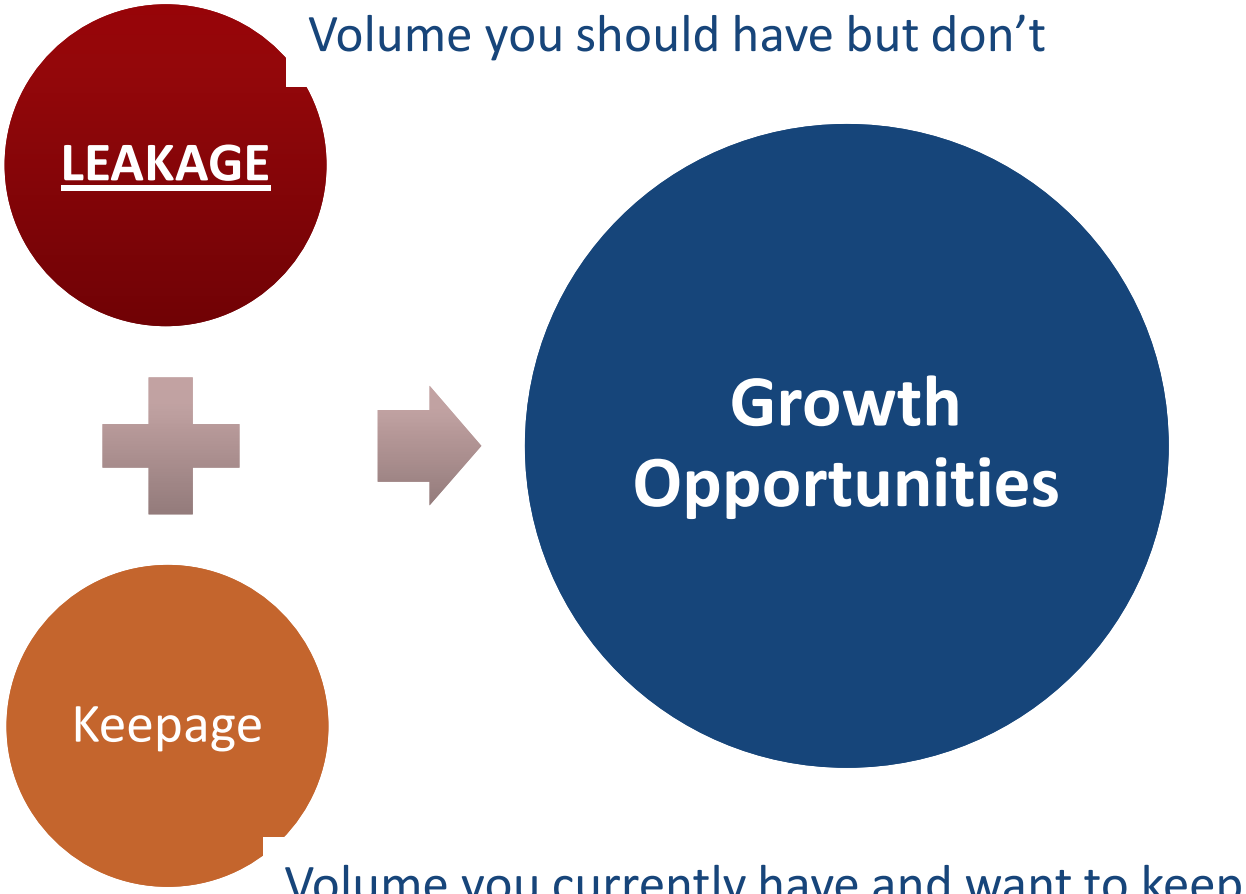
Leakage or “keepage” or both?



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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

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What Are the Most Important Criteria to Doctors in the Selection of Other Specialists That See Their Patients?

"The Complete Guide to Relationships…" HCPro, 2011, Kriss Barlow

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Where to look

1. Referral funnel
2. Ease of use
3. Lack of knowledge

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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.

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A PCP Refers to a Specialist…

- 656 referrals per year
- 55 per month
- 3 per day

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PCP Referral Patterns

Specialty	Average Annual Referrals	Average Monthly Referrals
GI	107	9
Orthopedics	69	6
Cardiology	51	4
Urology	36	3
General Surgery	34	3
Neurology	34	3
Pain Management	29	2
OB/GYN	14	1
Neurosurgery	11	1
Oncology	10	1
Vascular Surgery	9	1
Other	252	21
TOTAL	656	55

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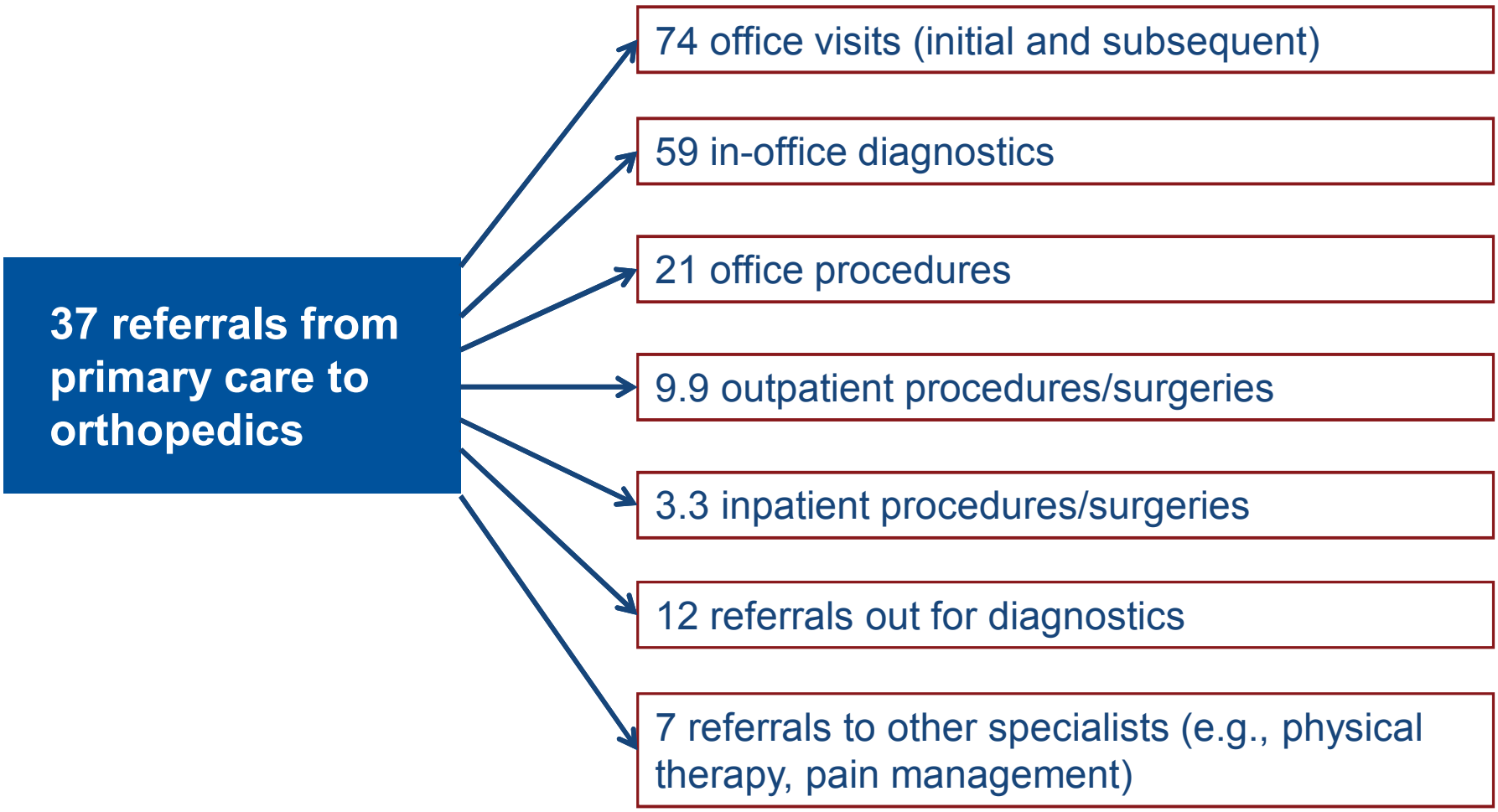
The downstream opportunity



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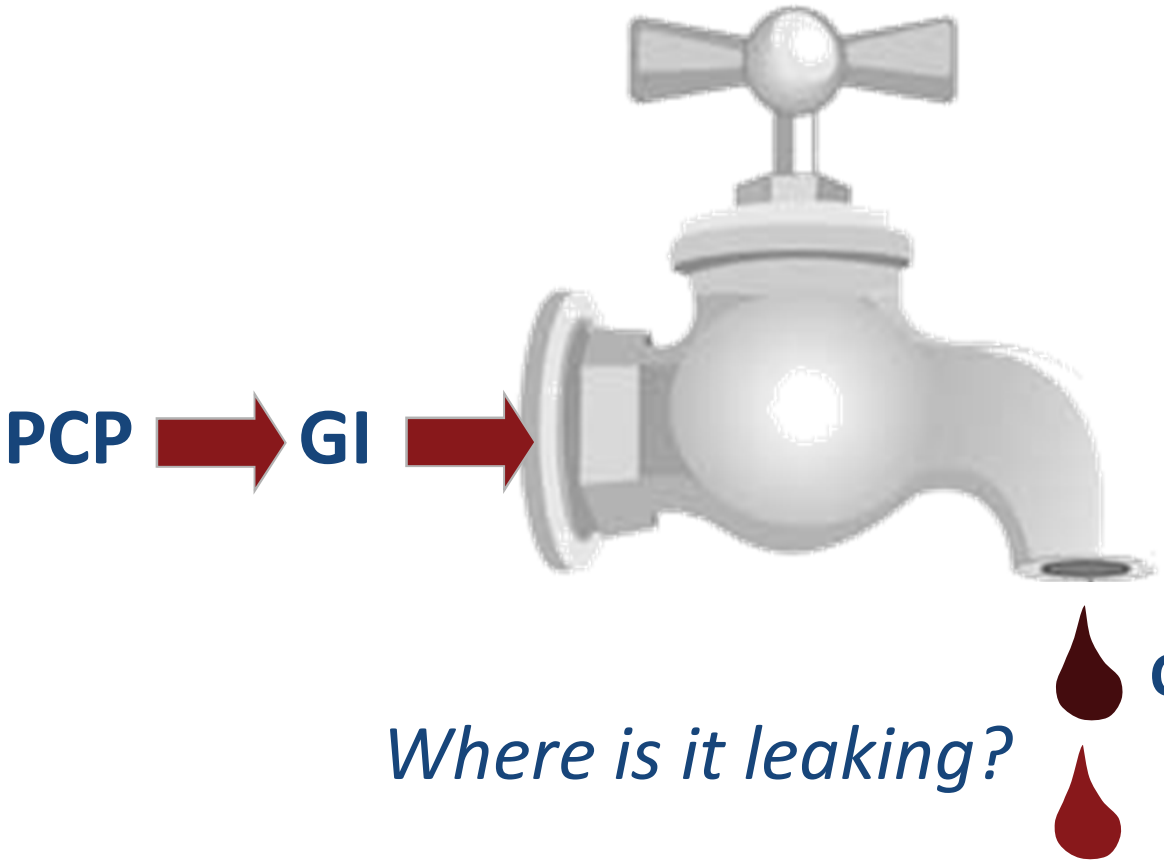
Understanding the Referral Funnel

Secondary referrals are key in controlling leakage



Where is it leaking?

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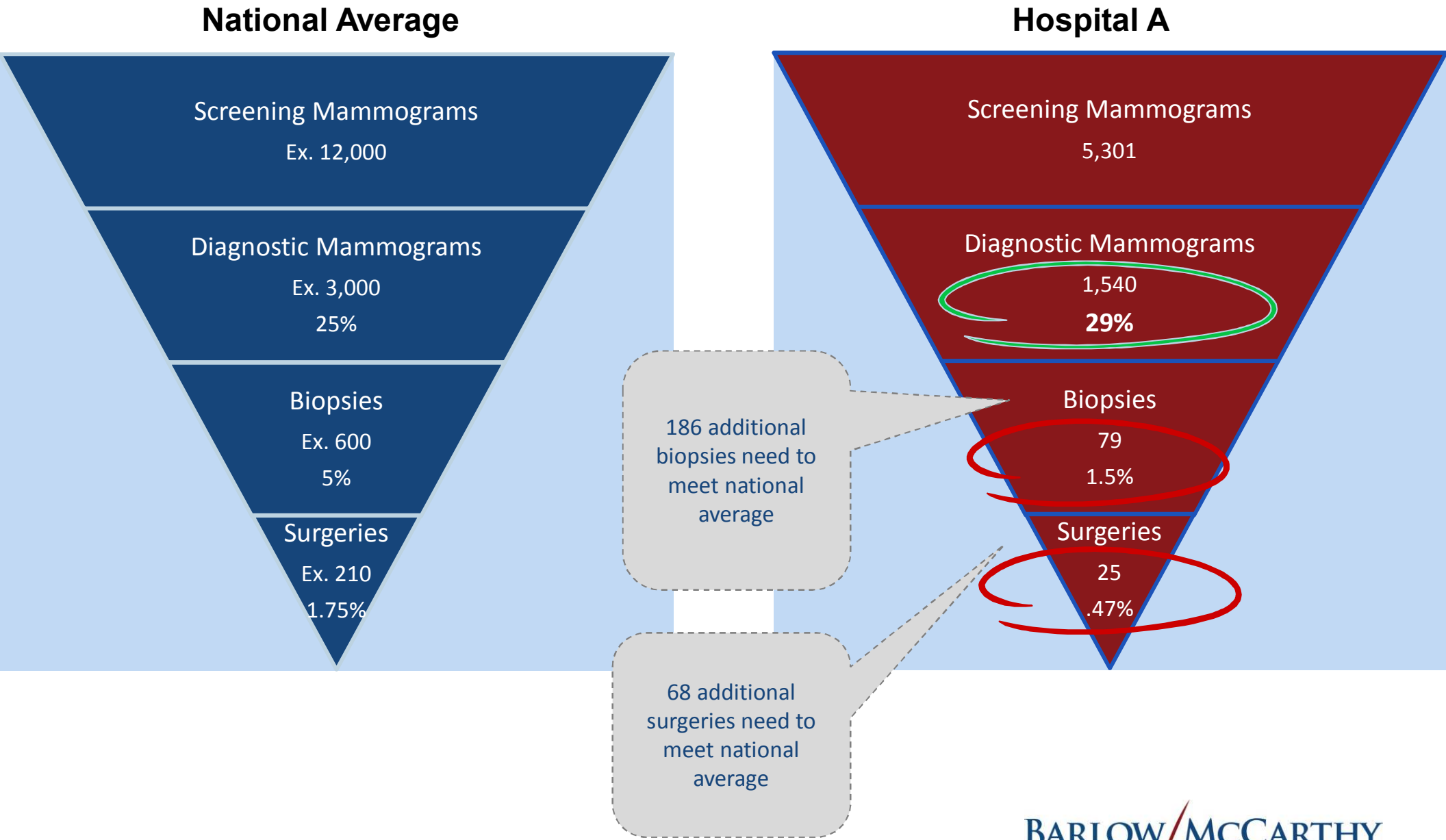
Leakage: Understanding the Mammography Funnel



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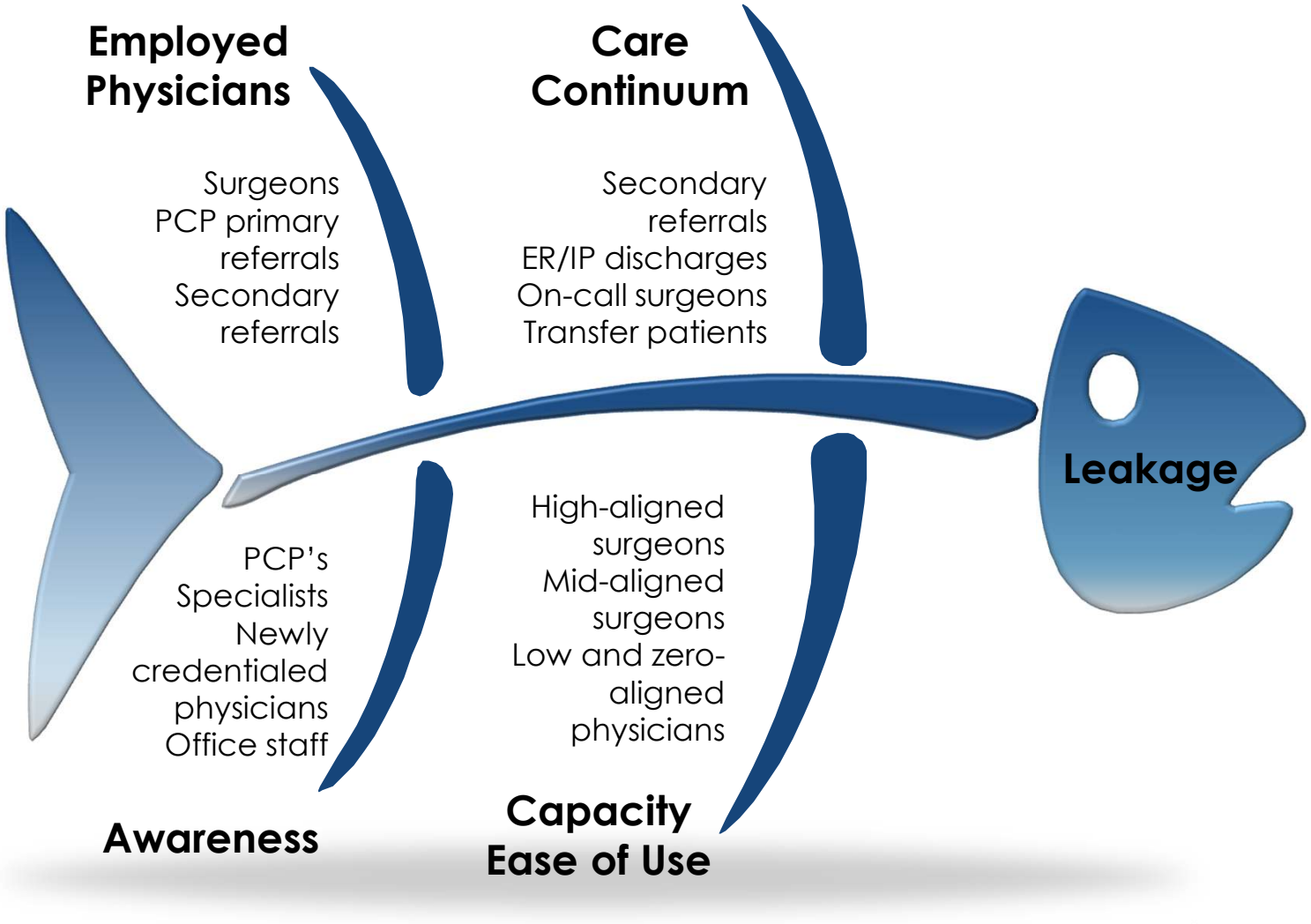
Where's it leaking?



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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

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Case Studies:
Leakage Strategies in a New Program

Alex Ellsworth
Director of Growth, Physician Relationship Management
UHS

UHS PRM Physician RELATIONSHIP MANAGEMENT

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

Growth. *Alignment.*

UHS PRM
Physician
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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

Growth.
Alignment.

UHS PRM Physician RELATIONSHIP MANAGEMENT

UHS 2014 Results: Where Did Growth Come From?

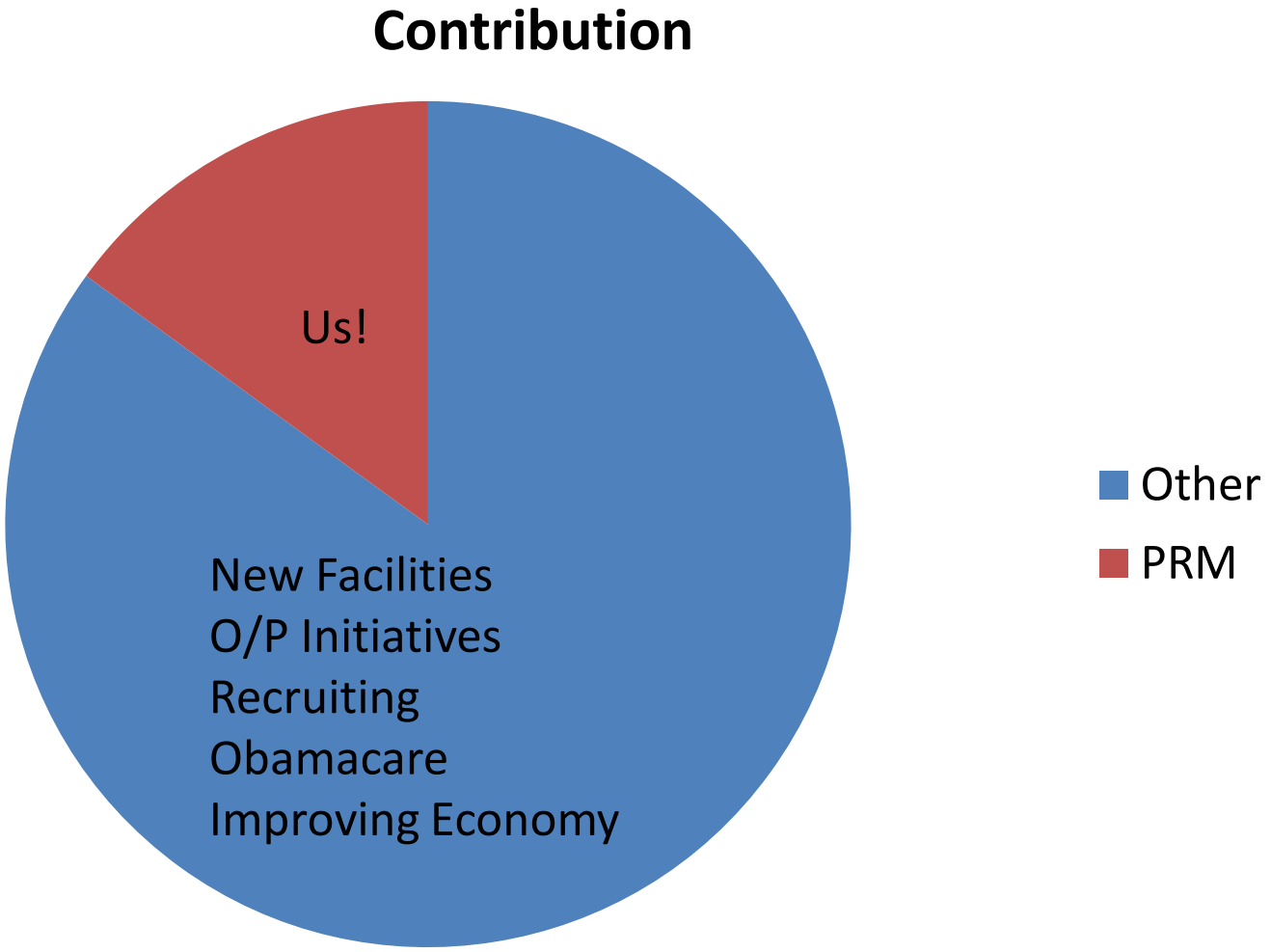

Chart metrics are not specific: for illustrative purposes only

PRM Works: The Right People, Process, and Tools

Growth. *Alignment.*

UHS PRM Physician RELATIONSHIP MANAGEMENT

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

Growth. *Alignment.*

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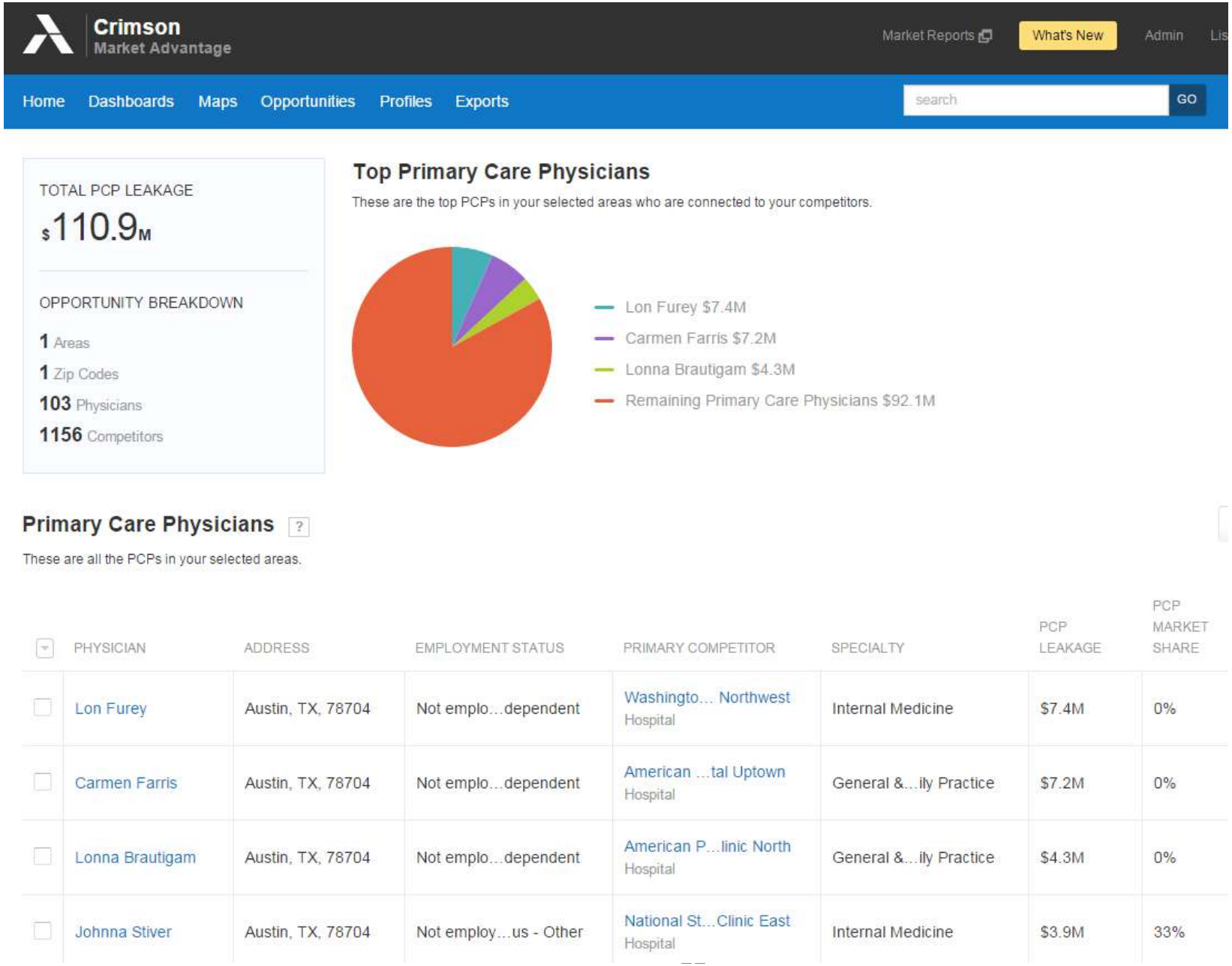
All Leakage In That Zip Code

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

Growth.
Alignment.



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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

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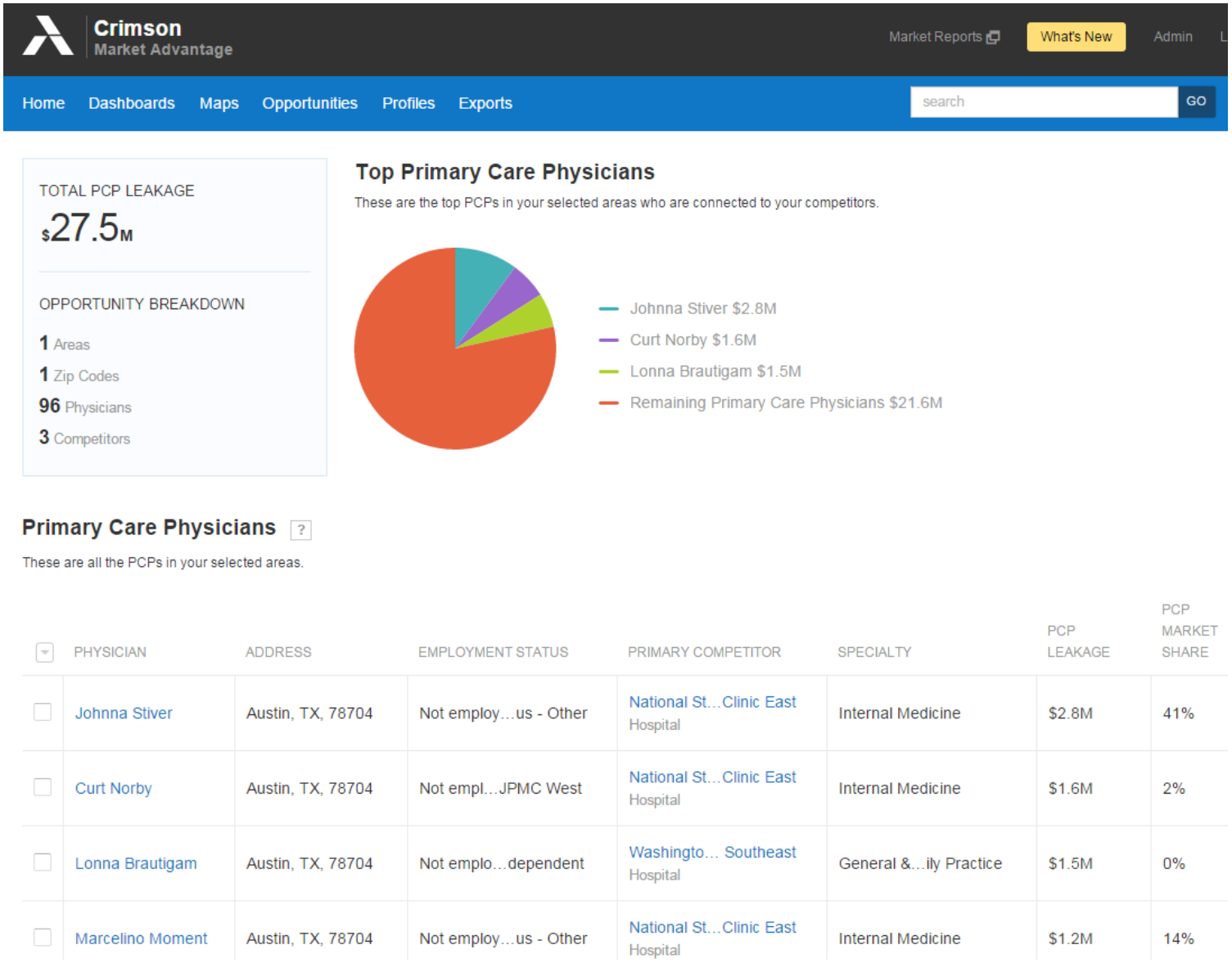
Mid-Level: All Leakage In That Zip Code Going to Competitor X



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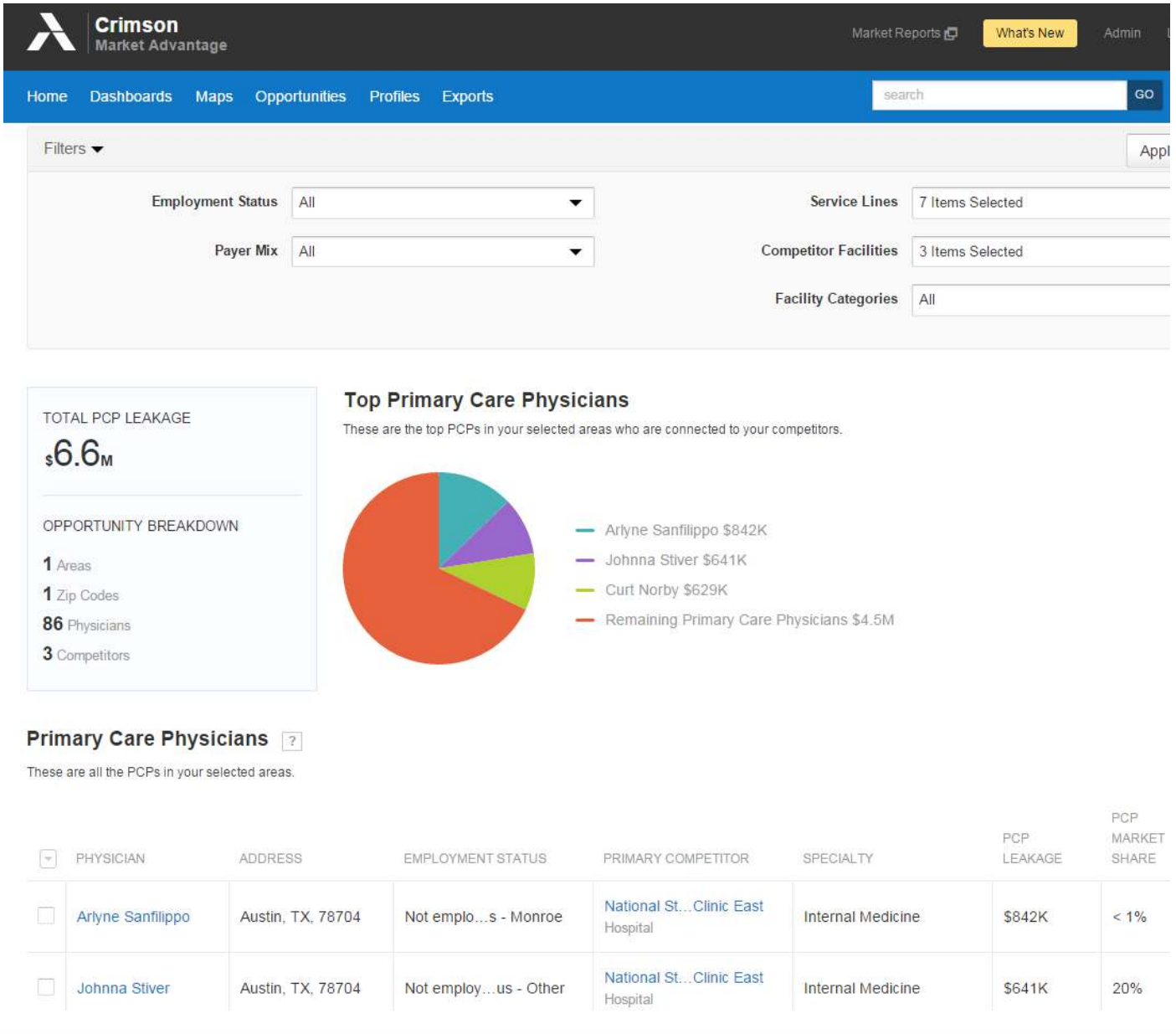
All Cardiology Leakage Going To Competitor X



Growth.
Alignment.

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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

Growth. *Alignment.*

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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)

Competitor	Main Street Hospital	
Practice City	All	
Sub Service Line	GI	
Smith	$	1,823,000
Jones	$	1,604,000
Anderson	$	1,400,007
…		

Growth. *Alignment.*

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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?

Growth. *Alignment.*

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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

Growth. *Alignment.*

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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

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UHS PRM Physician RELATIONSHIP MANAGEMENT

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

Practice Manager Becomes Force Multiplier for PRM
Equip Your Team With Technology…Focus and Coaching

UHS PRM Physician RELATIONSHIP MANAGEMENT

A Peek Into GI Referral Sources

PCP Smith, John Refers to:

Specialty	Physician Name	Connection Strength	Activity Strength
GI	Jones, Sara	7	9
GI	Bigstuff, Bob	6	8
GI	Happy, Heather	6	9
GI	…(7 other GI docs)	6	8
GI	Our Employed GI Doc	2	9

- 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!"

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UHS PRM Physician RELATIONSHIP MANAGEMENT

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!

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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:

Category	Weighting	Why
I/P and O/P Incremental Volume	>50%	Fits with career profile
Visit Volume	<25%	Reward activity, especially for new PRM
Overall Hospital Performance	<25%	Tie to larger goal

Quarterly Bonus

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UHS PRM Physician RELATIONSHIP MANAGEMENT

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
  - CEO Bus Dev Dept. Mgr.
- Effectively drives a process in the physician practice

Hire What You Know You Can't Train For

Growth. *Alignment.*

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Questions

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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

Beth Israel Deaconess HealthCare®

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

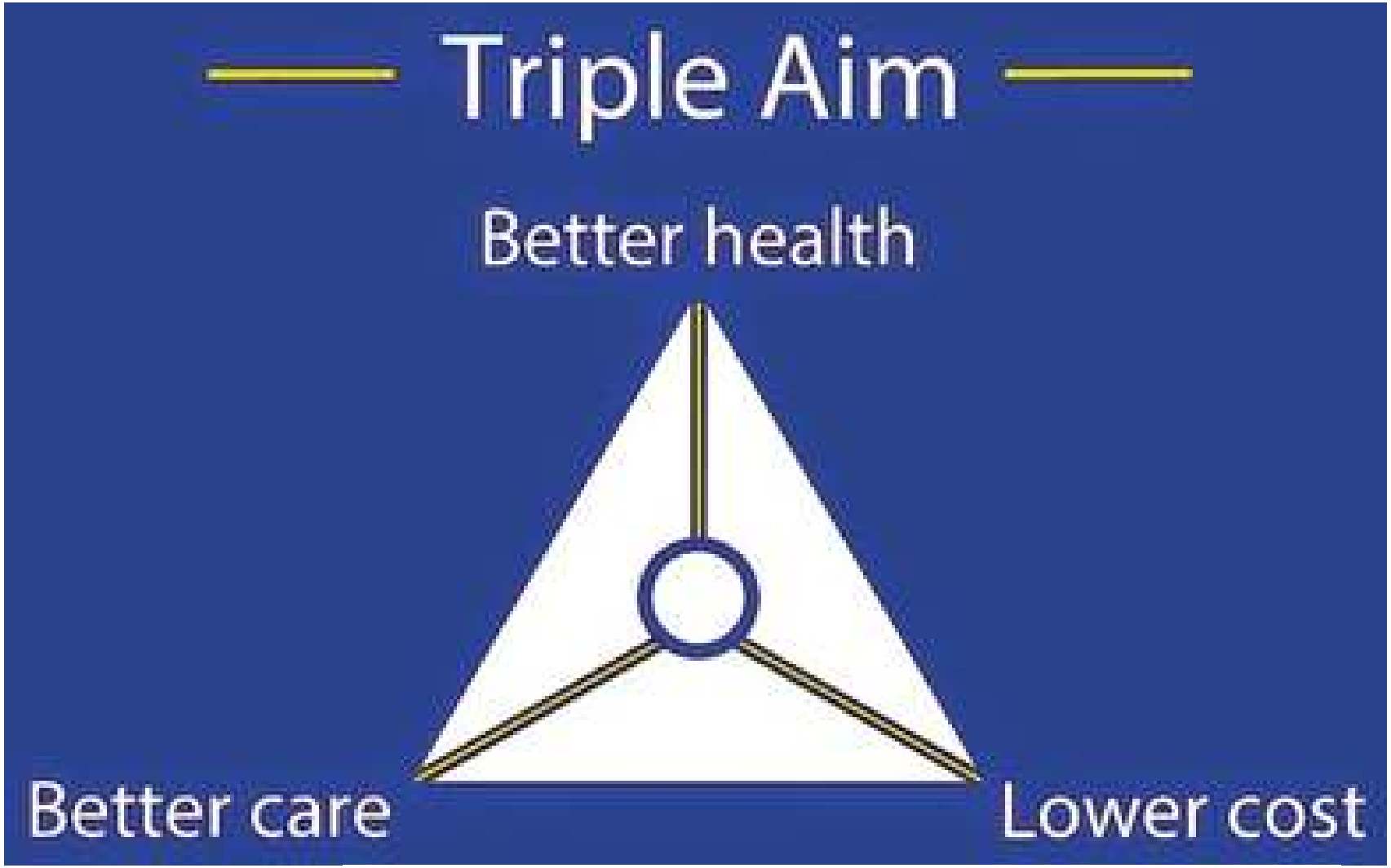


Image credit: www.ihi.org/

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

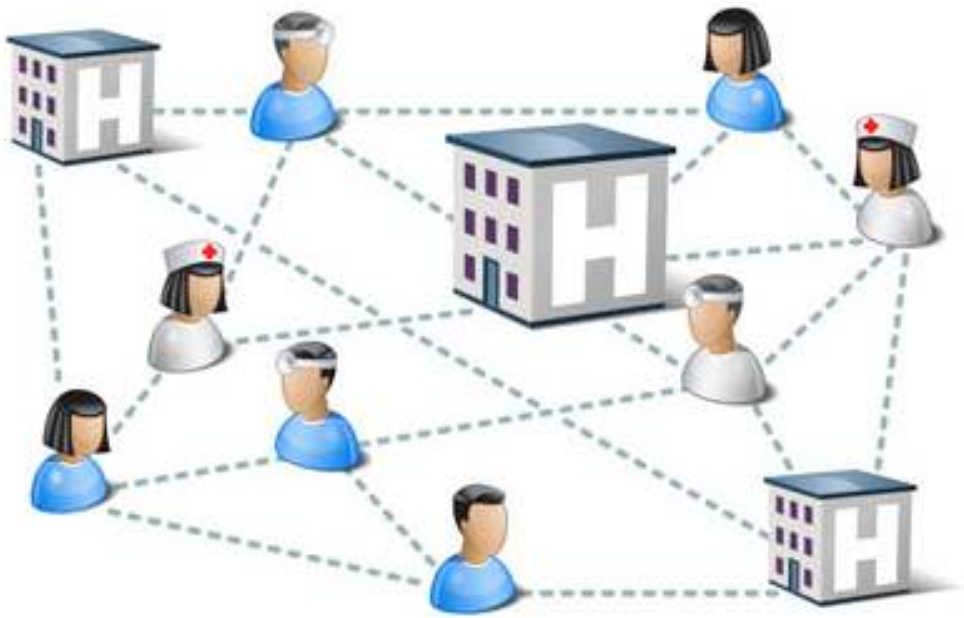


Image credit: https://www.linkedin.com

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

Image credit: http://studentsuccess.unc.edu

- 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

II. Qualitative and Quantitative Data

Q: Where to start?

A: Data should point you in the right direction

Image credit: 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

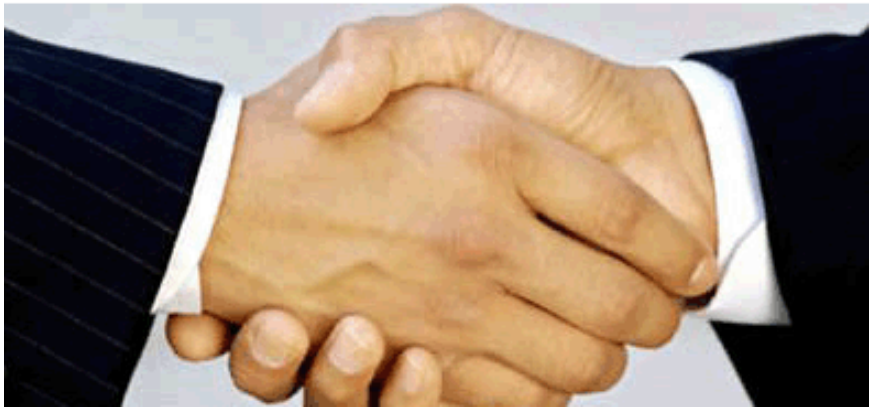


Image credit: http://credibility.weebly.com

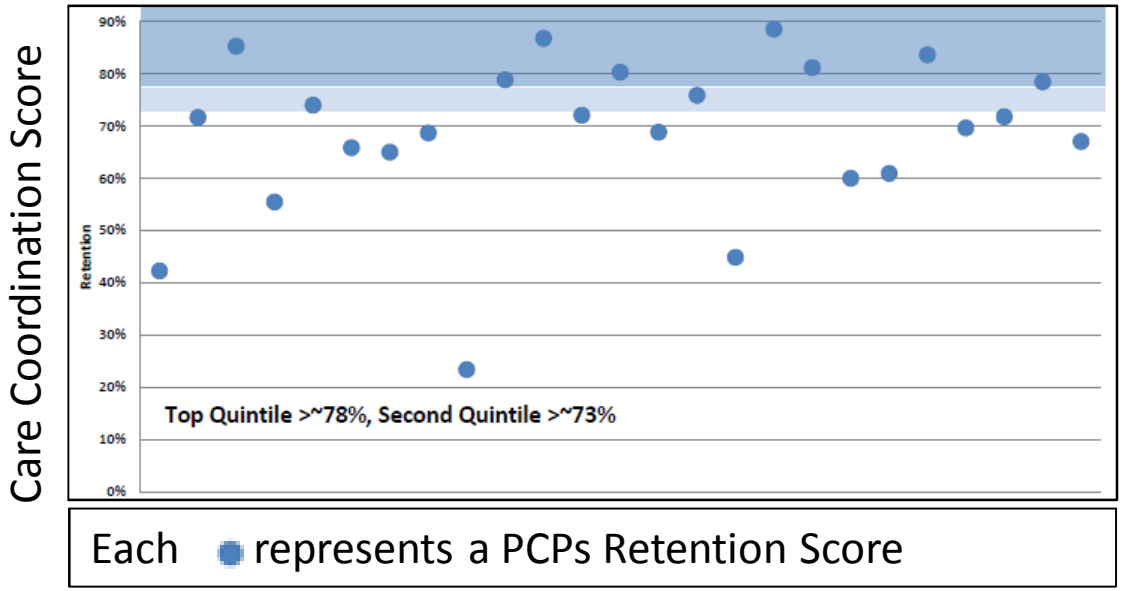
Quantitative and Actionable Claims Data

- 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



Reporting
Actionable Data

<<PCP Group Name>>
Retention Score by Market and PCP
BCBS; HPHC; TUFTS; MEDICARE ACO; July 2013 - June 2014

Legend
Top Quintile in Market
Second Quintile in Market

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

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

Image credit:
http://handoffreport.wikispaces.com

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

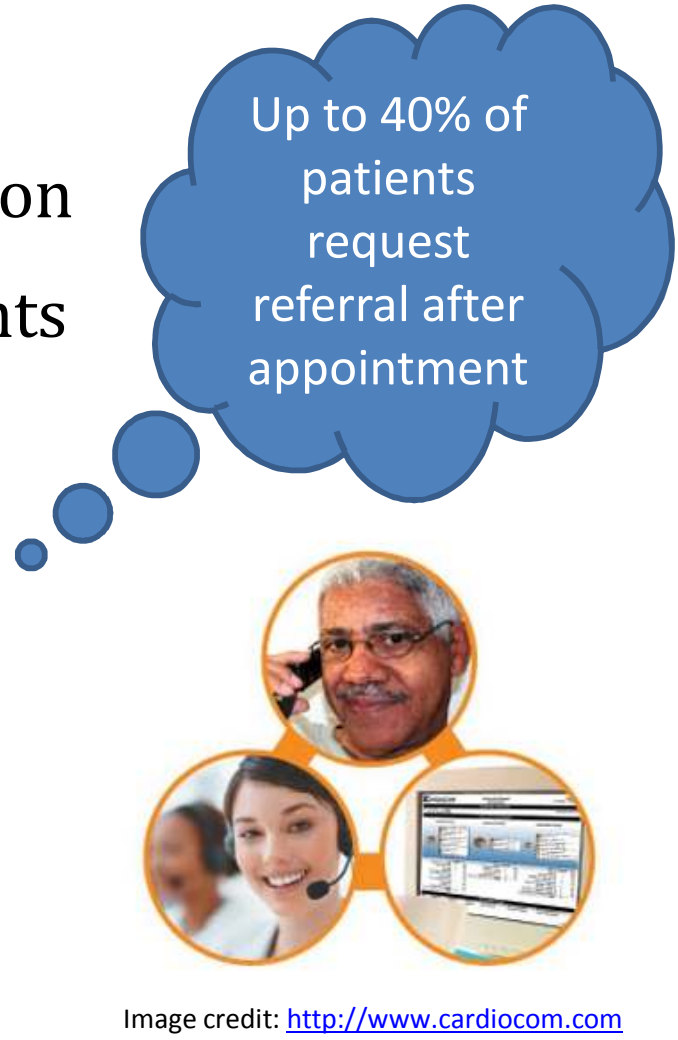
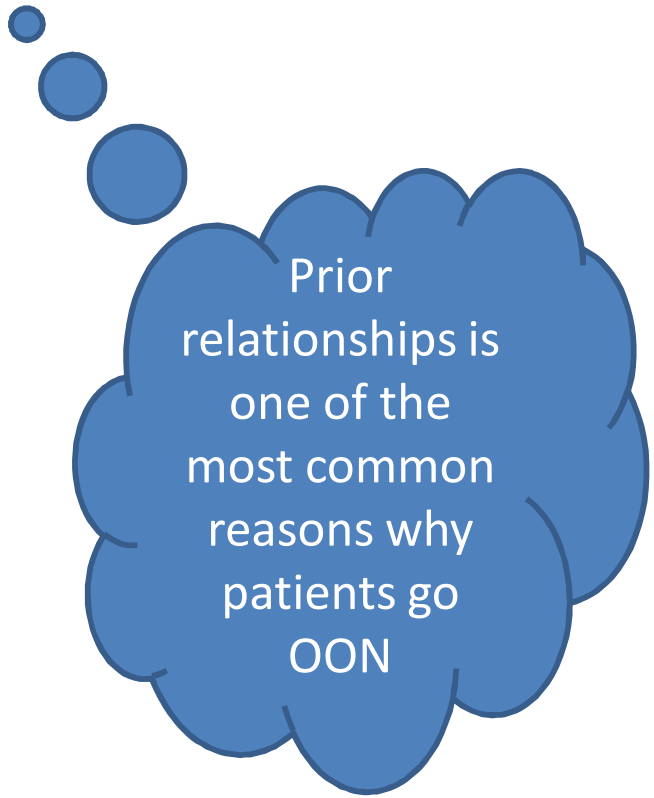


Image credit: http://www.cardiocom.com

When Should a Patient be Engaged in a Care Coordination Conversation?

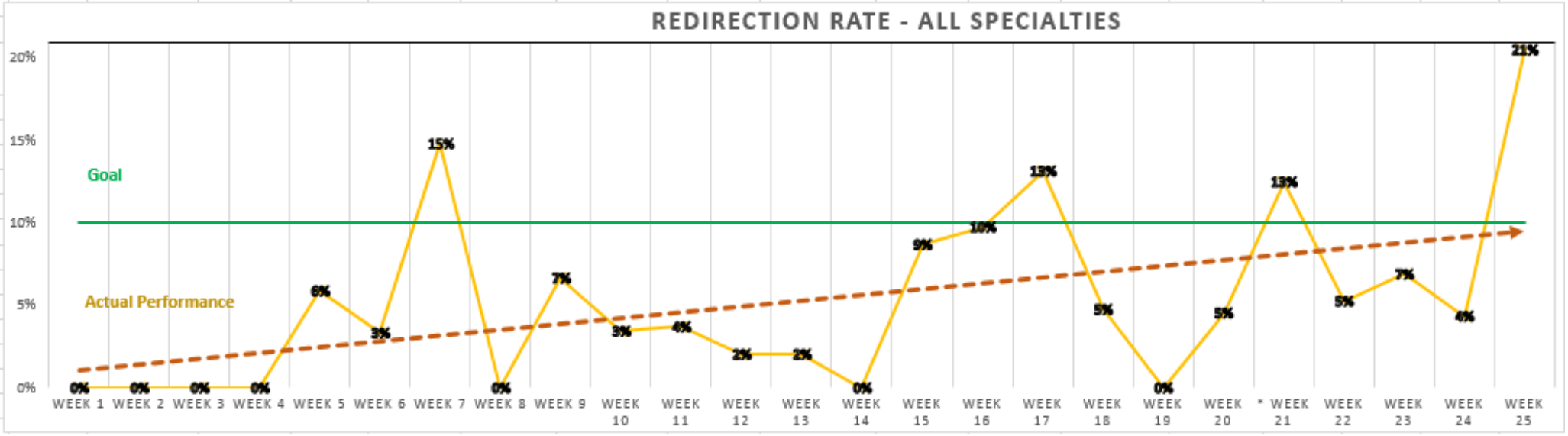
- Appropriate Out of Network (OON) Utilization
  - Prior relationship when disrupting the OON relationship could compromise the patient's welfare
  - Service not offered in-network
  - PCP approved prior to patient calling central team
  - Second opinion (in certain instances)
- Opportunities to Redirect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

*Patient Redirection Rate Exclusions:

1. Patient requesting referral on date of appointment or after date of appointment

2. Pre-existing Relationships when disrupting the out of network relationship could significantly compromise the patient's welfare. Does not apply to routine management of chronic stable problems under surveillance only.

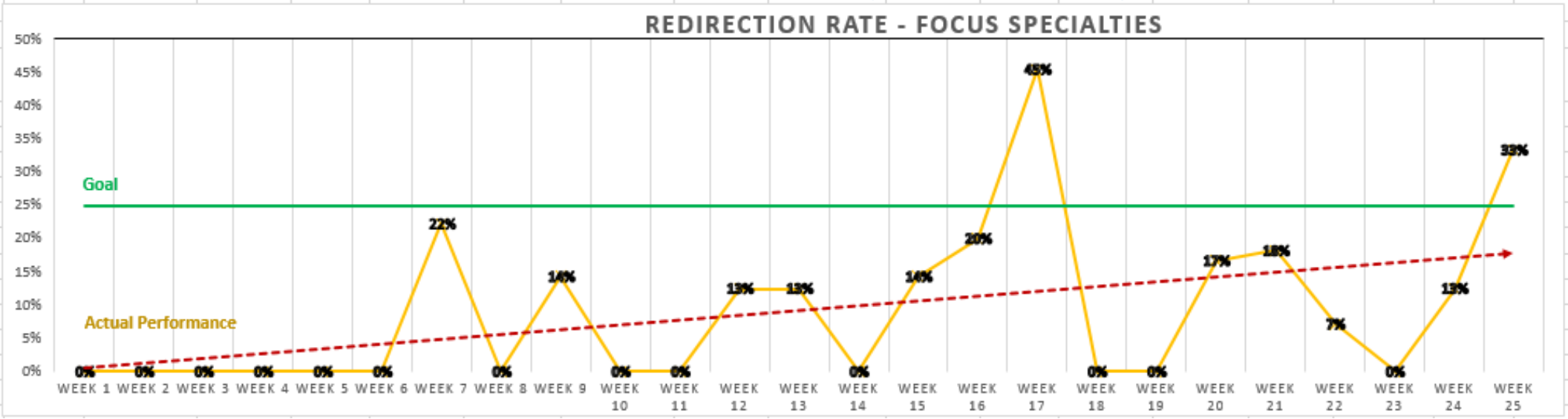
3. Service not offered within the BID network

4. PCP approved patient request before patient called Care Coordination.

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%**

*Patient Redirection Rate Exclusions:

1. Patient requesting referral on date of appointment or after date of appointment

2. Pre-existing Relationships when disrupting the out of network relationship could significantly compromise the patient's welfare. Does not apply to routine management of chronic stable problems under surveillance only.

3. Service not offered within the BID network

4. PCP approved patient request before patient called Care Coordination.

Excel Based Referral Tracking Tool

CARE COORDINATION - PATIENT REFERRAL AND REDIRECTION TRACKING TOOL

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

PT. REQ. IN OR OON?	PT. ENDS UP IN OR OON?	WAS PATIENT REDIRECTED?	APPT. DATE	IF PATIENT WAS NOT REDIRECTED, REASON	NOTES	Days Before (After) Appointment [AUTO-CALCULATED]
OON		Yes	9/19/2014	N/A. In-Network	SAMPLE	(89)

IV. Network Built to Support Care Coordination

Setting Patient Expectations

Image credit: http://www.cuhsm.org

- 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

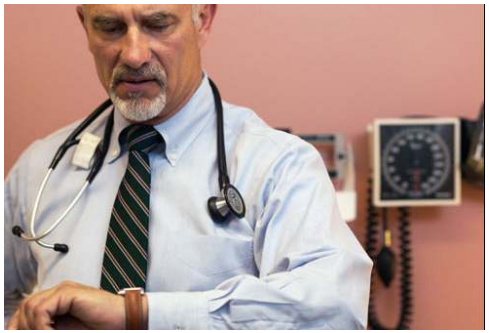


Image credit: www.webmd.boots.com

- 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”

Image credit: http://blog.timesunion.com

- 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

Image credit: http://info.healthdirections.com

- 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

Image credit: http://www.kevinmd.com

- 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

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Lessons Learned and What's Next

Alex Ellsworth
Angela Wayne
Jeremy Tarr

UHS PRM Physician RELATIONSHIP MANAGEMENT

Challenges

- How do we prove that business went up?
- ….and how do we know our team had something to do with it?

Growth.
Alignment.

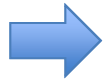
UHS PRM Physician RELATIONSHIP MANAGEMENT

1: Proof of Volume Increase

IP or OP	**I**
Facility	**St. Mary's Regional Med Ctr**
ER Admits	Non-ER
Pipeline Status	**100% Activity Logged - Won**
PRM	**(Multiple Items)**

Jan-Dec

Specialty	Admit Physician	Data Q4 2014 Cases	Q4 2013 Cases	Difference	January Cases
Grand Total	Smith – Ortho	30	10	**0**	



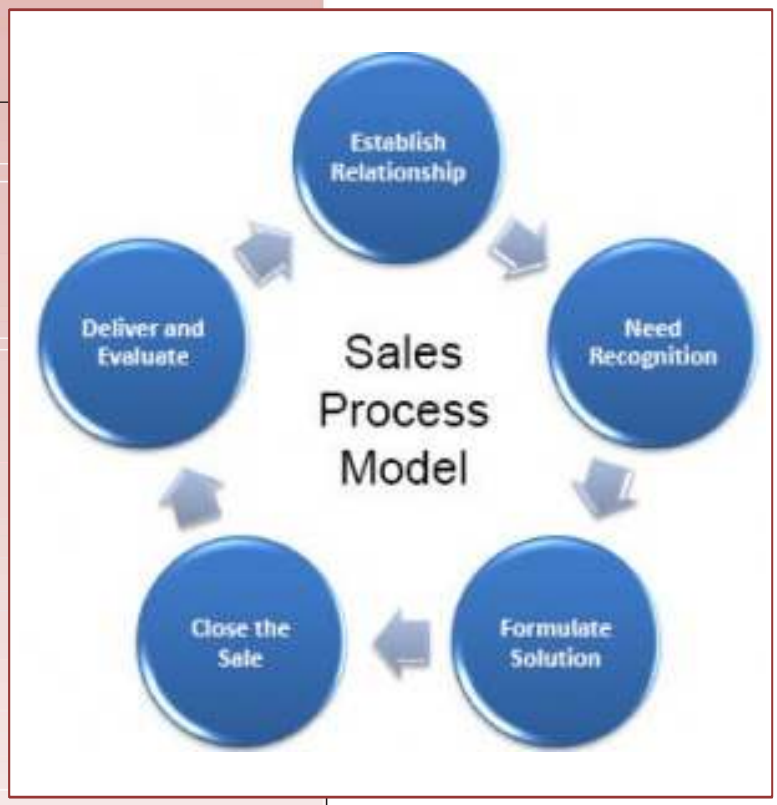
- Compare Cerner quarterly I/P + O/P volume, YOY
- Isolate by facility
- Turn off admits/volume originating in ER
- Only include those physicians logged in CMA at 100% by PRM
- Identify PRM responsible for the region

Volume Went Up!

Growth. *Alignment.*

UHS PRM
Physician
RELATIONSHIP
MANAGEMENT

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

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UHS PRM Physician RELATIONSHIP MANAGEMENT

2: CMA Documentation Indicates Attention To Detail by PRM With the Physician

Visit Notes in CMA	Date	Comments
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 **does not perform any procedures** (cath or interventions) anymore. He **refers them to his partners** and **which specific cardiologist he refers to depends upon the patient's problem and the physician's expertise: 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 straight forward surgeries, he uses Dr. K at UHS, **more complex cases go to Dr. B. All of his private insurance referrals for CVT go to Dr. L at Competitor X.** Hospital preferences **he does not send any patients to Competitor Y** 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.	10/13/14	Lots of detail on preferences, history, how the referral decision is made
Had dinner with Dr. Smith We **discussed directing cardiology referrals to UHS from City X** as well as the **new ER group that is in place at competitor Z effe**ctive 8/15. 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.	11/20/14	Details that affect the physician decision

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

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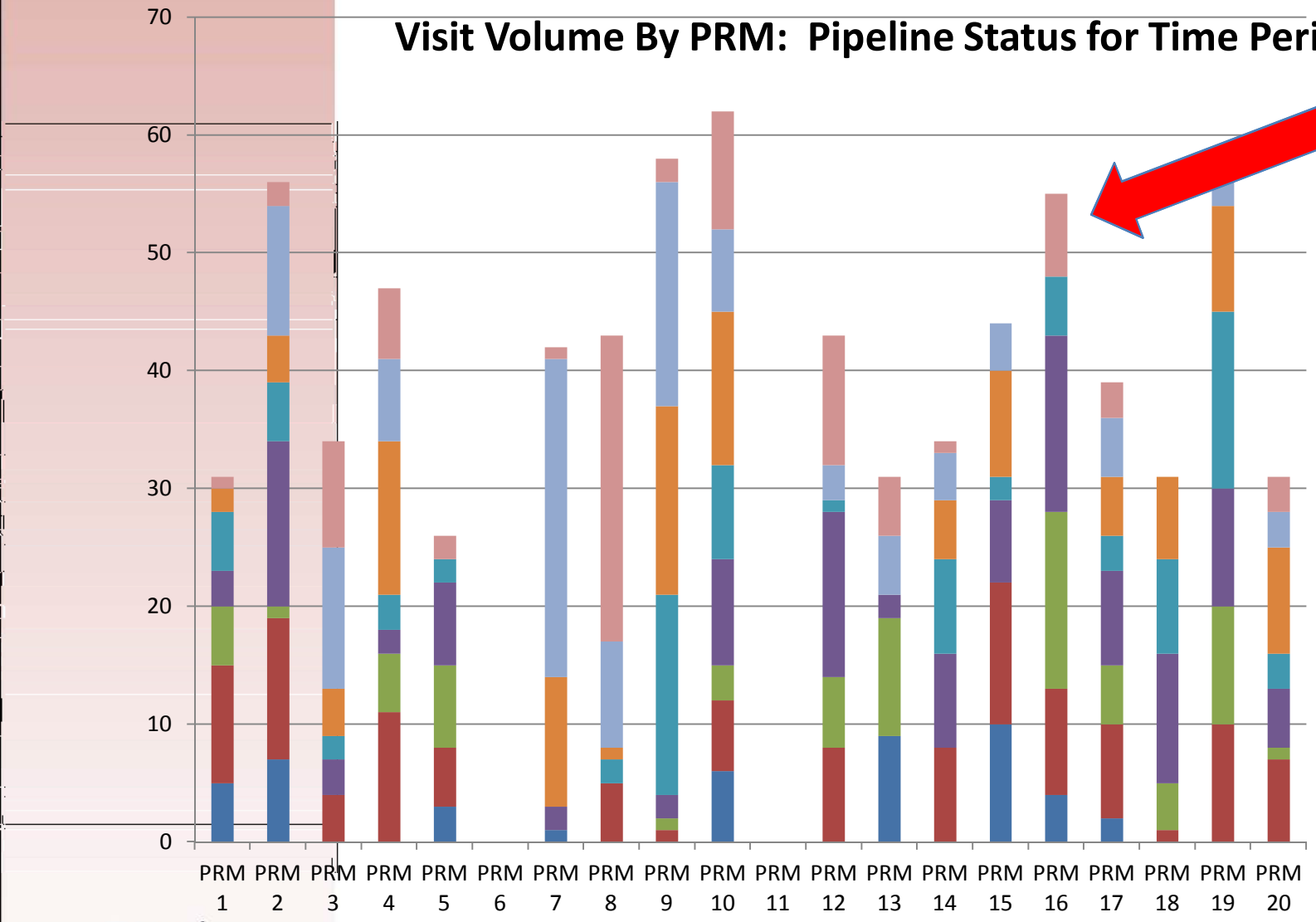
UHS PRM Physician RELATIONSHIP MANAGEMENT

Proof That PRM Contributed



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

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UHS PRM Physician RELATIONSHIP MANAGEMENT

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?

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UHS PRM Physician RELATIONSHIP MANAGEMENT

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?

IP or OP	I
Facility	St. Mary's Regional Med Ctr
ER Admits	Non-ER
Pipeline Status	100% Activity Logged - Won
PRM	(Multiple Items)

Specialty	Admit Physician	Data Q4 2014 Cases	Q4 2013 Cases	Difference	January Cases
Grand Total	Dr. Smith – hospitalist	400	300	0	

How much of that 400 was incremental?

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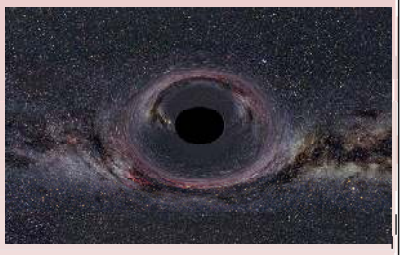
UHS PRM Physician RELATIONSHIP MANAGEMENT



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Alignment.

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

UHS PRM Physician RELATIONSHIP MANAGEMENT

Two Ways To Improve Attribution Accuracy in Plugging Leakage

- Measure it more
- Make your team better

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UHS PRM Physician RELATIONSHIP MANAGEMENT

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

UHS PRM Physician RELATIONSHIP MANAGEMENT

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

Growth.
Alignment.

V. Strategies to Consider

Breaking Down Silos

Image credit: http://www.outstand.org

- 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

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

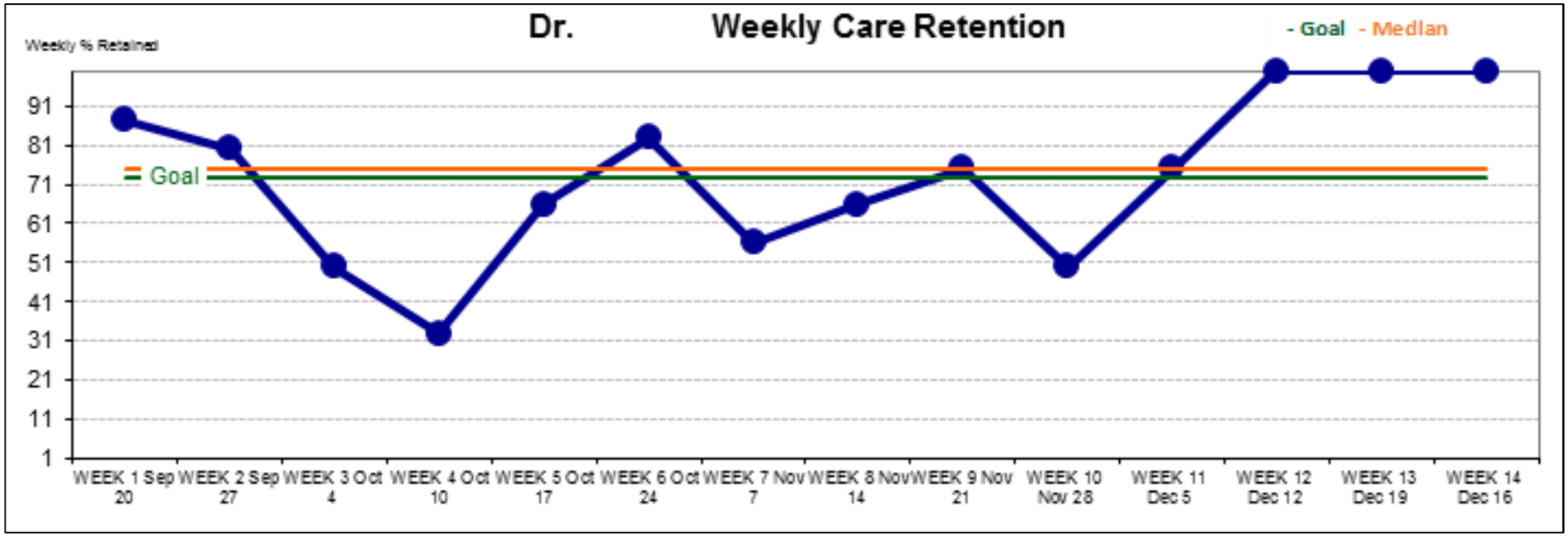
Coaching Videos

- Transitioning a patients 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

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

Image credit: http://www.blulana.com

Key Takeaways

Seek to Understand

Identify Opportunities

Quantify

Track and Report

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Don't take on the entire world of leakage!

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

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In denial?

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

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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

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Questions?

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