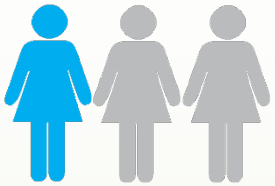
APPD Fall Meeting

Value Based Care Discussion
Key Topics and Explanations

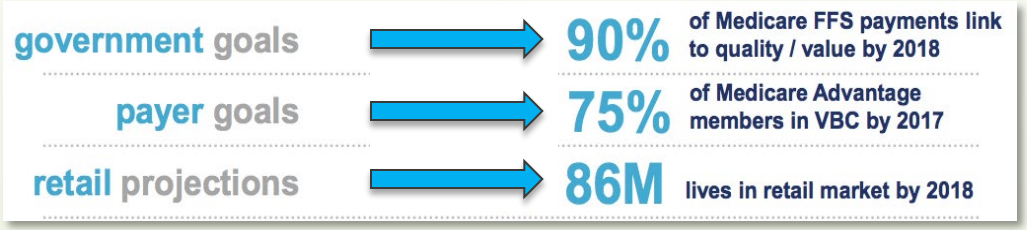
Describe the state of value-based care and population health in your market?

State of Value-based Care at Duke

Today, **nearly one out of three** Duke Health patients are enrolled in a health plan that incentivizes Duke based on delivery of positive **health outcomes.** These plans are called **"value-based" arrangements.**



However, market forces and policy changes indicate that this number will be increasing—**fast**.



Ultimately, Duke Health's future success will depend on its ability to deliver positive health outcomes—or "value"—for **all** patients.

Employee Plan and DukeWELL (2012)

DukeWELL

Lessons Learned

- Narrow Networks are critical to managing care
- Incentives (even small ones) keep patients engaged
- Patients want Care Management that is tied to their provider
- High cost does not mean highly impactable

How Others Are Responding…

	DukeHealth	WakeMed	UNC HEALTH CARE
Population Health Platform	**Duke Connected Care** (thru Duke PHMO)	**Wake Key Community Care** (thru Evolent)	**UNC Health Alliance** (thru Alignment Health)
Medicare Risk	**Yes** (50K lives, 2-sided)	**Yes** (30K lives, 1-sided)	**Yes** (30K lives, 2-sided)
Medicare Advantage	**Yes** (13K lives, 1-sided*)	**Yes** (1-sided*)	**Yes** (1-sided*)
Medicaid	**Yes** (80K lives via CCNC)	**No**	**No**
Employee Plan	**Yes** (48K lives)	**Yes** (13K lives)	**Yes**
ACA Exchange**	**Yes** (Ambetter with WakeMed)	**Yes** (Ambetter with DukeHealth)	**Yes** (Cigna, BCBSNC)
Telehealth Offering	**No** (In Development)	**Yes** (Launched April 2018)	**Yes** (Launched April 2018)

*One-sided risk models require investment and infrastructure

**ACA products require deep discounts

How is your faculty practice preparing for value-based care and population health?

Population Health Management Office

Mission

Partner with patients, providers, payers & communities to measurably improve health outcomes through results-driven care management, evidence-based practice support & actionable data & analytics.

Vision

Connected patients, empowered providers, healthy communities.

Value Based Taskforce Formed 2018

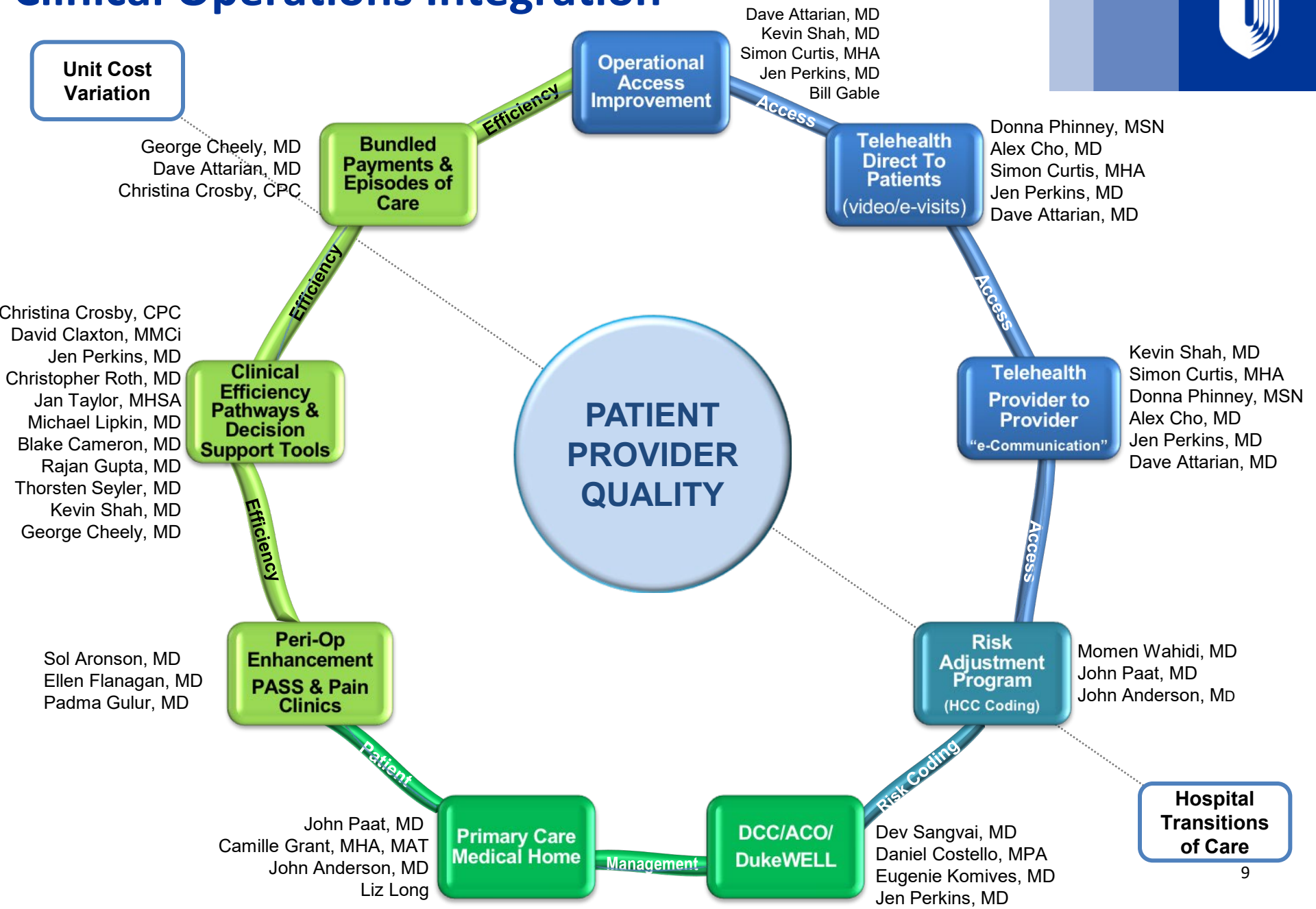
Cross-departmental Representation for Duke Health

- The Value Based Task Force represents:
  - All 15 Clinical / Academic Departments of the PDC
  - Duke Primary Care Leadership
  - 7 Entities and 5 Associated Services

- The Participants Include:
  - 25 Physicians
  - Nursing and Advanced Practice Leadership
  - 16 Administrative/Operations Resources
  - 5 Analytical and IT Resources

See appendix for full listing

Clinical Operations Integration



Core Tenets of Success

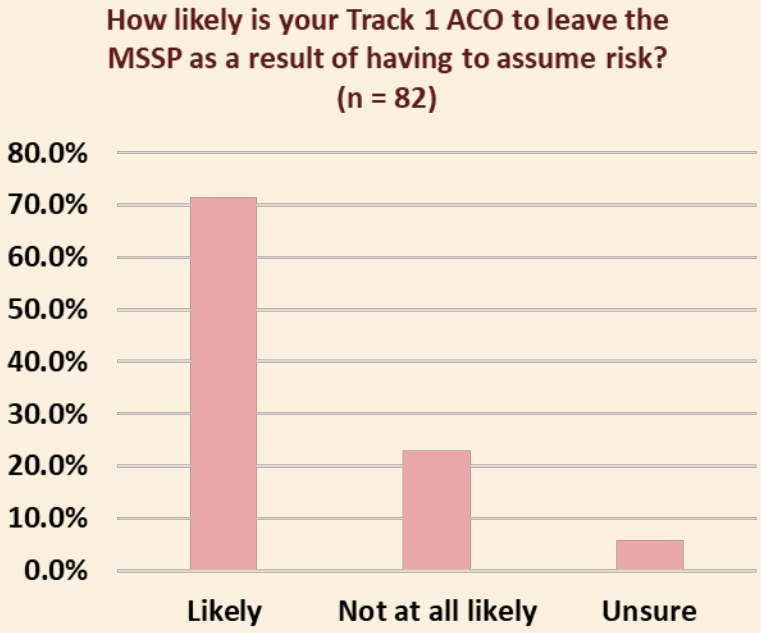
1. Case management for high risk patients
2. Chronic disease management
3. Unit cost variation management
4. Service utilization and continuum of care management
5. Physician motivation
6. Health plan product management
7. Patient access and priority intake process
8. Patient-centric internal cost control
9. Data processing
10. Patient direct strategy
11. Scope of care
12. Epic and IT integration

See appendix for full listing

Do you participate in or own a Clinically Integrated Network (CIN)? How is it structured?

How Duke Health Is Responding…

Most ACOs are **not ready** to assume downside risk.



Source: NAACOS

However, **Duke Health's MSSP ACO** continues to move forward…

Duke Connected Care

2014 Began initial three-year participation in MSSP as Track 1 (**upside-only**) ACO

2017 Renewed participation in MSSP for four more years

2018 Assumed **downside risk**, qualifies as AAPM under MACRA

How important are these initiatives to the overall strategic direction of the practice?

Fee For Service to Value Based Migration

1. **Sustainability:** Medicare will become a managed program and will require reductions in cost in relations to competitors in order to remain sustainable

2. **Paradigm Shift:** Next five years will require providers to migrate from FFS to valued based payment model while achieving enhanced quality metrics

3. **Migration of Risk:** Medicare (Medicaid and Commercial) will now require a multiple product approach and further coordination with Payors and potential network partners

Physician/Organizational Support Initiatives

4. **Strategic Investments:** System investments and potential decreases in utilization will require growth and clinical efficiencies to sustain financial margins

5. **Physician Engagement:** It will be key to identify the core value based concepts that can be deployed and be useful under any future state scenario (i.e. care management, physician engagement, risk identification management)

6. **Organizational Team Approach:** The ability to manage across a patient population, a provider network in coordination with our facility platform. Support of physicians, real time data, and enhancing patient outcomes will be required in a value based environment

Source: PDC 2017

Pace of Change…Drive To Value

2015	Today
Local market was evolving at a ***moderate*** Pace of Change when compared to national markets.	Local market is evolving at a ***moderate-fast*** compared to 2015 and remains behind national markets.

Overall, the local market is **evolving faster** than it was in 2015.

National Influences

- Prevalence of risk-based products
- Consumerism (driven by cost/quality transparency and high deductible plans)
- Pressure from self-insured employers to manage costs
- Technology as a disrupting influence

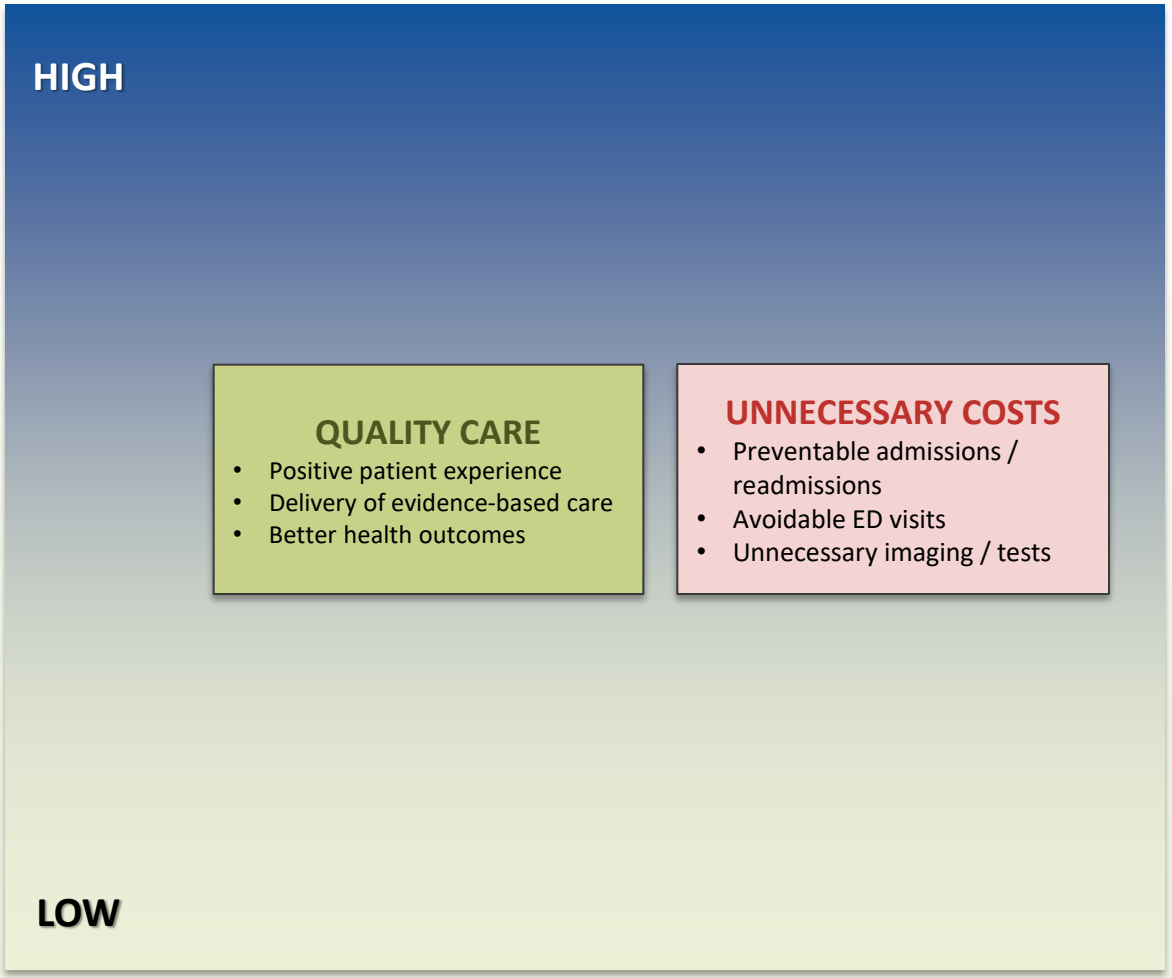
Local Influences

- Health system and physician consolidation
- Impending transition of NC Medicaid from FFS to managed care
- Payer consolidation in NC healthcare exchange
- Exclusively narrow-network products on healthcare exchange

How Value is Measured

Providers are measured on our ability to deliver "value" by measuring how well we **control unnecessary costs** while **delivering quality care**.

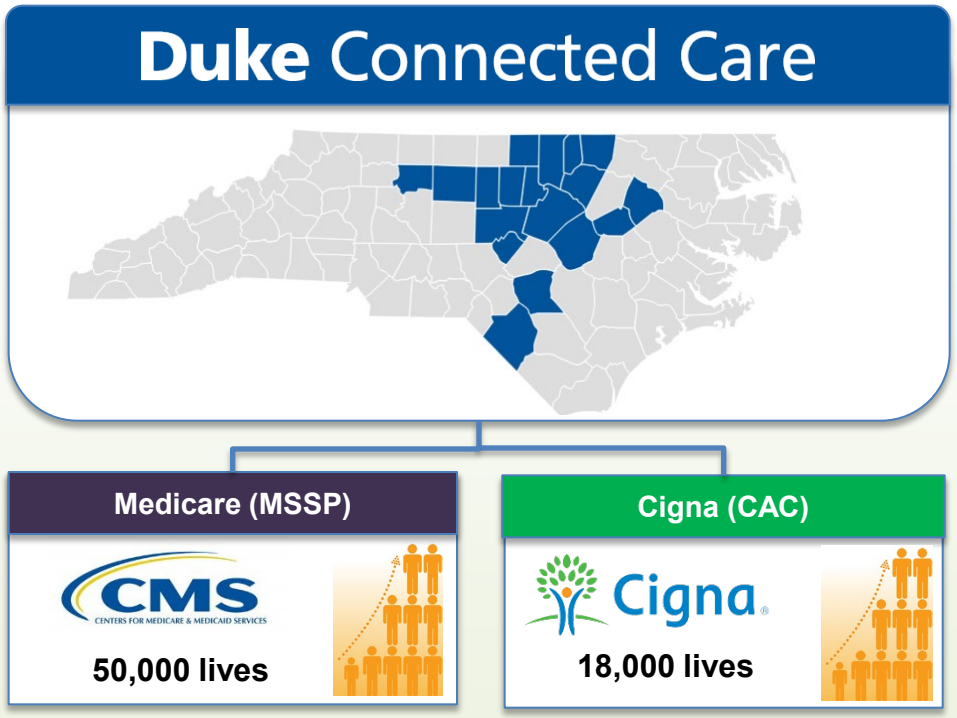
When we succeed at delivering high-quality care while reducing unnecessary costs, we maximize the **value** of our care delivery.



Does your practice participate in an Accountable Care Organization(s)? Describe the model(s) and your practice's level of participation.

Established an ACO (2014)

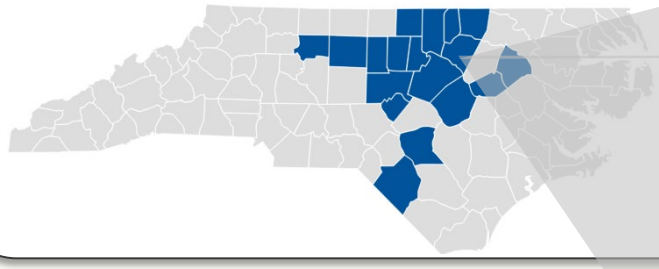
Duke Connected Care is a vehicle to enter into value- and risk-based contracts.



Duke Connected Care (DCC) is a special type of provider network called an **accountable care organization (ACO)**. ACOs partner with **Medicare** and **commercial payers** to improve outcomes for assigned populations of patients.

Value-Based Networks

Duke Connected Care



Medicare (MSSP)

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

50,000 lives

Cigna (CAC)

Cigna

18,000 lives

Duke Connected Care **(DCC)** is a Track 3 Medicare Shared Savings Program **Accountable Care Organization (ACO)*** and FTC/DOJ-approved **Clinically Integrated Network (CIN)*.**

**qualifying APM under MACRA*

**eligible for commercial value-based arrangements*

DukeHealth participants

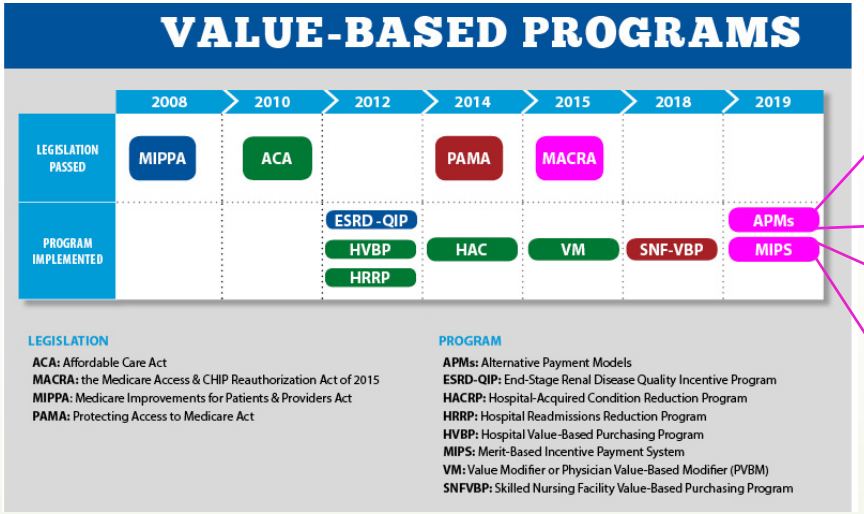
- All 40 **Duke** Primary Care locations
- All 100 **Duke** Specialty Clinic locations
- All 3 **Duke** Hospitals

Independent community participants

- Duke LifePoint Maria Parham Medical Center, LLC **(Vance)**
- Duke LifePoint Maria Parham Physician Practices, LLC **(Vance)**
- Duke LifePoint Wilson Physician Practices, LLC **(Wilson)**
- Allmed Clinic **(Wake)**
- Beckford Avenue Medical Center, PA **(Vance)**
- Carolina Family Health Centers, Inc. **(Wilson, Nash & Edgecomb)**
- Lincoln Community Health Center, Inc. **(Durham)**
- North State Medical Center **(Person)**
- Primary Medical Care **(Wake)**
- Roxboro Internal Medicine & Pediatrics, PA **(Person)**
- Roxboro Medical Associates, PA **(Person)**
- Sundar Internal Medicine Associates, PA **(Vance)**
- Triangle Community Physicians, PA **(Durham)**
- Vance Family Medicine, PA **(Vance)**
- William B. Olds, MD, PA **(Person)**

What is your practice's stance on MACRA and other Medicare initiatives in this area

MACRA: Accelerating the Shift to Risk



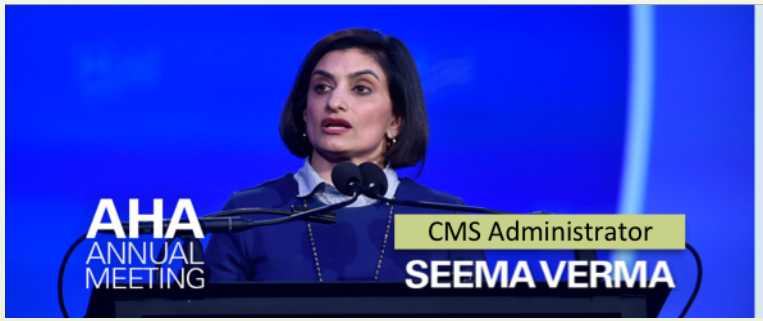
Financial upside & downside

- MSSP Track 1+, 2, 3 & Next Gen ACOs Comprehensive Primary Care (CPC+)

Financial upside only

- MSSP Track 1 ACOs
- Bundled Payment

Source: CMS



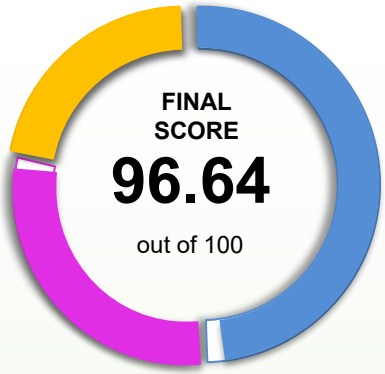
*"The presence of these **upside-only** tracks may be encouraging consolidation in the marketplace, reducing competition and choice for our beneficiaries…While we understand that systems need time to adjust, our system cannot afford to continue with models that are not producing results."*

May 7, 2018

August 9th CMS Proposed Rule: "MSSP ACOs: Pathways to Success"

- Pushes ACOs to risk much more quickly and requires annual risk increases
- Introduces restrictions on ACOs reforming and applying as new ACOs
- Reduces shared savings rates for shared savings only and low risk models
- Pushes ACOs out of the program with new early termination policies based on spending increases outside a certain corridor
- Continued policy to require more / earlier risk from hospital-based ACOs

DCC Performance in MIPS



Billing adjustment of
+1.83%
(max +2.02%)

Components	Score
Quality (50%) **Taken from ACO measures**	**48.1 of 50**
Advancing Care Information (30%) **Formerly "Meaningful Use", reported per clinician**	**28.54 of 30**
Improvement Activities (20%) **Automatic full credit for all ACO participants**	**20 of 20**

RESULT

Each **individual provider** who was part of a DCC TIN in 2017 gets:

- The same MIPS individual score of **96.64**
- The same billing adjustment of **+1.83% in Part B** starting January 1, 2019

NC Medicaid's Shift to Value

Vision

By implementing managed care, and advancing integrated and high-value care, North Carolina Medicaid will improve population health, engage and support providers, and establish a sustainable program with more predictable costs.

Goals

1. Measurably improve health
2. Maximize value to ensure program sustainability
3. Increase access to care

Progress

TODAY

- Enrollment broker RFP
- PHP licensure
- Behavioral health integration
- 1115 waiver approval by CMS

Ongoing: Listening & Talking to Stakeholders

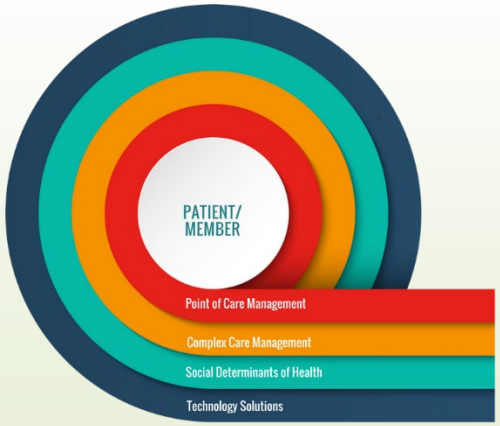
How Duke Health is Responding…

11 health systems, 15,000 physician partners

MY HEALTH BY HEALTH PROVIDERS

New Hanover Regional Medical Center · DukeHealth · CONE HEALTH The Network for Exceptional Care · Atrium Health · Wake Forest Baptist Medical Center · UNC HEALTH CARE · CAPE FEAR VALLEY HEALTH · NOVANT HEALTH · VIDANT HEALTH · PRESBYTERIAN

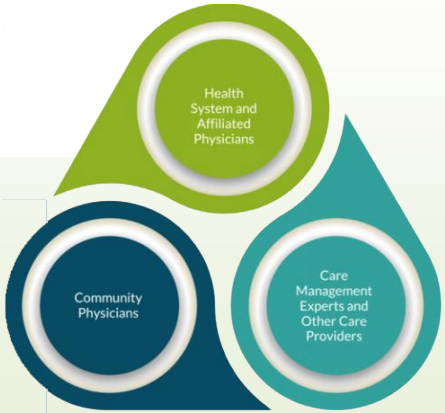
Ease & efficiency



MyHealth will directly compensate practices for how they choose to support their Medicaid MCO patients, including:

- Building internal capabilities
- Utilizing network care management services
- Purchasing services from community-based care management entities

Provider-led



MyHealth Governance Structure includes:

- Community physician advisory council
- Quality committee
- Utilization management committee
- Pharmacy & therapeutics committee

Can you identify specific successes or unique areas of focus within your practice that highlight engagement by your faculty/leadership in managing at risk populations

Taskforce Membership

Cross-departmental Representation for Duke Health

- The Value Based Task Force represents:
  - All 15 Clinical / Academic Departments of the PDC
  - Duke Primary Care Leadership
  - 7 Entities and 5 Associated Services

- The Participants Include:
  - 25 Physicians
  - Nursing and Advanced Practice Leadership
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See appendix for full listing

Organizational Value Based Taskforce

Co-Chairs: Bill Schiff, MHA and Kevin Shah, MD

Departments:
Anesthesiology
Cardiology
Endocrinology
Family Medicine/Internal Medicine
Nephrology
Neurology
Orthopaedics
Pediatrics
Psychiatry
Psychiatry
Pulmonology
Radiology
Surgery
OB/Gyn
Urology

Organizational Entities:
PDC, DPC and DUHS
PHMO
PRMO
DHTS
Performance Services

Associated Services:
Nursing
Hospital Admissions
Hospital Inpatient Transition of Care
Homecare, Hospice
Complex Care Clinic

Physician Representation:
John Anderson, MD – Family Medicine/ DPC
Sol Aronson, MD - Anesthesiology
David Attarian, MD – Orthopaedics
Armando Bedoya, MD – Pulmonology/ACE Medical Dir
Blake Cameron, MD - Nephrology
George Cheely, MD – Care Redesign
Alex Cho, MD – Internal Medicine/ Telemedicine
Ellen Flanagan, MD – Anesthesiology
Padma Gulur, MD -- Anesthesiology
Rajan Gupta, MD - Radiology
Aatif Husain, MD – Neurology
Eugenie Komives, MD – Family Medicine/DCC Med Dir
Michael Lipkin, MD – Surgery/ Urology
Angelo Milazzo, MD - Pediatrics
John Paat, MD – Internal Medicine/Signature Care
Jen Perkins, MD - Endocrinology
Joseph Rogers, MD - Cardiology
Christopher Roth, MD - Radiology
Dev Sangvai, MD – Family Medicine/ PHMO
Lorraine Sease, MD – Family Medicine
Thorsten Seyler, MD – Orthopaedics
Kevin Shah, MD – Internal Medicine/ PHMO
Anthony Visco, MD – OB/Gyn
Momen Wahidi, MD – Pulmonology/Coding/PRMO CMO

DPC/PHMO Administration:
Daniel Costello - PHMO
Liz Long - DPC

PDC Administration/Operations:
Christina Crosby – PDC Value Based Care
Samuel Klotman – PDC
Tammy Berry – Operations
Cheryl Brewer - Nursing
Simon Curtis - Operations
Bill Gable – Access Services
Rachel Liao – Administrative Fellow
Camille Grant – JC Accreditation & PCMH
Allison Dimsdale, NP – Advanced Practice
Todd Turnbill – PDC Quality Reporting

DUHS:
Donna Phinney – Office of Telemedicine
Zachary Rosenthal – Psychiatry
Stuart Smith – DUH Finance
Jan Taylor – Radiology

DHTS/ACE:
David Claxton
Matt Roman
Mary Schilder

Performance Services:
Desmond Cutler
Johnathan Woodall

Initial Top Ten Priority Areas

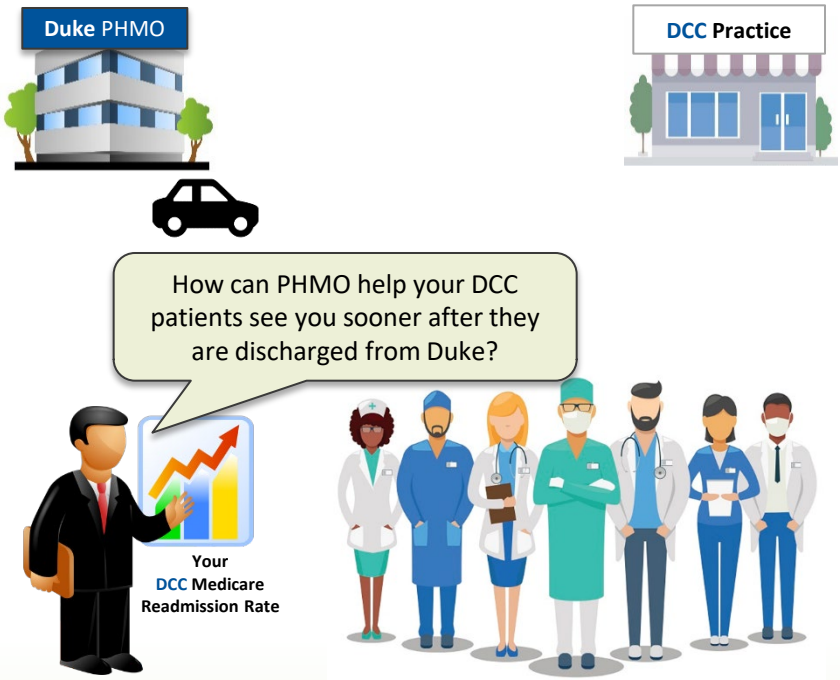
1. Eliminating preventable admissions and readmissions
2. Limiting use of ED for non-emergent issues
3. Ensuring appropriate use of DME and other medical supplies
4. Optimizing appropriate use of specialty referrals
5. Clinical evidence-based support for appropriate use of imaging
6. Identifying optimal site of service in accordance with clinical needs
7. Coordinate evidence-based medication prescribing
8. Appropriate laboratory testing
9. Increasing coordination of palliative care and advanced illness planning
10. Coordinate post-acute transition of care settings (SNF)

Has your institution established data sets, dashboards and/or metrics to achieve success in managing an at risk population(s)?

Data, Analytics & Integration

The **data & analytics team** supports practices by analyzing information from electronic medical records payer claims & to track performance and inform efforts at improving outcomes.

The **provider-facing team** helps practices that treat PHMO patients improve outcomes by advising on workflow redesign, sharing performance data and improving care coordination.



How to Focus in a Dynamic Environment

Quality

- Payments based on higher quality care are increasing
- Lower cost + higher quality care = the path forward

Cost/Utilization

- Transition from fee for service to value based care will have impact on revenue, utilization, site of service, and impact our patients

Patient Access

- Appropriate access to care
- Right Location
- Right Price
- Right Time

Patient/Provider Experience

- Scores tied to reimbursement
- Higher quality can enhance patient experience/satisfaction

Benchmarking Implementation

- **Patient Experience & Enhanced Efficiency -** The PDC Clinical Efficiency and Decision Support Team will work to enhance patient experience across the health system through work with all providers, in order to establish protocols and workflows that improve cost and utilization efficiency.

- **Physician Engagement -** This team will be work with primary and specialty providers on areas of opportunity, design and will be available to specialty providers during implementation and ongoing enhancement of designs.

- **Cross-organization Participation -** Will work in conjunction with the Access Improvement Team, Population Health Management Office, Telehealth, DHTS Maestro Care, Primary Care and PDC Clinic Operations.

- **Leverage Current Functionality -** The scope includes assessment of readiness for managed care/increased value-based accountability, including, but not limited to, referral protocols, resource utilization, specialist review of incoming requests for service, workflow tools to improve cost and utilization for all Duke patients.

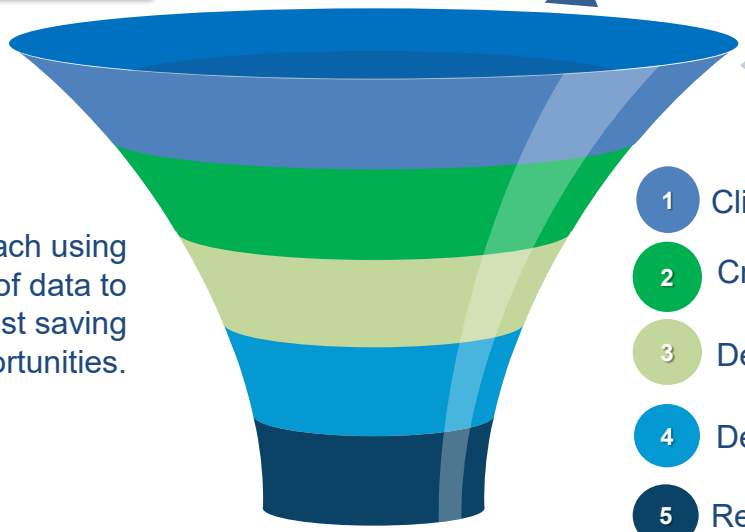
Continuous Feedback Loop

Data Management, External Benchmarking and Continuous Quality Improvement

Provider Feedback and Engagement

Primary Source Data into External Benchmark Product
Where are we an outlier?

Duke Clinical Assessment
Why does this happen?
What do we need to change and how?



A multilayered approach using multiple sources of data to identify cost saving opportunities.

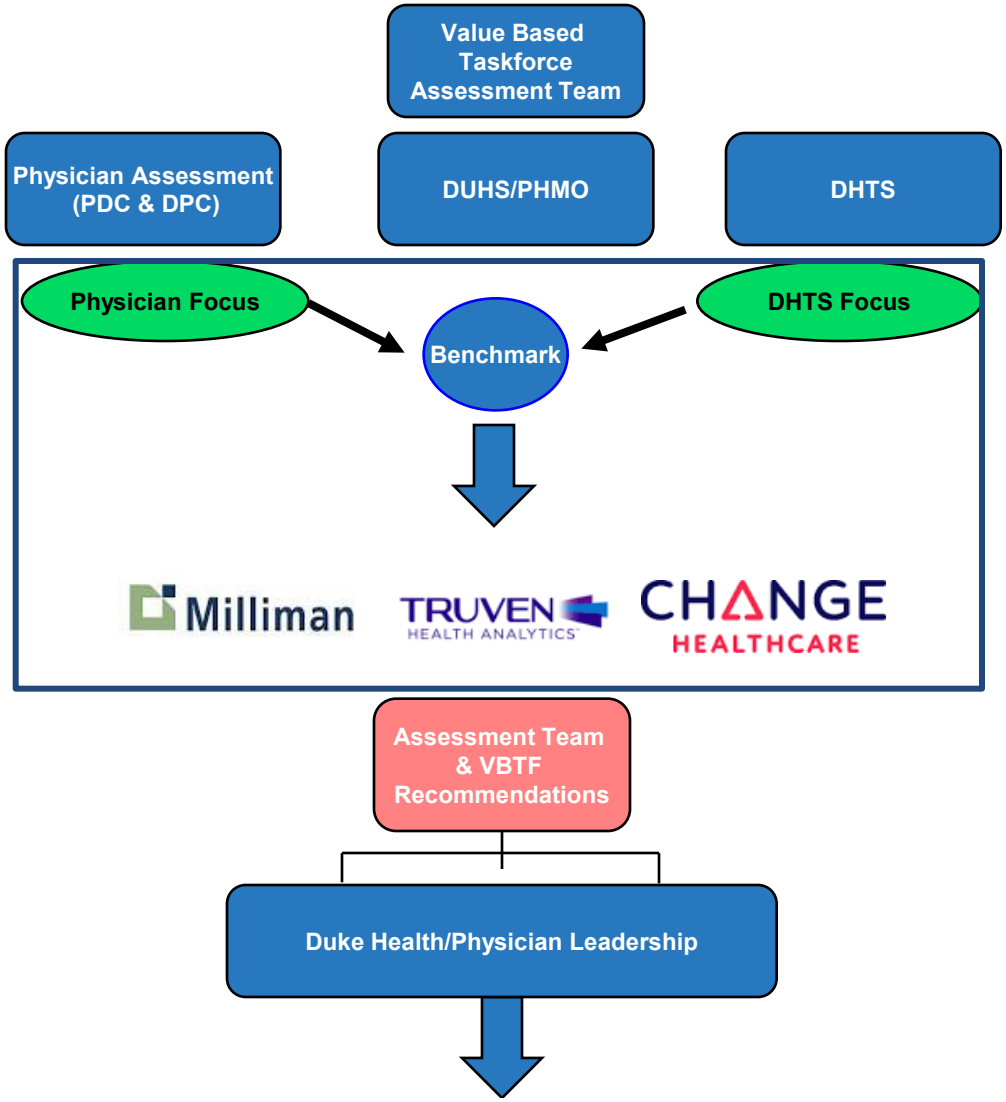
1. Clinical/Operational Leadership Analysis
2. Cross Organizational Evaluation
3. Design Protocols, Workflows, Changes
4. Deployment
5. Repeat Benchmark Analysis

Findings and Observations

From here we will activate clinician workgroups to review the findings and develop changes, workflows, pathways based on our internal data.

Reassess again, for impact.

Vendor Review Process



Organization's Point Person		
Vetting and Information Sharing	May 2018	✓
Vendor Analysis	May 2018	✓
	June 2018	✓
Leadership Input	June 2018	✓
	December 2018	

A Phased Approach

TRUVEN HEALTH ANALYTICS

Phase I - Benchmarking "Stand Alone Tool and Content"

Identify where we stand against well-managed health system and best practice.
Compare to national & regional performance, evidence-based guidelines and other academic medical centers.

Phase II – Addition of EMR Data & Analytics "Duke Data"

Using clinical EMR data, further assess and refine strategy. Pull lists of service categories to work directly with our physicians on any changes in tactics and delivery.

Phase III - Modeling of Impact "Consulting"

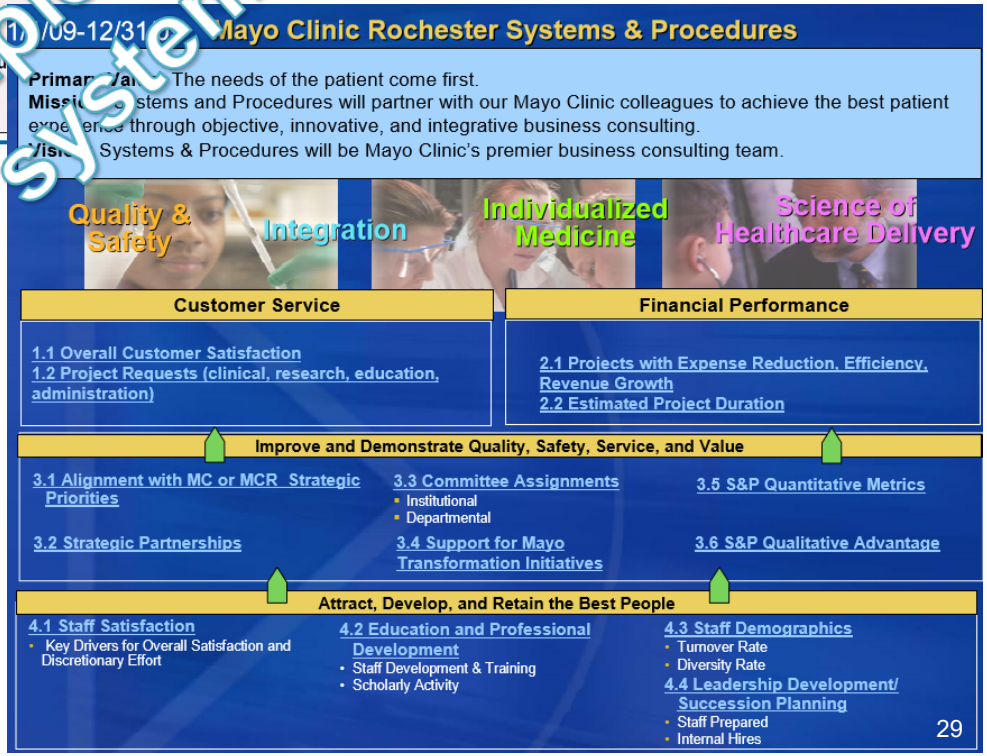
Model the impact of any proposed changes in Phase II. Provide financial and volume impact projections.

Value Based Balanced Scorecard Examples

	Clinical Outcomes	Patient Safety
Process measures	Physical Therapy day of surgery Decrease in pain medications needed Compliance with Care Path	Core measures Patient optimization prior to surgery
Outcomes measures	PRO, Koos/Hoos Return to work/sports Range of motion PT test, Pain free	Pt safety indicators, SSI, Readmissions, Re-operations, Post Operative falls, Post Op Nausea/vomiting Transfusion
	Patient Experience	**Efficiency**
Process measures	Patient and family education Engaged and activated patients Family/Support person involvement Quality shared decision making Appt. when wanted Feel prepared for discharge Joint Class	Resource utilization Cost of care Utilization Review: avoiding unnecessary tests, Reduced LOS, Discharge disposition Rapid Recovery program
Outcomes measures	HCAHPs Return/second surgery	Total cost of care Contributions to cost (acute, p[illegible] venue, complications, read[illegible]

Cleveland Clinic

Examples, other Systems



Private Diagnostic Clinic
THE PHYSICIAN PRACTICE OF DUKE HEALTH

Balanced Scorecard Development

☑ **January – June 2018**

Performance Service Methodology:

- The strategic priority the measure addresses
- Source of data
- Consistency of data
- Frequency of measurement calculation
- Met and exceeds definitions per measure
- Cumulative or by time period

July – December 2018

- ☑ Collected initial recommendations from Impact Groups
- ☑ Reviewed recommendations with Performance Services
- Include physician input (point physicians as well as VBTF)
- Monthly meetings with Performance Services
- Ongoing review with each Value Based Impact Group

What other strategic factors are guiding your decisions and investments in value-based care and population health?

Recent Developments

CMS: Proposed Part B Medicare Reimbursement Policy Changes[1] (July 25th, 2018)

- Streamlining Evaluation and Management (E&M) Reimbursement
- Reimbursement for technology based services
- Site Neutral Payment Policy
- WAC (Wholesale Acquisition Cost) Based Payment for Part B Drugs
- Bundled Payment for Substance Use Disorders
- Price Transparency Information

Intended Impact:

- Proposed rule changes would reimburse care performed at outpatient hospital facilities and independent physicians office's equally
- *"would save CMS about $610 million in hospital payments and Medicare patients would pay an estimated $150 million less in copayments a year"*[2] (August 13th, 2018)

Other Payor Announcements:

- **BCBS of NC SmartShopper:** Offer patients between $25 and $500 dollars to seek out cheaper doctors and procedure costs[3] (July 24th, 2018)
- **BCBS of TX:** Halt payments for non-emergent out of network ER visits[4] (August 6th, 2018)
- **CVS to acquire Aetna:** Valued at $69 billion[5] (December 3rd, 2017)
- **Cigna to acquire Express Scripts:** Valued at $67 billion[6] (March 8th, 2018)

Delivery System Reactions

Centene Corp:

- ACA product development with Duke Health, WakeMed[7] (August 9th, 2018)

LifePoint Health:

- Purchased by Apollo Global Management, LLC (Private Equity Firm)[8] (July 23rd, 2018)

Tryon Medical Partners:

- Newly formed independent physician group consisting of 90 doctors previously employed by Atrium Health's Mecklenburg Medical Group[9] (July 23rd, 2018)

Henry Ford Health System:

- Healthcare contract with General Motors[10] (August 7th, 2018)

Emory Healthcare:

- Creating Accountable Care Plan with Walmart in Atlanta Area [11] (April 20th, 2018)

New Entrants and Industry Response

"Healthcare organizations announced the highest number of healthcare merger and acquisitions deals in 2017"[12] (August 3rd, 2018)

"225 deals in second quarter of 2018"[13] (August 1st, 2018)

ZOOM+care®

- On-demand urgent, primary, and specialty care in your neighborhood.
- Same-day, no-wait visits.[14]

UBER Health

- Help patients and caregivers get reliable rides.
- HIPAA Compliant, Cost Effective, Reliable Scale.[15]

pager

- Mobile-first, patient-facing technology
- Chat with a nurse anytime and get immediate advice about your health.
- Talk to a doctor by video and have prescriptions filled as needed
- Schedule appointments with nearby doctors and specialists in your network.
- Schedule physicals, vaccinations, and more. [16]

amazon CHASE BERKSHIRE HATHAWAY INC.

Amazon, Chase and Berkshire Hathaway JV

- Consortium for healthcare coverage
- Working together to offer better health coverage for their employees[17] (June 7th, 2018)

Commercial payers: Shift to value

- BCBSNC has been very open about interest in having providers assume more risk
- New leadership at BCBSNC formerly at Centers for Medicare & Medicaid Innovation

BlueCross BlueShield of North Carolina

Senior VP & Chief Medical Officer, Blue Cross Blue Shield of North Carolina

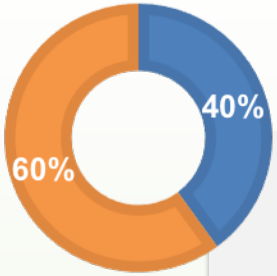
"We want all of our members to have provider who is accountable for total cost of care."

May 2018

July 2018 release:
BCBSNC no longer offering Blue Local with Duke Health & WakeMed on NC Health Exchange

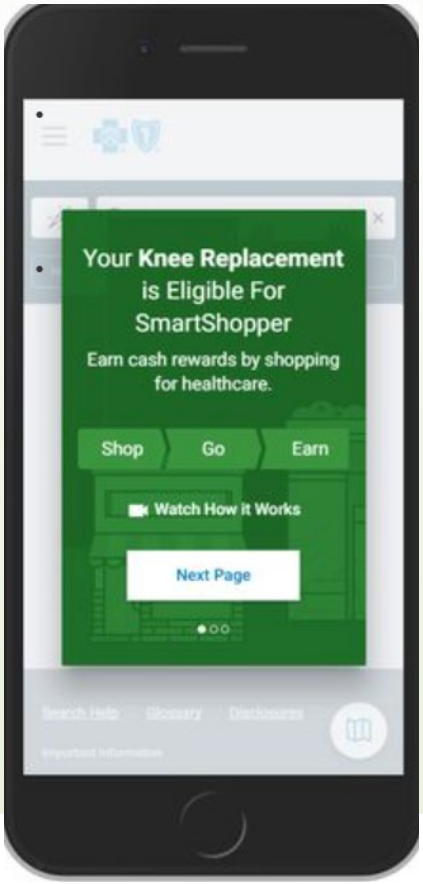
BCBS SmartShopper

Historically cost has driven employer product-plan decisions. Increasingly, payers are targeting consumers directly to modify their selection for health care based on cost.



40% of all patients change their treatment decision after receiving cost information[1]

BCBSNC "SmartShopper helps customers save money by **paying a cash reward – up to $500 per procedure** – for choosing high-quality, cost-effective locations for their procedure."[2]



Source: 1. Accenture; 2. BCBSNC

How Duke Health Is Responding…

CENTENE® Corporation

Better Health Outcomes at Lower Costs

WakeMed, Duke Health to fill gap left by Blue Cross ending ACA plan

Tags: Affordable Care Act, health care costs, WakeMed, Duke Health, Blue Cross Blue Shield

Posted 2:41 p.m. Thursday

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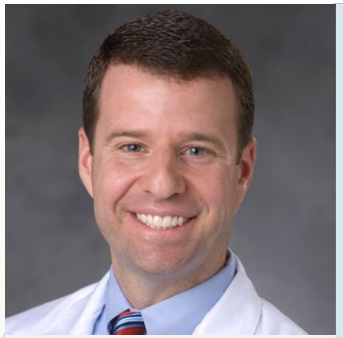

Thomas Owens, MD
President, DUH
Senior VP, Duke Health

"We are very pleased that Ambetter will provide an exchange plan in Durham and Wake counties in 2019 that will allow our exchange patients to maintain uninterrupted continuity of care with their Duke providers."

August 2018

August 2018 release:
Duke Health and WakeMed partner with Centene to offer Ambetter on NC Health Exchange

Other Topics?

Core Tenets for Success (1 of 2)

Value-Based Task Force Definitions

Purpose: To ensure all parties involved in the Value-Based Task Force reach common understanding through consistent use of terminology related to all Duke Health-wide initiatives preparing the organization for the transition to value-based reimbursement for provision of health care services.

Core Tenets for Success

Term	Definition
Case Management for High-Risk Patients	Population of focus is high-cost/high-risk patients (top 5%) with co-morbid conditions requiring team-based care management. Typical interventions include: "Multidisciplinary Clinic" models and involvement of "Case Managers" (typically RNs).
Chronic Disease Management	Focus is the preventative aspect of interventions and management for patients with typically moderate to low costs, but have an identified chronic disease. Typical intervention is Care Management preventative care plans.
Unit Cost Variation	Focus on services where Duke Health unit costs are outliers compared to benchmarks. Additional focus on payer contracts and include "Site of Service" analysis, which will analyze impact on patient out-of-pocket costs. Evaluation will also look at payer fee schedule approaches that would impact patient cost-share (What services have the biggest impact to patient cost-share and thus impact patient choice?). Pilot interventions include: Infusion, Imaging, Laboratory, Ambulatory Surgery, Hospital Based Clinics, etc.
Service Utilization and Continuum of Care Management	Focus primarily on use of ancillaries and hospital-based service management. Tracked metrics might include: ALOS, Re-admission Rates, Avoidable ED, Avoidable Admission, Peri-Operative and Post-Operative initiative outcomes, etc.
Physician Motivation	Focus on physician compensation and incentives. Out of the gate there would not have to be a change to compensation plans within Departments, but the PDC may look at adding in an entity-wide "Value Based Performance" plan using funds generated from value-based programs (Shared Savings, 5% ACO Medicare fee for service, Duke Select Residual Funds, etc.). Potential for Value Based incentive plans to be on top of existing compensation plans to start.
Health Plan Product Management	Focus on key levers for all value-based contracts to identify contractual provisions that could derail or dilute initiates. Examples: patient assignment criteria, minimum physician participation criteria, referral leakage (external), adverse selection bias, conflict between FFS pricing vs Cost Savings initiatives, patient benefit impacts, etc.

Core Tenets for Success (2 of 2)

Value-Based Task Force Definitions

Patient Access and Priority Intake	Focus on "Clinical Pathway" analysis on patient flow through system between PCP and Specialists. Process would support other initiatives and also focus on improving access to services with long lead times. Priorities include: centralized intake process per service, referral protocols, clinic throughput reporting/tracking, communications process back to referring providers, development of new provider optimization consult models (E-Consults, E-Visits, PA-only visits, etc.). Interventions would transcend typical scheduling and access services and would focus more on priority patients and/or hard-to-schedule services required for value-based initiatives.
Internal Cost Control	Focus on aggregate organizational cost to provide and manage patient care. Priority areas will include: supply chain management and purchasing.
Data Processing	Focus on effective dissemination and communication of collected organizational data, as well as real-time education on available tools and resources for physicians and leaders to improve metrics related to organizational goals.
Patient Direct Strategy	Focus on providing patients with greater access to tools and information to more effectively match patient demand and preferences with supply. Current strategies include: patient inbox, direct scheduling and alternative providers of care.
Scope of Care	Focus on appropriately assigning responsibility to various levels of care providers within organization. Emphasis is to have providers and clinic staff working at top of license without working outside of license.
EPIC and IT Integration	Focus on integrating MaestroCare and DHTS IT structure, user interface, and technological capabilities with operational workflows to support organizational value-based reimbursement readiness.

Articles

1. https://www.federalregister.gov/documents/2018/07/31/2018-15958/medicare-program-proposed-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical
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