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GROUP PRACTICE GPJ JOURNAL

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The latest trends in clinic staffing from the 2023 AMGA Clinic Staffing Survey PAGE 14

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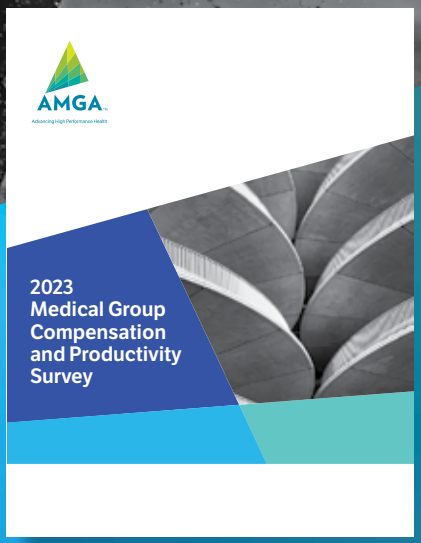

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PUBLISHER'S COMMENT

Battling the Continuing Shortage

By Jerry Penso, MD, MBA, President and Chief Executive Officer

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An uncomfortable truth we have to sit with is that the healthcare workforce shortage is beyond a challenge—it's a public health crisis. The causes behind this shortage had been mounting even before the global COVID-19 pandemic, when burnout reached critical levels.

The results of our *2023 Clinic Staffing Survey*—detailed in this issue's cover story—indicate that the healthcare industry is still facing the fallout of the pandemic, as well as the stress of the economic environment overall. Our members are facing challenges in labor expenses, turnover, and finding qualified candidates.

The *2023 Clinic Staffing Survey* offers insights to help you navigate this crisis, including multiple clinic staff benchmarks by various criteria. With this survey, we aim to provide our members with a clearer and more complete picture of the market and current trends affecting the healthcare industry. Learn more at **amga.org/amgaconsulting/our-data/clinic-staffing**.

Our 2024 AMGA Annual Conference, April 9–12 in Orlando, offers more opportunities to explore solutions to this crisis. In our immersion session on "Addressing Workforce Challenges," you'll hear strategies for managing ongoing staffing shortages and mitigating the impacts of burnout while continuing to provide care to patients in the most compassionate, efficient, and safest way possible. Learn more about the conference and register at **amga.org/ac24**.

You can also always learn more about addressing this crisis online at the Workforce Focus Area of AMGA's website at **amga.org/focus-areas/workforce**.

I would like to wish all of our members a safe and happy holiday season, and I look forward to seeing you all in sunny Orlando next year. GPJ

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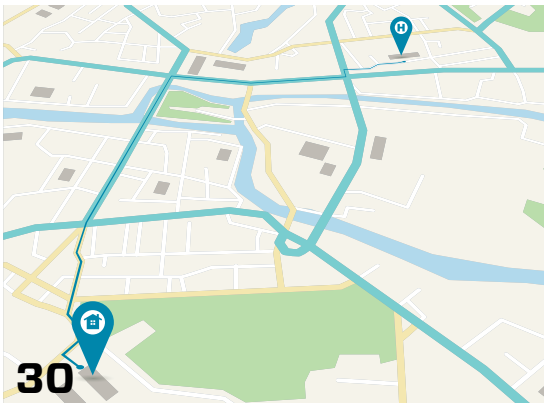

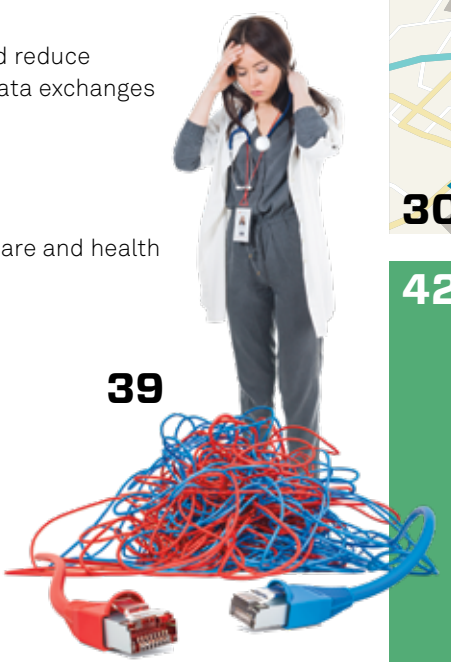

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Skip the Trimming

It's "Stop the Cuts" season again

By Jamie Miller, MBA

Nothing quite says season's greetings like strife in Congress, potential cuts to Medicare, and the AMGA Stop the Cuts campaign. As the seasons begin to change, so does a potential change to physician reimbursement, even as costs for providing care continue to rise. As the year draws to a close, AMGA members continue to pressure congressional leadership to address the potential cuts to the Medicare conversion factor on Medicare Part B services. The AMGA public policy department also outlined the need to address these cuts in a fall priorities letter to congressional leadership.

Medical groups and integrated systems of care are faced with weathering a third year of cuts to Medicare reimbursement when it is already facing numerous strains, including a workforce shortage, record burnout following the COVID-19 pandemic, unprecedented inflation, and an ever-rising Medicare population. The continued cuts add another straw to the growing pile on providers' backs. An additional cut to physician Medicare reimbursement at this time would be devastating and threaten providers' ability to take on new Medicare patients.

Concerning Cuts

The continued Medicare cuts are an increasing concern for AMGA members. In their calendar year 2024 Physician Fee Schedule proposed rule, the Centers for Medicare and Medicaid Services (CMS) propose a 3.4% cut to the conversion factor to Part B reimbursement payments. The continued cuts to Medicare have caused AMGA members to experience a 26% drop in inflation-adjusted Medicare reimbursement from 2001 to 2023.

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In 2021, the conversion factor decreased by 3.3%, in 2022 by 0.80%, and in 2023 by 2%. With the rule set to go into effect January 1, now is the time to make our voices heard on the Hill to ensure these cuts do not go into place.

In response to proposed Medicare cuts, AMGA's public policy team launched the "Stop the Cuts 3.0" campaign to urge Congress to address the proposed cuts by the end of the year. Through the AMGA grassroots network, members are able to connect with their representatives to call for congressional intervention. Congress intervened in December 2021 and 2022, delaying some of the cuts to Medicare. Congress must act again to ensure Medicare reimbursement accurately reflects the cost of delivering high-quality care to patients.

Preparing for the Worst

The fallout from these cuts is already deeply impacting AMGA members. As part of the Stop the Cuts campaign, AMGA surveyed members asking what steps they may be forced to undertake should proposed cuts in Medicare reimbursement go into effect in 2024, as well as what actions they undertook in 2023 in reaction to the prior year's cuts. Half of all members instituted hiring freezes in 2023, and 65% expect to extend that same policy into 2024. Additionally, 44% of members eliminated services in 2023, and 65% expect to continue that policy in 2024. When it comes to investing in social determinants of health programs, 21% of respondents stopped in 2023, and 57% expect to delay or stop these investments in 2024. These statistics illustrate the staggering ramifications of the compound effect of continued cuts.

As the year's end approaches, healthcare providers' challenges loom large. AMGA remains steadfast in its commitment to delivering quality care. It is imperative that lawmakers recognize the broader implications and take decisive action to protect the future of healthcare delivery. AMGA will continue to advocate tirelessly for the best interests of our members and, most importantly, the patients they serve. Together, providers can ensure that the season's greetings in Congress include a resounding message of support for quality healthcare for all. GRJ

***Jamie Miller, MBA**, is senior director of government relations at AMGA.*

Figure 1

National Institute on Minority Health and Disparities Research Framework

		Levels of Influence			
		Individual	Interpersonal	Community	Societal
Domains of Influence (Over the Life Course)	Biological	Biological Vulnerability and Mechanisms	Caregiver-Child Interaction, Family Microbiome	Community Illness Exposure, Herd Immunity	Sanitation, Immunization, Pathogen Exposure
	Behavioral	Health Behaviors, Coping Strategies	Family Functioning, School/Work Functioning	Community Functioning	Policies and Laws
	Physical/Built Environment	Personal Environment	Household Environment, School/Work Environment	Community Environment, Community Resources	Societal Structure
	Sociocultural Environment	Sociodemographics, Limited English, Cultural Identity, Response to Discrimination	Social Networks, Family/Peer Norms, Interpersonal Discrimination	Community Norms, Local Structural Discrimination	Social Norms, Societal Structure, Discrimination
	Healthcare System	Insurance Coverage, Health Literacy, Treatment Preferences	Patient-Clinician Relationship, Medical Decision Making	Availability of Services, Safety Net Services	Quality of Care, Health Care Policies
Health Outcomes		Individual Health	Family/ Organizational Health	Community Health	Population Health

Closing the Gap

COVID-19 management: Health equity challenges and planning solutions

By Elizabeth Ruvalcaba, MSPH; Alicia Rooney, MPH, MSW; and Elizabeth L. Ciemins, PhD, MPH, MA

As temperatures decrease and groups move indoors, COVID-19 cases, along with flu and respiratory syncytial virus (RSV), continue to rise.[1] This is an ideal time to consider how healthcare organizations (HCOs) can contribute to equitable management of COVID-19 for all patients, from vaccination and testing to inpatient and outpatient treatment.[2]

In September 2023, AMGA Research launched a study titled "Reducing Health Inequities for Populations Experiencing Disparate Care in the Context of COVID-19," developed in collaboration with and funded by Pfizer, Inc. Four AMGA member organizations—AtlantiCare, Atlantic City, NJ; Sutter Health, Sacramento, CA; Tulane Medical Center, New Orleans, LA; and Prevea Health, Green Bay, WI—are collaborating with AMGA to develop and implement interventions to improve health equity in the management of COVID-19. The ultimate goal of the four HCOs is to apply processes used for developing tools/resources and learnings from this project to other health inequities within their systems.

Health equity, as defined by the Centers for Disease Control and Prevention (CDC), is "the state in which everyone has a fair and just opportunity to attain their highest level of health."[3] Interventions developed to address health disparities and health inequity target priority populations to confront

unique barriers and facilitators within different communities. In this study, the National Institute on Minority Health and Health Disparities (NIMHD) Research Framework guides AMGA's approach by aiding researchers and participating health systems in the development of such interventions. The framework advises using multilevel interventions to improve health equity and reduce disparities, as health outcomes are influenced at multiple levels throughout the life course and in different settings (see Figure 1).[4]

Inequities in COVID-19 cases, disease severity, and vaccination have been well documented in the literature, with Black and Hispanic patients experiencing higher infection rates, hospitalizations, and mortality.[5–16] Disparities also extend into COVID-19 management in the form of treatment delays and inequitable prescription of COVID-19 treatments.[17–25] For example, during the first half of 2022, Black patients were 36% less likely than White patients and Hispanic patients were 30% less likely than non-Hispanic patients to receive oral antiviral treatment, with larger disparities among patients with severe COVID-19 risk.[17] Potential contributors to treatment disparities included more frequent hospital transfers among Black patients and overestimation of oxygen saturation in Black and Hispanic patients.[24–26] Not only did Black and Hispanic patients receive treatment at a lower rate than White and non-Hispanic patients, respectively, but Black patients were also less likely to receive effective COVID-19 treatments, such as oral antivirals, steroids, immunomodulators, monoclonal antibody treatments, and outpatient rehabilitation, and were more likely to receive ineffective treatments.[17–25]

Launch of COVID-19 Health Equity Study

The AMGA study "Reducing Health Inequities for Populations Experiencing Disparate Care in the Context of COVID-19" convened a kickoff meeting in September 2023, during which HCO representatives heard from national advisors on health equity interventions and engaged in shared learning and hands-on exercises to begin initial planning of interventions to address health inequities in COVID-19 management. All participating organizations conducted a preliminary review of their electronic health record (EHR) data and noted that Black and Hispanic patients were provided outpatient COVID-19 treatment about half as often as White patients.

Key takeaways from this meeting suggest that health equity interventions must be multimodal with an eye toward long-term sustainability and partnerships within and outside of health systems (see Table 1). HCO experiences from the pandemic highlighted the ability of HCOs and community agencies to partner, mobilize, and provide interventions to patients in a variety of settings. Participants in this new study intend to take lessons learned along with new information to be proactive in providing equitable COVID-19 management by engaging in both the health system/healthcare provider and patient/community levels.

Considerations: Health System and Healthcare Provider Level

- **COVID-19 fatigue/need to reinvigorate on treatment**
  Study participants noted that, while there has been a fair amount of COVID-19 fatigue, reinvigoration of clinic staff is needed as additional COVID-19 cases are brought into health

Table 1

Key Takeaways for Health Equity Interventions

These takeaways apply in both the healthcare system/provider and patient/community levels.

Intervention Considerations	▶ COVID-19 fatigue ▶ Sustainability of interventions ▶ Understand where patients are receiving treatment outside of ambulatory clinics (ED, specialists, urgent care) ▶ Take action on what data are already collected ▶ Do community-based organizations (CBOs) have anything to share ▶ Mixed method evaluation ▶ Establish long term partnerships ▶ Feedback loops ▶ Leverage existing infrastructure (e.g., mobile units) ▶ Start small ("going deep" within a narrow population)
Intervention Partners	▶ All departments ▶ CBOs (health and non-health focused) ▶ Churches ▶ Employee Resource Groups ▶ Federally Qualified Health Centers (FQHCs) ▶ Local Health Departments ▶ Other HCOs

systems for treatment in anticipation of COVID-19 surges.

- **Targeted messaging to healthcare professionals**
  When engaging on health equity, language matters. Targeted messaging can facilitate buy-in when there are differing goals among staff. For example, HCOs can present the cost benefit perspective to operations and finance and emphasize patient outcomes to nursing. Intentional language should be used to highlight the focus on gold standard and equitable care to all patients across diseases rather than seeming accusatory toward healthcare professionals.
- **Regular review of data and feedback**
  Participants discussed the importance of reviewing treatment data and providing feedback to providers and clinic staff. Benchmarking across and within practices can help highlight where specific strategies are working and allow others to learn from those best practices. Drilling these data down to the practice and provider level also allows for transparency and accountability. Incorporation of qualitative data as part of the evaluation of health equity interventions is essential to gain a more complete snapshot of the care experience, processes, or encounters and to understand what worked well and where potential opportunities for future interventions remain.
- **Need for engagement across multiple divisions with senior leadership support**
  The effort toward health equity is occasionally relegated solely to diversity, equity, and inclusion officers and their teams. However, it is essential to break down silos and take a collaborative approach to this work as patients interact with the health system across multiple settings. Engaging everyone, from physician champions to students to marketing teams—and holding them accountable—is key to ensuring a unified approach for interventions and participation across the health system. The active involvement of senior leadership is also critical to ensure top-down support for health equity initiatives.
- **Strategizing with other entities supporting patients and communities**
  Community-based organizations (CBOs), local health departments, and federally qualified health centers (FQHCs) were described as eager partners on health equity interventions but are infrequently utilized by HCOs. Engagements with these partners in addition to other local HCOs were viewed as resources for long-term sustainability of health equity interventions. However, consultation with internal legal departments is needed to support the establishment of these partnerships.

Considerations: Patient and Community Level

- **Establishing feedback loops and bidirectional long-term partnerships**
  When engaging with community partners, it is imperative to establish feedback loops and bidirectional partnerships with equal exchange of resources, expertise, and information so the relationships are not viewed as transactional by the community they are intended to support. Through such partnerships, HCOs can leverage patient data collected by CBOs and FQHCs and existing relationships of CBOs and FQHCs with trusted community leaders to support health equity in multiple communities. HCOs' engagement with patients at the community level must be sustained with an eye toward the future rather than being "one and done," as long-term community partnerships can lead to greater health equity by growing in impact over time.[27]
- **Power of patient voice and actions**
  Patients need to be empowered to use their voices and bargaining power to ensure health systems listen to what needs are present in their communities and take action.
- **Combating patient misinformation**
  Preliminary experiences shared by attendees highlighted that patients may be unsure of when and where to seek treatment, how to access testing, and what treatment options are available. Patient uncertainty of conditions putting them at high risk for COVID-19 was another potential opportunity for education. Participants were unclear on the impact that COVID-19 vaccination misinformation may have had on patient perspectives on treatment.
- **"Going deep" within narrow populations and scaling up when possible**
  Among all participants there was an intention of "going deep" within a narrow population and scaling up to other populations when possible.[27] Health equity interventions require a depth and expertise that is developed when going narrow and deep, while a wide and shallow approach risks overpromising and underdelivering.

Proposed Health Equity Interventions

Several health system and patient-facing intervention components for improving equity in COVID-19 management were discussed within the behavioral, environmental, and healthcare system domains of influence as described by the NIMHD Research Framework (see Table 2).[4] Health system-level interventions were multimodal, considered long-term feasibility, and included both broader high-level interventions and smaller, "biteable chunks."[27]

Behavioral interventions focused on addressing individual behaviors through provider and patient education. Patient education regarding when and where to seek treatment after testing positive was discussed. HCOs noted that patients seek and receive care for COVID-19 in many different locations, so it is important to educate and engage within multiple departments (especially ambulatory care, emergency medicine, urgent care, and telehealth). Provision of continuing education on COVID-19 treatment guidelines and high-risk

Table 2

Health Equity Interventions*

Domain of Influence	Component/Resource	Examples
Behavioral	▶ Provider education ▶ Patient education	▶ Provider bias training ▶ Patient education on symptoms, high-risk conditions, treatment options
Environment (physical and sociocultural)	▶ Culturally/linguistically appropriate materials ▶ Utilize community members as educators ▶ Existing resources within health systems	▶ CBOs and lay health educators ▶ Ambassador program
Health Care System	▶ Existing infrastructure ▶ Utilize staff as champions ▶ Existing health partners in local community ▶ EHR integration	▶ Mobile units ▶ Promotoras (lay Hispanic health educators) ▶ Physician champions or ambassadors ▶ Partnerships with local health departments and community health organizations, and FQHCs ▶ Add COVID-19 to measure dashboard ▶ Treatment protocol-based checklists

*Intervention domains of influence are based on the NIMHD Research Framework. Intervention components or potential resources are elements that your HCO could examine further as part of a needs assessment for health equity interventions. Examples provided are interventions discussed during this study's kickoff meeting.

conditions for patients and providers was also considered important as these evolve over time.

Environmental interventions included both the physical and sociocultural environments. CBOs, local health departments, and FQHCs were considered resources to be mobilized within the local community for education, outreach, or direct intervention implementation (for example, an ambassador program where local trusted community members are engaged with the HCO for patient education). Interventions for the sociocultural environment centered on the interpersonal and individual levels (for example, ensuring all interventions are culturally and linguistically appropriate for minority populations). Interventions for the interpersonal relationships between healthcare professionals and patients could include education on effective strategies to reduce provider bias/discrimination and education/resources to provide linguistically and culturally appropriate care.

Healthcare system-level interventions focused on leveraging existing resources and relationships within HCOs to compliantly improve COVID-19 management. For example, one participant is considering adapting existing mobile units going into communities with complete lack of healthcare access to incorporate COVID-19 vaccination, testing, and treatment. HCOs' EHR systems could be reviewed and revised to add COVID-19 to the quality measure dashboards or create protocol-based checklists for COVID-19 management to ensure all patients are treated the same, thus reducing provider bias. Leveraging existing relationships, HCOs could also establish physician champions within multiple departments to facilitate education among physicians in advance of increased COVID-19 cases.

Conclusion

Overall, this work, as one of our expert advisors expressed, should be "not just a moment, but a movement."[27] In an attempt to impact disparities, with a particular focus on inequity in the management of COVID-19, the study team and HCOs utilized the different levels of the NIMHD Research Framework to guide exploration of intervention considerations, partnerships, and components. Through the course of this study, and by engaging multiple champions both within and outside their HCOs, our participants hope that this work will lead to measurable changes in COVID-19 treatment and outcome disparities and contribute to better engagement with patients. HCOs can leverage preliminary takeaways from the study to consider how to prepare their own organizations to provide more equitable care to patients. GPJ

Acknowledgments
Our thanks to Pfizer, Inc. for funding this study. AMGA Research considers all available treatments (i.e., is not brand specific), disease-state focused, and centers on care process design and implementation science—how medical groups and health systems improve population health. Thanks also to the 11 clinical leaders from AMGA member organizations and our expert advisors who shared their experience and expertise in this meeting.

***Elizabeth Ruvalcaba, MSPH**, is senior research project lead; **Alicia Rooney, MPH, MSW**, is population health research analyst; and **Elizabeth L. Ciemins, PhD, MPH, MA**, is senior vice president, research and analytics at AMGA.*

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Got Staffing Challenges?

AMGA understands the ongoing struggles medical groups are experiencing with clinic staffing and the significant impact on overall group performance. Our **2023 Medical Clinic Staffing Survey** provides useful data for medical groups to understand and address workforce challenges, including:

- Clinic staff benchmarks by title and role
- APC-to-physician ratios by specialty
- Benchmarks per physician, per provider, per 10,000 wRVUs, and per visit
- Data available at the specialty type rollup and specialty levels

Online and PDF options available.

Visit **amga.org/amgaconsulting/our-data/clinic-staffing**

AMGA CONSULTING

Fill in the Blanks

The latest trends in clinic staffing

By Elizabeth Siemsen and Mike Coppola, MBA

The lingering effects of the pandemic and overall economic environment continue to impact staffing in medical groups. From the results of our *2023 Clinic Staffing Survey* based on 2022 performance, the most critical issues facing AMGA members were turnover, a lack of qualified applicants, and labor expenses.

The *2023 AMGA Clinic Staffing Survey* included both qualitative and quantitative findings. Quantitatively, the benchmarks include metrics by specialty and for each clinic role, and ratios per physician, per provider, and per 10,000 work RVUs (wRVUs). On the qualitative side, medical group leaders were questioned about priorities and tactics relating to the ongoing workforce instability. The goal of combining these two methods was to understand more fully how groups were dealing with the staffing issues, adapting, and preparing for future staffing constraints.

We aim to discuss the trends in the survey results on clinic staffing levels and provide insights on how the market is working to continue to provide care and optimize operations despite the operational difficulties created by workforce shortages. The insights provide a glimpse into how groups are thinking about care redesign in the face of ongoing labor challenges and tactics to recruit and retain staff.

Demand for Staff

In the *2023 AMGA Clinic Staffing Survey*, the median total clinic staff of 2.12 per provider has returned to pre-pandemic levels, when three years ago, the *2020 AMGA Operations and Finance Survey* results showed a median of 2.13 (Figure 1). Beginning with the 2021 survey results (based on 2020 data), overall staffing was impacted by fluctuations in clinic staffing levels and provider levels throughout the pandemic.

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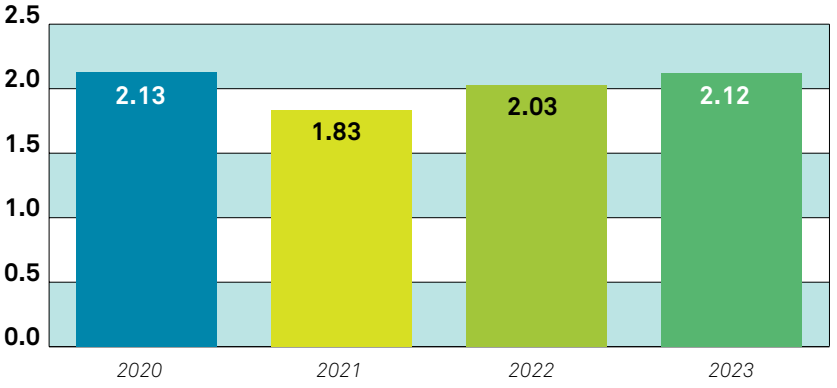
Figure 1
2023 Median Total Clinic Staff per Provider



Looking at the 2020 results as a baseline, the decline in the 2021 survey was the result of the sharp volume decline at the onset of the pandemic combined with substantial operational changes. These changes included layoffs and furloughs to manage staffing-to-demand under extreme circumstances. At the onset of the pandemic, some groups went so far as to close clinic locations in response to the drop in demand and as operations evolved during the pandemic.

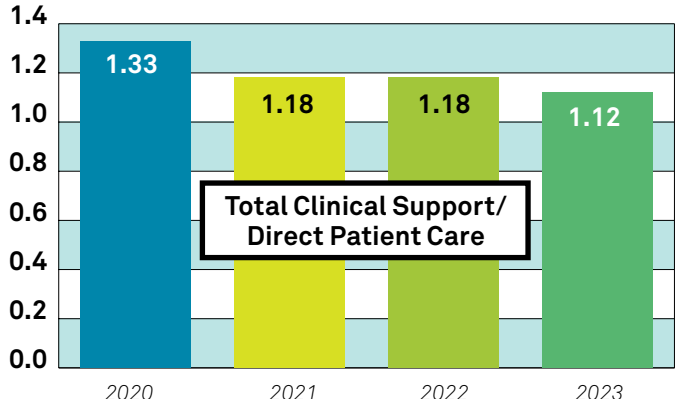
On a closer look, the recovery in the staffing seen in the 2023 survey results can be attributed more to increases in front office/administrative roles rather than clinical roles. Groups became more efficient through a combination of staffing challenges and operational improvements resulting in a decline in the medical staffing levels for medical assistants (MAs) from 0.93 in the 2020 survey down to 0.77 in the 2023 survey. By contrast, the trend for median total front office/administrative support roles show a nominal increase from 0.63 per provider in the 2020 survey to 0.71 in the 2023 survey. The recovery in staffing overall appears to mask the challenges to staff most patient care roles.

Real Differences when Volume Adjusted

Looking at the staffing trend using a per 10,000 wRVU basis provides a lens for how groups staffed to demand over the four-year period. The median total clinic staff per 10,000 wRVU in the 2023 survey is 3.79. This metric has seen a steady decline from the 2020 survey results. One factor impacting this metric is the 2021 Centers for Medicare and Medicaid Services (CMS) physician fee schedule changes, which increased wRVU, particularly in the outpatient setting, beginning in the 2022 survey year results. The decline in the 2021 ratio is to be expected, given a decline in both number of staff and overall wRVU from patient care impacted by the onset of the pandemic. In the 2022 results, further decline is partially attributable to the combination of the volume recovery and the CMS wRVU weight changes. The even lower 2023 results indicate a smaller number of staff in total compared to the prior year. Where the trend in the per provider metrics indicates an increase in clinic staff outpacing the increase in the number of providers, the trend on the median per 10,000 wRVU basis indicates the staffing recovery is slower than the increase in wRVU in the clinic setting.

This trend is driven primarily by staffing for direct patient care roles of registered nurse (RN) and MA. The same decline in the per provider metrics is present for ratios of these roles in the per 10,000 wRVU metric. The graph below shows the trends for these roles, each indicating lower staffing levels (see Figure 2).

Figure 2
Trend Comparison: Median Staffing per Provider



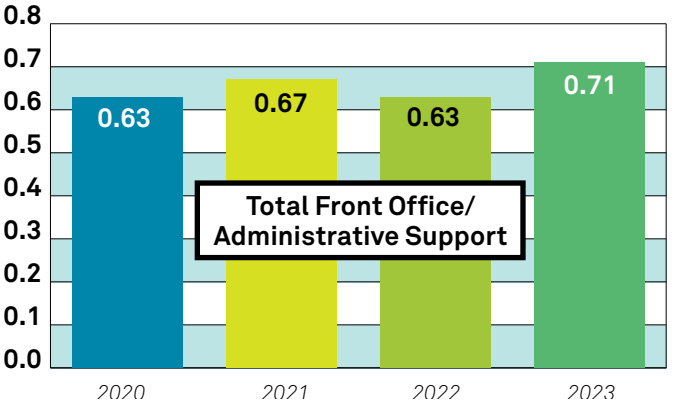


Figure 3

Median Total Clinic Staff per 10,000 wRVU

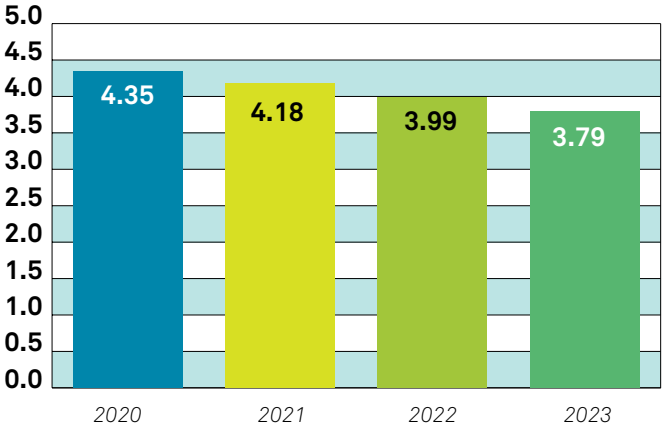
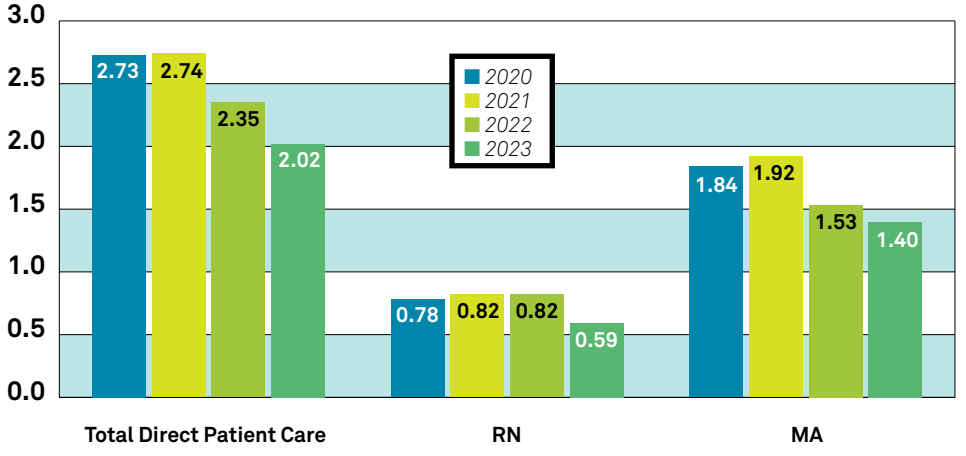


Figure 4

Median Clinic Staff per 10,000 wRVU



Overall, the trend from the 2020 through 2023 survey results, on a per 10,000 wRVU basis, indicates careful management of clinic staff resources to patient demand, whether driven by intentional operation decisions or a lack of available staff resources.

Working Through Workforce Challenges

Survey results indicate that the median increase in staffing cost from 2022 to 2023 was 10%. The increase in staffing cost is driven by engaging temporary labor resources, paying premiums over standard wage rates to current staff to fill open shifts, and overall inflationary wage increases that will not reverse.

Medical group executives identified the lack of reliable staff in the MA role as most detrimental to clinic operations. Medical groups have been employing myriad potential solutions to manage staffing instability while meeting demand for patient care during this time. The *2023 AMGA Clinic Staffing Survey* specifically attempted to identify tactics deployed to meet the current challenge. This includes tactics focused on three areas: compensation and incentives, process improvement and automation, and care model changes (see Figures 5–7).

Compensation and incentive tactics vary between those focused on attracting applicants and those focused on retaining existing talent. Leveraging wages and labor expenses is a common tool organizations use both to retain and to attract talent, and the survey results outline several levers groups use involving wages. Comparing the 2023 results to those from the prior year, the percentage of groups pursuing these options increased. For example, 88.2% of respondents indicated the use of referral bonuses in 2023, an increase from 82.8% in 2022, and 55.7% of respondents are looking at making changes to benefits packages, also an increase from 2022 at 41.1%. Sign-on bonuses are a common recruitment tool, and 77.6% of respondents indicated their use in 2023, up from 69.0% in 2022.

Now more than ever, medical groups are focusing on approaches to improve clinic operations with increased efficiency. Groups are beginning to explore the use of AI technology to automate processes and reduce or eliminate administrative tasks to help address staffing challenges. Of those responding, 90.6% are increasing the use of their online patient portal to reduce phone calls for scheduling services, reviewing results, and accepting payment. Of the groups responding, 66.7% indicate increasing utilization of automated approaches to copay collection prior to the visit. Resources to support the check-in process are further streamlined for 65.8% of respondents who have deployed self-check-in/kiosks for office visits. Leveraging technology is one key approach groups are employing to reduce the reliance on person-to-person interactions for these types of tasks.

Care model changes are not new, but staffing shortages have also led groups to research different care models and resources in the clinic setting to meet patient care needs more effectively and efficiently. Of the respondents, 72.2% are making changes to the care team in 2023, up from only 52% in 2022. Groups are increasing efforts to ensure staff are working at the top end of their skill sets in efforts to drive engagement and retention.

Figure 5

Tactics Implementing in 2023 and/or Implemented In 2022 as a Response to the Staffing Challenges in the Market

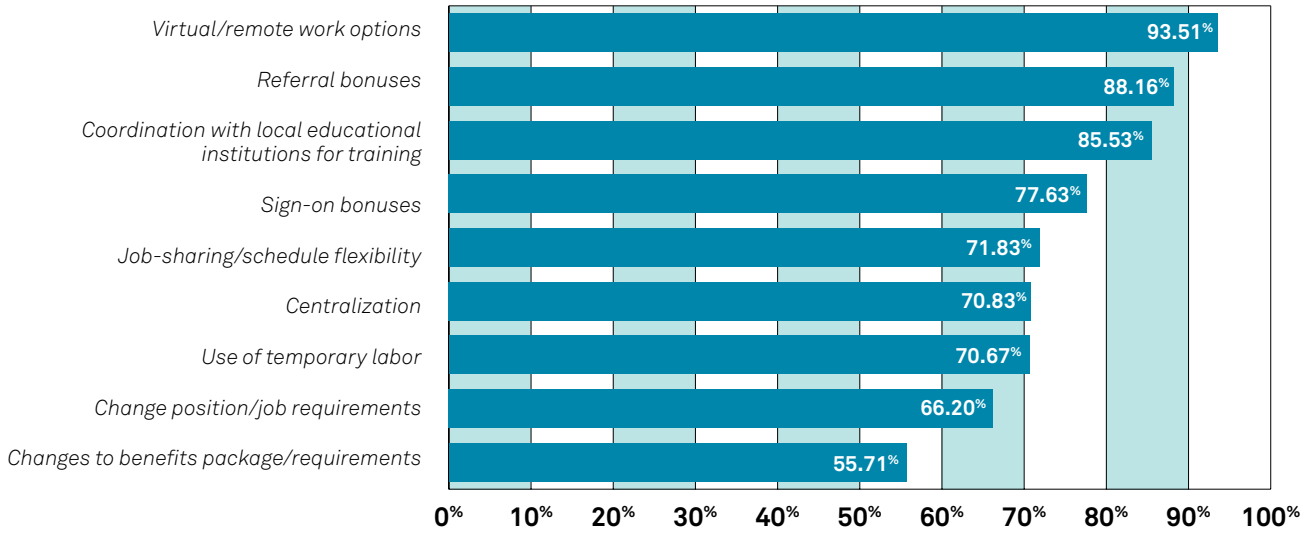
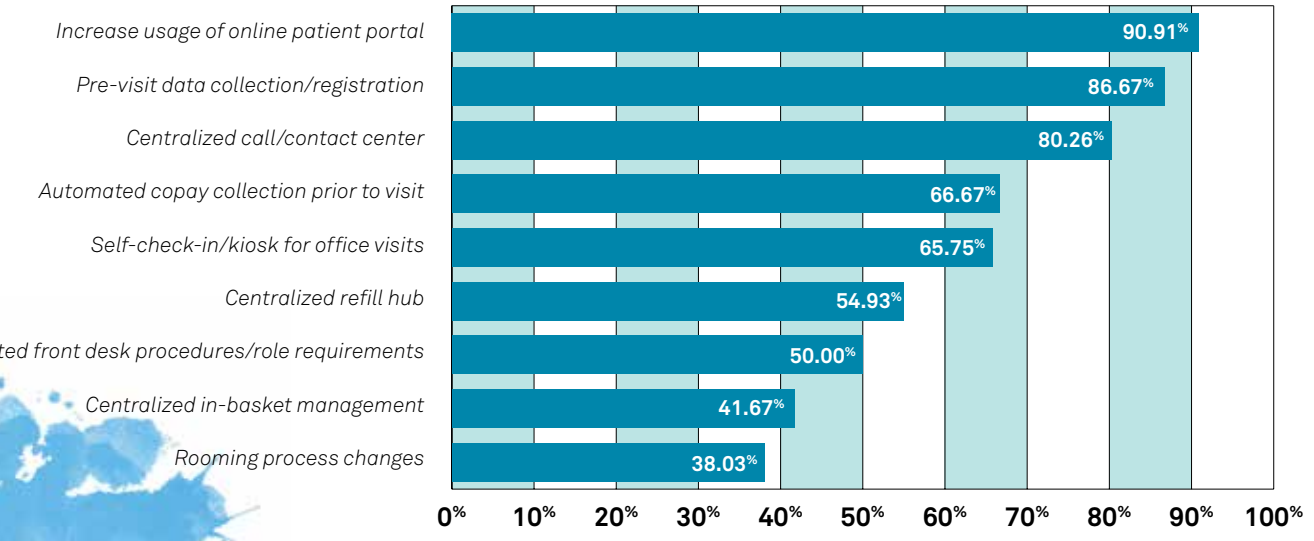


Figure 6

Process Automation/Improvement Tactics Implementing in 2023 and/or Implemented in 2022 as a Response to the Staffing Challenges in the Market



Survey Demographics

The *2023 AMGA Clinic Staffing Survey* results contain responses and data from medical groups with more than 7,900 clinics and 30,000 physician FTEs. A total of 86% of the respondents are from system-affiliated medical groups. More than 60% of the clinics represented in the data are in the North and South regions, with 11%–20% from the East and West regions. Approximately 90% of participating groups are multispecialty groups with primary care.

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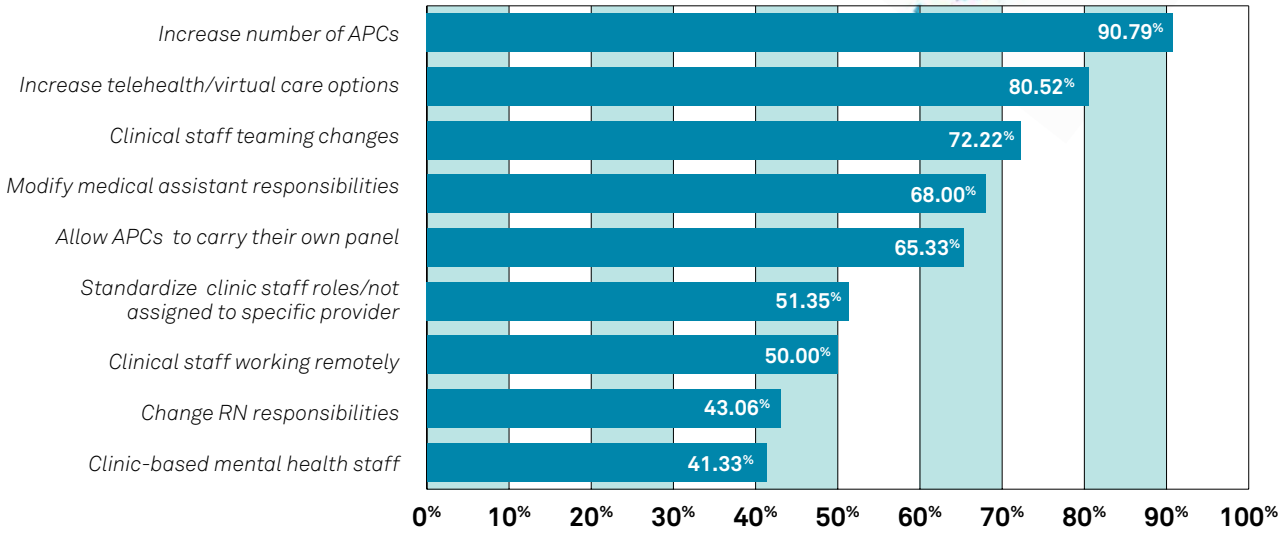
Figure 7

Care Model/Staffing Structure Tactics Implementing in 2023 and/or Implemented in 2022 as a Response to the Staffing Challenges in the Market



The continued projection of physician shortages has led to increased use and recruitment of advance practice clinicians (APCs), as evidenced by 90.8% of respondents indicating an increase in the number of APCs in 2023, up from 70.4% in 2022 (see Figure 7). A key consideration when considering APCs in care models is whether the APCs are extenders or replacements for physician capacity. APCs as a percent of total providers is a metric worth monitoring as APCs continue to grow within more medical groups and in support of more specialties.

The pandemic magnified the need for specialized skill sets like behavioral health and social work. These roles were more likely to have been reduced during the height of the pandemic, but are increasing in prevalence in the survey data. While RNs and medical assistants (MAs) are vital to the operations of most clinics, data in the 2023 survey show a rebound in the use of licensed practical nurses (LPNs) as part of the care team. After several years of decline, 61% of clinics reported data for LPNs in the 2023 results, compared to 38% in the 2021 survey. Large increases are also apparent in groups reporting ancillary staff resources (pharmacy and radiology), as well as increases in the ratios for behavioral health staff, social workers, and RN care coordinators—further evidence of the full recovery of a wider breadth of clinical resources in the clinic setting.

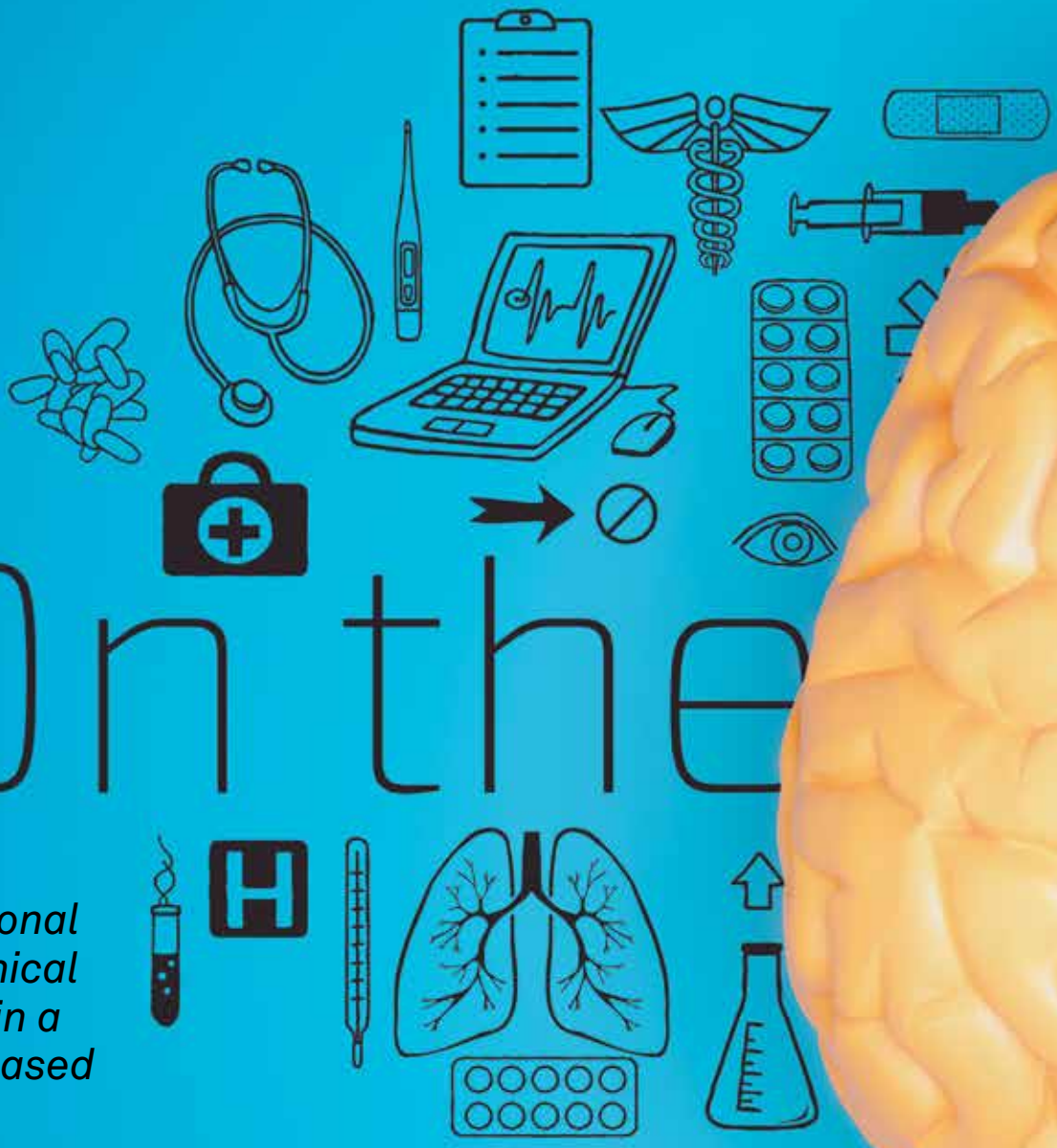
Looking Forward

We may be starting to see light at the end of the tunnel, at least in some areas. The leaders surveyed indicated that hiring challenges for APCs would resolve in 2023, with MAs stabilizing in 2024.

According to respondents, the outlook for RNs and physicians was not as clear and could take three years or longer to be managed. Again, the focus on APC hiring enabled groups to quickly expand access and meet demand. The most successful groups will integrate these resources into the care team in a deliberate way to optimize operations.

Groups will continue to evaluate and implement approaches to address clinic staffing, regardless of recovery made in this area. Even if clinics stabilize turnover and hiring, margin pressure will continue to push ongoing change in clinic processes, care team development, skill sets, and technology. Some of the strategies have a longer timetable to see the results, like education programs and relationships with local schools, but the investment provides a pipeline for potential future candidates. The makeup of clinic staff resources and care teams will continue to evolve. At the same time, groups recognize the need to retain current employee talent as a key component of their workforce strategy and will be looking at tools and engagement strategies to decrease turnover. The focus on compensation changes to ensure market competitiveness and process improvements to assist in day-to-day operations and flow both align with a work environment in which employees choose to remain. All of these pieces lay the groundwork for emerging from the current crisis and being prepared for the next one. GPJ

Elizabeth Siemsen *is director and* ***Mike Coppola, MBA****, is vice president of AMGA Consulting.*



On the

Joining operational and clinical lenses in a value-based world

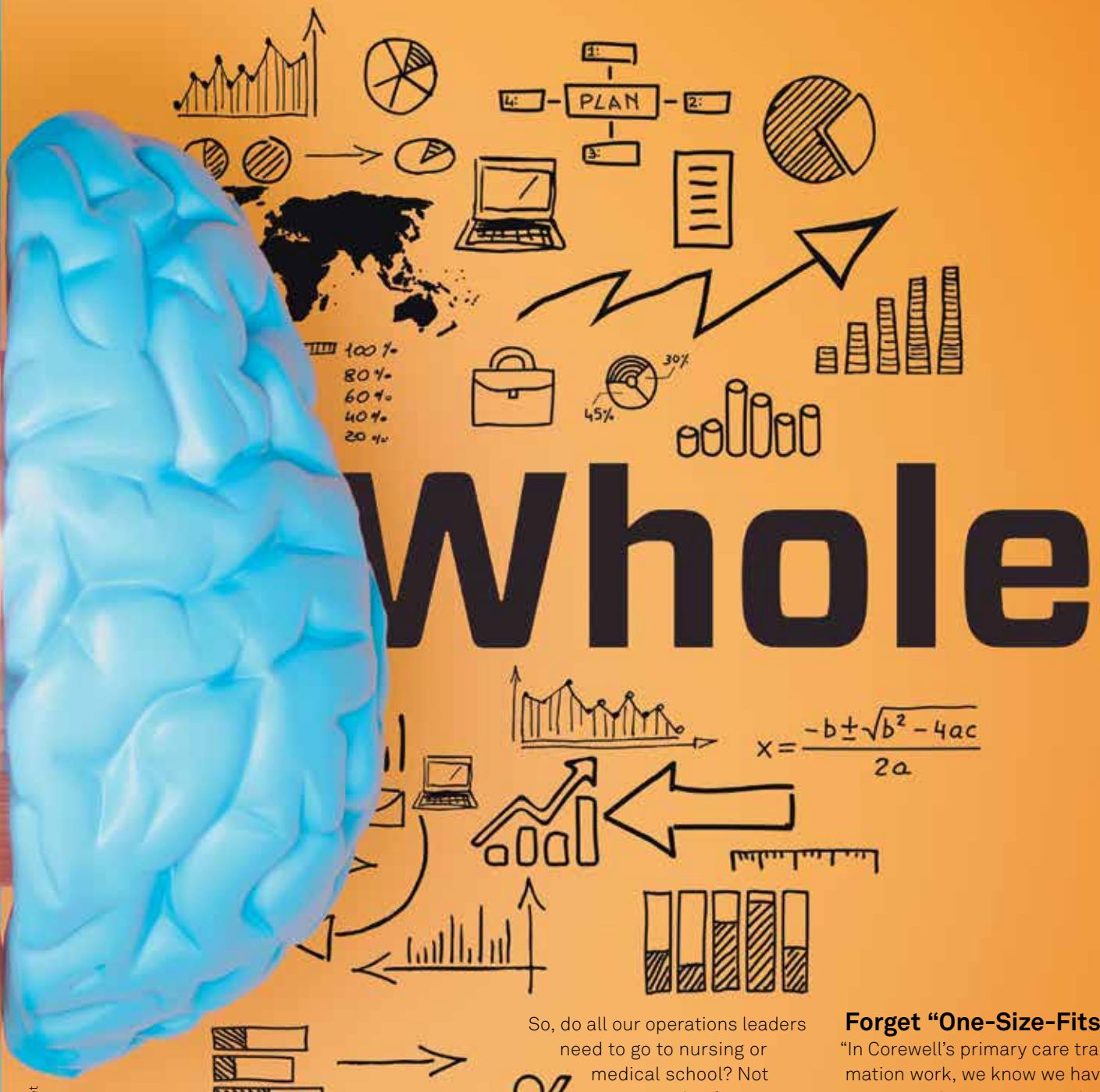
By Kevin McCune, MD

Stacy Brummel, RN, MBA, vice president, value operations at Corewell Health, had an unusual career trajectory.

When I had the chance to speak with her recently, she told me, "I went backwards. I earned a bachelor's degree in business administration and started for a hospital in administration." But she left the business side of healthcare and went back to school full time, earning her RN in an accelerated nursing program. With that degree in hand, she spent 10 years on the clinical side before returning to operations.

As unusual as this path was, Brummel's rationale is surprisingly sound. "In operations, whenever you try to talk to a clinical provider, it's like they don't understand you," she told me. "They automatically assume you do not know what you are talking about because you are not clinical. I felt frustrated—I could not get anywhere because I only understood one half of the business."

Understanding both sides of the equation is vital to the success of any healthcare organization. "Many



Whole

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times, in operations, we can identify a problem easily," Brummel said. "What is really helpful is the clinical lens to understand how to *fix* the problem. It is important to see how we can solve a clinical issue with the appropriate infrastructure."

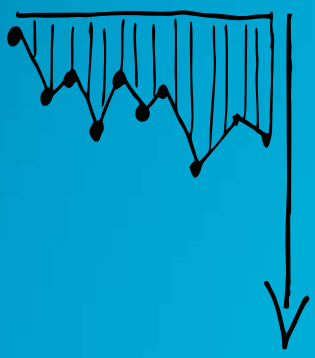
So, do all our operations leaders need to go to nursing or medical school? Not necessarily, if you maintain an effective dyad or triad relationship, Brummel said. "With a clinical partner, an operations leader has the opportunity to understand healthcare through both lenses."

Once you have joined the two sides, it's time to start solving those problems.

Forget "One-Size-Fits-All"

"In Corewell's primary care transformation work, we know we have an aging population," Brummel said. "We know that older adults need more care, but how do we manage the cost of care while getting them the care they need in the right place, which is primary care?"

Responding to this opportunity, Corewell Health opened its own advanced primary care clinics. "These are for patients 65 years and



"We went from a readmission rate of 23% for our patients at high risk down to 7%. It's really about being intentional in your understanding. Look at your data. What's the problem you need to solve? Create a program and staff it appropriately with the right people who are passionate about the work."

—Stacy Brummel, RN, MBA

older with multiple chronic conditions," she explained. "This setting allows extra time with small provider panels that are really focused on managing those patients within a highly structured clinical model."

As this population continues to age, what happens when they can no longer make it into the office? Brummel said, "As patients age, a significant percentage become homebound. How do we reduce avoidable emergency department visits and hospitalizations?"

The answer may sound a little old fashioned at first, but it makes perfect sense. "We offer home-based primary care. We will go to those patients in their homes, and we have the staffing that can help with that."

Delving deeper into varied populations, Brummel brought up patients on Medicaid. "We have a Medicaid Clinic," she said. "We know this is a vastly different population with unique needs. We knew we needed more behavioral health. We needed a psychiatrist. We needed a community health worker."

In the end, addressing the needs of Corewell Health's Medicaid population came down to access. Brummel explained further, "Where are the patients, many of whom are homeless or in shelters? Having a better understanding of social determinants of health, substance use disorders, and behavioral health wrapped into that ensures we can manage and meet patients where they are on their journey."

At its core, this iterative transformation is realizing the goal of value-based care (VBC): to deliver the right care to the right patient in the right place.

Of course, the transformation does not happen overnight. For Brummel and Corewell Health, the journey began in 2017.

Corewell Health's Value Transition

"We started in 2017 with a clinically integrated network, and then we formed an ACO [accountable care organization] in 2019," Brummel told me. "We contracted with CMS [the Centers for Medicare and Medicaid Services] for the MSSP [Medicare Shared Savings Program] through the ACO, and that was really our first step into the value arena."

She continued: "As we moved into 2020, with everything that happened with COVID, we decided to take a bigger look at value-based healthcare. We recognized that the best place for us to start was with our own health plan, Priority Health. In effect, it's a full-risk arrangement across our product lines to learn without the fear of losing money—still keeping it within the system. So this was a good test case for us to see how we can perform and gain a better understanding of what the drivers of avoidable medical expense are and where we have opportunities."

As with the rest of the healthcare world, the COVID-19 pandemic had a significant impact on Corewell Health. "We didn't have a lot of patients coming into the ambulatory space," Brummel said.

Moving into a more normal situation in 2022, Corewell Health "really started to better understand our performance," she explained. "We developed programs and entered other contracts with Blue Cross Blue Shield to really start to dive into more of the upside/downside risk now that we felt we had a better handle on how to manage it. I think the big places we have put intentional focus and resources to are care management, behavioral health, and primary care transformation."

The Right Leaders

As we have heard from so many others making the transition from fee-for-service to VBC, what enabled the transition started at the top with leadership. Brummel said, "One huge benefit for us that really pushed us forward is that Tina Freese Decker, our CEO, just said, 'Value is it. This is where we need to be, this is what we need to do, and this is part of our strategy.'"

Corewell Health named Alejandro Quiroga, MD, as the physician

leader to oversee population health. "They said, 'This is your job. You need to take this and drive it,'" she told me. "And he really stood up that department at about the same time we began our risk contracting in 2020 and 2021. Quiroga is a disruptor within our own environment, and he's right when he says we need to do things differently."

Moving Beyond Two Touches

Brummel explained that a big piece of realizing that difference was in examining how Corewell Health was being paid by its own insurance company: "For example, our plan was set up so that as long as you have two touches with a patient, you're going to get paid for care management. We thought, 'Well, we do that, but there are no outcomes.' How do know the patient improved just because we touched them?"

I had to chuckle when Brummel said, "This is probably crazy, but we went to our payer to say, 'Can you stop paying us that way?' They agreed and asked us what we wanted to do. I said, 'We're going to put programs around readmissions. We're going to look at disease management. We will measure outcomes and be paid accordingly. We want to see what our teams are doing and how it is making a difference.'"

She explained: "Flipping around how our care managers are paid freed up our care managers to really think differently about their work. We started to look at our data to see where we have big opportunities in this space. We could see that readmissions was an issue for us, so we asked ourselves whether we needed to have all these care managers embedded within primary care. Could we pull them out and centralize them? If we did that, what would it look like and what would we want them to work on? That's what really created our transition care team, who focus on patients at those transition points."

Focused Intention

Knowing that readmissions were a problem, Corewell Health assigned the transition team to follow patients for 30 days after discharge. "We started with our high-risk patients," she told me, "and really put in intentional focus to make sure that they had the right medications and follow-up appointments. Can they get to their follow-up appointment? What are their concerns, issues, and things that are going on that might make them bounce back?"

The effort paid off. "We went from a readmission rate of 23% for our patients at high risk down to 7%," Brummel shared. "It's really about being intentional in your understanding. Look at your data. What's the problem you need to solve? Create a program and staff it appropriately with the right people who are passionate about the work."

Brummel believes firmly in the importance of passionate workers for this space. "These roles are so connected to the patients that if you don't have someone who is passionate about the work, it's really going to be a struggle. We can train them on the job. We can create work standards and clinical programs. We have pathways. But if that person doesn't really want to do this work—likes this work, is passionate about this work—that's where we see trouble a lot of times. We have had nurses come into the care management role from the inpatient side of things saying, 'I just want better hours and lifestyle.' But they get into the work and realize it's not for them."

Advice to AMGA Members

When I asked what advice she had for AMGA members, Brummel said, "I think you have to be open to new ideas. Now is a great time to learn, because there are so many other people who are doing this work. There's a lot you can pull from other colleagues and other organizations. Don't be afraid to reach out. Don't be afraid to ask questions. Get a good understanding of your data, and make sure you're involving your clinical team members—especially those closest to the work."

She said, "I think sometimes we in operations think we need to fix the problems outright. We say, 'This is what we're going to do,' and we move on. But really involving the clinical team members will not only get them to buy into what you're doing, but also offer you a lot of insight you might not have."

Finally, Brummel warns that as we look at tackling the problems of team member shortages, we need to take an approach of "constant iteration." I think that's the perfect reminder that our work will never truly be done, but as long as we staff our organizations with passionate people, we'll keep inching closer to realizing all of the benefits of VBC. GPJ

***Kevin McCune, MD**, is the senior advisor on value, AMGA, and chief physician executive, AMGA Consulting.*

Cyber Attack!

Lessons learned—some the hard way

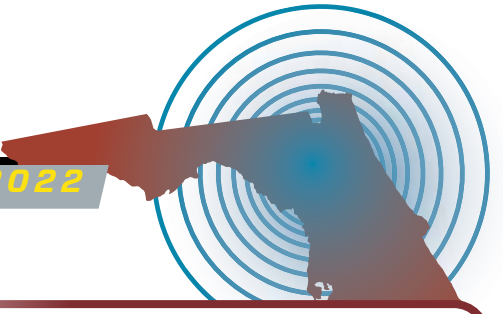
Featuring Daniel Duncanson, MD, CPE; Kristin Roberts, MBA, SHRM-CP, PHR, CHHR; and Ron Wilkins, MS (DIS)

Life experiences can often provide some of the most rewarding and retainable instances of education. Practice always has an edge over theory. Unfortunately, there are moments when the real-world understanding of things can feel less like a controlled simulation and more like a trial by fire.

Such was the case when SIMEDHealth, the largest independent multispecialty healthcare system in north central Florida, was the victim of a cyber attack last year. At AMGA's 2023 Annual Conference, Chief Executive Officer Dan Duncanson, MD, CPE; Vice President of Support Services Kristin Roberts, MBA, SHRM-CP, CHHR, PHR; and Chief of Integrated and Information Services Ron Wilkins, MS (DIS), provided an in-depth account of what it was like to have their entire network compromised and held for ransom.

"As physicians, sometimes we take care of people that have been victims," explained Duncanson. "And one of the things we talk to them about is not to keep everything internal—to find somebody or a group they can talk to. In January of 2022, we became the victims of a cyberattack, so we thought it was important for our healing process to talk, and in the process of talking, we can give you all some insight."

Providing a bit of attention-holding drama to their story, Duncanson, Roberts, and Wilkins retold their narrative with up-to-the-minute timestamps, giving the proceedings a feel similar to the style of the early-aughts action series *24*.



THURSDAY, JANUARY 13, 2022

5:30 am

After starting his day with his usual routine of taking part in some isolated hot yoga, Wilkins received a phone call from his lead lab tech, who usually goes about her own quality assurance procedures at this time of the morning to make sure all the lab machines are up and running smoothly.

"She calls me up and says, 'I can't get in anything,'" Wilkins explained. "And for anybody who has ever been in IT, you get these kind of calls, and the call I hate the most is: 'Everything's down,' 'What does that mean?' 'Everything's down!' So I say, 'OK, I'll take care of it.' I call my IT engineer and say, 'I just got a call that everything's down.' He says, 'I'll check it out.' I go back to my business. Two minutes later, he calls me back and says, 'We've been hacked.'"

6:15 am

Duncanson was driving into work and saw a call coming in from Wilkins. "Chances are that's not going to be a really good call," said Duncanson. He thought maybe Wilkins was just sick and wouldn't be able to make it into the office. He ended up wishing that were the case. Wilkins related the emergency, that SIMEDHealth has been hacked. Scrambling to clean himself up and make his way to the office, Wilkins was receiving updates from his engineer on the specifics of the breach, learning that the network's electronic medical records were down, and that—among others things—its practice management and employee files were locked. No messages or means of communication could be found from the perceived perpetrators. Wilkins gave the engineer instructions to shut everything down, even things that were still working, due to the fear of another "bomb" waiting to go off. Management teams were notified the network was down and to plan for it to stay down for the remainder of the day.

7:00 am

Roberts, who had just dropped her car off for an oil change and was walking the half block to the main office, was called by Duncanson to inform her of the hack and to tell her calls needed to be made to figure out whom they needed to reach out to for help. Upon being informed of the situation, Roberts immediately went into risk-management mode, bracing herself with the hypotheticals of whether SIMEDHealth had cyber insurance, whether HIPAA and personal health information would be exposed, how payroll would be affected, and whether the personal information of the employees, such as social security numbers, had been stolen.

9:00 am

Having spent the last two hours organizing and running through a litany of internal communications with other executives, Wilkins was informed that approximately 80% of their servers were locked down—and that every single one of those servers had been embedded with a message demanding money.

"That's when we knew we were victims of ransomware," says Wilkins. "I'm sure you've all heard that term before. It's simply when a hacker breaches your system, goes in, and uploads a program encrypting all of your files so you cannot access them. The only way to get that information back is through a decryption key that is held by the hackers."

While SIMEDHealth's CFO was tasked with outreach to their insurance agency, Roberts attempted to find out whom in law enforcement she should contact. Knowing that local law enforcement would be of little use, Roberts called the regional Florida FBI office.

"Apparently, when you're reporting a crime to the FBI, you have to leave a voicemail," explained Roberts. "So I did."

While waiting for a response, Roberts also reached out to the Florida Department of Law Enforcement and Homeland Security, who in turn told her to call the FBI.

"So I went back to the FBI," said Roberts. "I finally got ahold of somebody there, and they said, 'We can't help you here, but we do have information on our website, the IC3 [the Internet Crime Complaint Center], and you can go on there, fill out a form, and report your cybercrime.' So I went ahead and checked that out and saw I needed to answer 30-plus very detailed questions specific to the type of attack we were under, the kind of things that an IT person would really need to fill out. It was also asking for information that at that point in the morning we still did not have."

Jumping off of Roberts' account, Duncanson recalled how he had envisioned a much different kind of response. "My vision was you call the FBI. And I've talked to some people from massive health systems that have had cyberattacks, who told me how agents were sitting right next to them in their computer room with their IT team. I realized we weren't going to get that. We're too small. Besides, their focus is on catching the criminal, not getting us back up and running or fixing what's been damaged. Their focus was very different than what our immediate need was."

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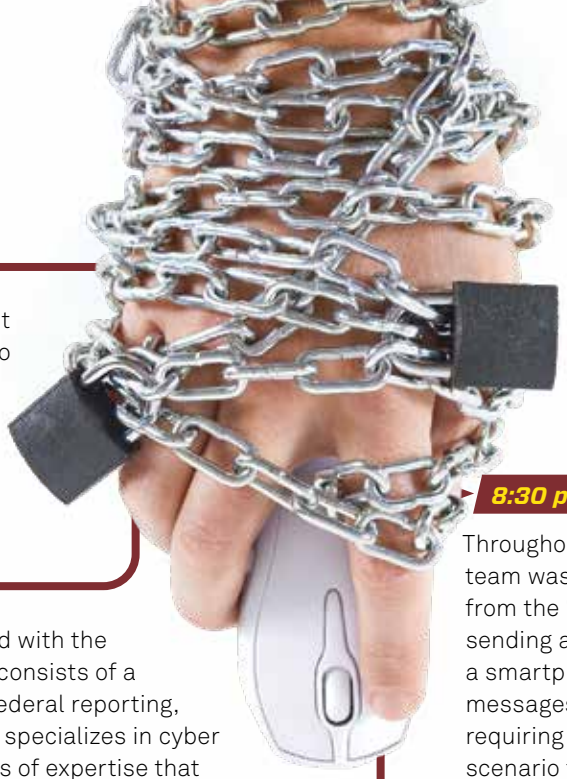


10:00 am

SIMEDHealth's CFO successfully made contact with the organization's insurance provider, who then connected with Wilkins. "It was the quickest, best phone call I think I've ever had," said Wilkins. "It was pretty much, 'We got you. Let's set up a call immediately and get the team together.'"

1:15 pm

Duncanson, Roberts, and Wilkins connected with the insurance company's team, which not only consists of a lawyer who specializes in cybercrime and federal reporting, but also representatives of a company that specializes in cyber extortion, negotiation, and forensics—areas of expertise that Wilkins said they didn't even know they needed. Though hardly out of the woods, a small sense of relief found a foothold as SIMEDHealth was no longer dealing with the situation on its own.

"It was encouraging," explained Duncanson. "The immediate thought from that initial conversation was, 'Oh, they've done this before. This is not new to them.' Whereas with us, it was all new."

As it turns out, the cybercrime response group actually had an ongoing relationship with the hackers and even had an online portal already established for communicating with each other.

"Being bluntly honest, before this, I had this image of some kid in the basement of his parents' house with a hoodie eating Hot Pockets®," said Wilkins. "It's what we've seen in the movies, right? But this is organized crime."

Essentially, as Wilkins and Duncanson described it, cybercriminals are in the business of repeat business. Although they are in fact holding valuable information hostage and asking for an inordinate amount of money for the key to the digital vault they've locked that information in, they also want to be known as reliable hostage takers—criminals who make good on their word with negotiators—so they can initiate the dance all over again down the road.

While initial communications were being made, not only were forensics being conducted on just how much information and data had been compromised from the hack and whether or not further damage could still be in the cards, but Roberts was also overseeing the external and internal reporting of the hack. With the hired legal team offering their services for the external report, it was agreed that transparency was an absolute requirement for SIMEDHealth's physicians, employees, and patients. They were all informed of the cyberattack, that the network systems had been shut down, and that all processing going forward until further notice would be conducted via paper.

While some clinics had difficulty adjusting to this new paper "parachute" reality and had to cut back on their scheduled appointments, others were able to continue at their regular speed of business. Patients, too, were very understanding of the situation.

8:30 pm

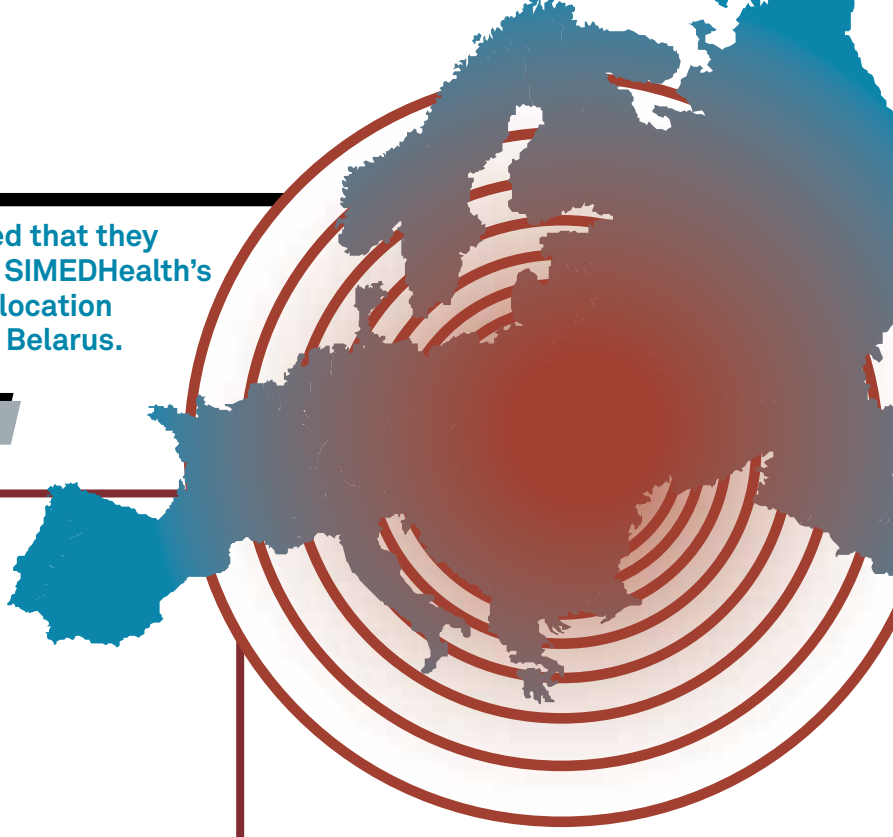
Throughout the day, the negotiating team was waiting for a response from the "threat actor." Unlike sending a simple text message over a smartphone, time between these messages can be hours apart, requiring a level of patience in a scenario that is not conducive to resiliency. Finally, the threat actor responded with the official monetary demand.

"It was significant," said Wilkins. "And of course, we go with the tried-and-true method of responding with 'That's too high. Please be reasonable.' What do you think their response was? They went higher. OK, so that didn't work. We'll try Plan B. 'All right, be reasonable.' We give them a timeframe. 'We'll pay first thing in the morning. We'll go ahead and get this done and get it done now.' So they said, 'OK, we'll drop the price $5,000.'"

Despite the fact they were facing an unenviable price tag, Duncanson admitted that he actually felt reasonably good about the amount, because it suggested that the hackers didn't get quite as much data as they wanted.

As this back-and-forth was taking place, contingency options were still being floated. Earlier in the day, SIMEDHealth's network engineer had suggested the possibility of a workaround, destroying their servers, and rebuilding all new ones off their extensive backup files. Unfortunately, the time it would take to successfully accomplish this task was four to six weeks. Clearly, this was not a viable course of action.

Timestamps from the threat actors showed that they were approximately seven hours ahead of SIMEDHealth's Eastern Time Zone, putting the criminal's location somewhere in the vicinity of Romania and Belarus.



FRIDAY, JANUARY 14, 2022

2:30 am

Throughout the night, Roberts continued to assess every plausible worst-case scenario she could think of and how each situation could potentially be addressed.

"We have well over 100,000 [active and non-active] patients in our system," Roberts explained. "So I'm thinking, how many of those were breached? How are going to notify the HHS [U.S. Department of Health and Human Services]? How are we going to notify these patients? We have 461 employees, including the providers. That's not enough staff to notify 100,000 people that they've potentially had a breach. I also started thinking about the fact that if it were more than 500 patients, we were going to have to report this not only to HHS, but also to the news outlets. I started drafting that press release in my head. The clinic level also became a sudden thought coursing through my mind. Patients have labs, they have stat images, they have other reports. The physicians couldn't access the medication lists. Were there going to be patient interactions with their medications? I was envisioning all of these risk-management cases of delayed diagnosis that were going to start hitting us."

Roberts also had to start thinking about the employees. While some employees were still seeing patients, others were not as they had to close. For those employees who weren't working, did they have to use their PTO? Do you pay them because it's not their fault they couldn't work? Do you give them unpaid days? Payroll was also a week away. How are they going to get paid? How will time be verified? How will money be transferred? Will SIMEDHealth have to write checks? Does SIMEDHealth even have checks? Then there is the HR perspective. All the employee files are on the encrypted servers. Although SIMEDHealth currently had 461 active employees, it still had well over 2,000 previous employee records. On top of that, it didn't just have the employees' information, but their beneficiaries' information, as well.

8:30 am

Having stayed awake most of the night with his phone next to him, waiting for any kind of update from the negotiators, Wilkins came back to the office only to be informed that the online portal the negotiators were using to communicate had gone down.

11:00 am

Wilkins received another message from the negotiating team. Russia had decided that this day was the day they would enact a crackdown on known hackers. It should be noted that, over the course of the communications, timestamps from the threat actors showed that they were approximately seven hours ahead of SIMEDHealth's Eastern Time Zone, putting the criminal's location somewhere in the vicinity of the former Soviet bloc of Romania and Belarus. Having not even settled on the ransom amount yet, there was no telling whether the hackers were part of the contingent arrested, were lying low, or were just slow to respond.

2:30 pm

After seemingly losing any glimmer of hope of getting their data back, Wilkins was informed by the negotiators that the portal had come back online.

4:11 pm

Communication with the hackers resumed. They had somehow avoided arrest.

iStock.com/nezezon2

6:09 pm

Negotiations resulted in an agreed-upon sum. A kind of "proof of life" was requested.

"We came to an agreement that we would send them two benign files," said Wilkins. "We knew exactly where they were locked down, and we knew what was in them—which was absolutely nothing of value—and they had to prove they could unlock them."

7:14 pm

With the hackers demonstrating that they could in fact unlock the files, the ransom was forwarded as cryptocurrency, and a key to unlock the files was sent to SIMEDHealth.

9:30 pm

In their attempt to use the key, Wilkins learned the key didn't work. Fortunately, the nonworking key was not some kind of Trojan horse designed to inflict further damage on the network, but Wilkins said he was still in "panic mode, version 3.0. I have a key that doesn't work, and we've already paid the ransom." Thankfully, the negotiators were still talking with the hackers through the portal.

11:00 pm

The hackers acknowledged their faulty key was unintended and sent a new key, which was then verified. While the deal was effectively done, the work was not over.

"It's never that simple," said Wilkins. When a virus is detected within a network, the servers have built-in protection mechanisms that engage an immediate shutdown. And while the shutdown protects the data, the process of shutting down at such a rapid speed also corrupts the database.

SATURDAY, JANUARY 15, 2022

12:46 am

Wilkins and his team spent the remainder of the night working to restore the servers to an uncorrupted state. By the time doctors were open to see patients at 8:00 am, SIMEDHealth's electronic medical record (EMR) and practice management systems were back and fully functional.

Over the following days and weeks, Duncanson, Roberts, Wilkins, and their teams proceeded with an extensive forensic analysis of the attack. The first thing they learned was the hackers got into the network using what is called a "brute force attack," accessing a port of one of SIMEDHealth's vendors, sending in a bot to keep trying passwords until it gets in. (Duncanson made it clear that SIMEDHealth no longer works with the vendor in question.)

They also discovered the hackers were unsuccessful in acquiring any personal health information of their patients or their employees. "They did try," said Wilkins. "But our firewall prevented them from pulling the files." Confirming that no personal health information had been breached, Roberts was thankfully off the hook for having to report the incident to HHS.

Taking what value they could from the experience, Duncanson said SIMEDHealth now makes all managers regularly update a contact sheet tree separate from the network in the event of a sudden shutdown of clinics, whether such closings are caused by a natural or digital disaster.

SIMEDHealth also established an alternative means of communication with patients, pharmacies, and other practices and hospitals in the event their phone, fax, or email systems go down. Preparations are now in place to be well stocked with paper forms with printers unconnected to the network. They have made sure there are means of accessing certain forms without going exclusively through the network. They have also gone through a more rigorous vetting process with their vendors to determine whether vendor security offers the level of protection that meets SIMEDHealth's new standard.

Ending the presentation, Duncanson expressed one final insight.

"I'm not here to sell insurance," he said. "But insurance was a good thing for us. We learned a lot of stuff that was important to us through our insurance. If you decide not to go with cyber insurance, I think that's fine. That's a decision each group has to make. But here's what I would encourage you to do: research what options you have out there. Having a team like the one we had available so early in the process was lifesaving for us. If you're not going to go with insurance, research them anyway. Have them in your old-fashioned Rolodex ready to go. If you do have cyber insurance, make sure they have these kind of vendors—negotiators, forensics, legal—connected so that they can act rapidly if something happens." GPJ

***Daniel Duncanson, MD, CPE**, is CEO; **Kristin Roberts, MBA, SHRM CP, PHR, CHHR**, is VP of support services; and **Ron Wilkins, MS (DIS)**, is chief of integrated and information services at SIMEDHealth.*

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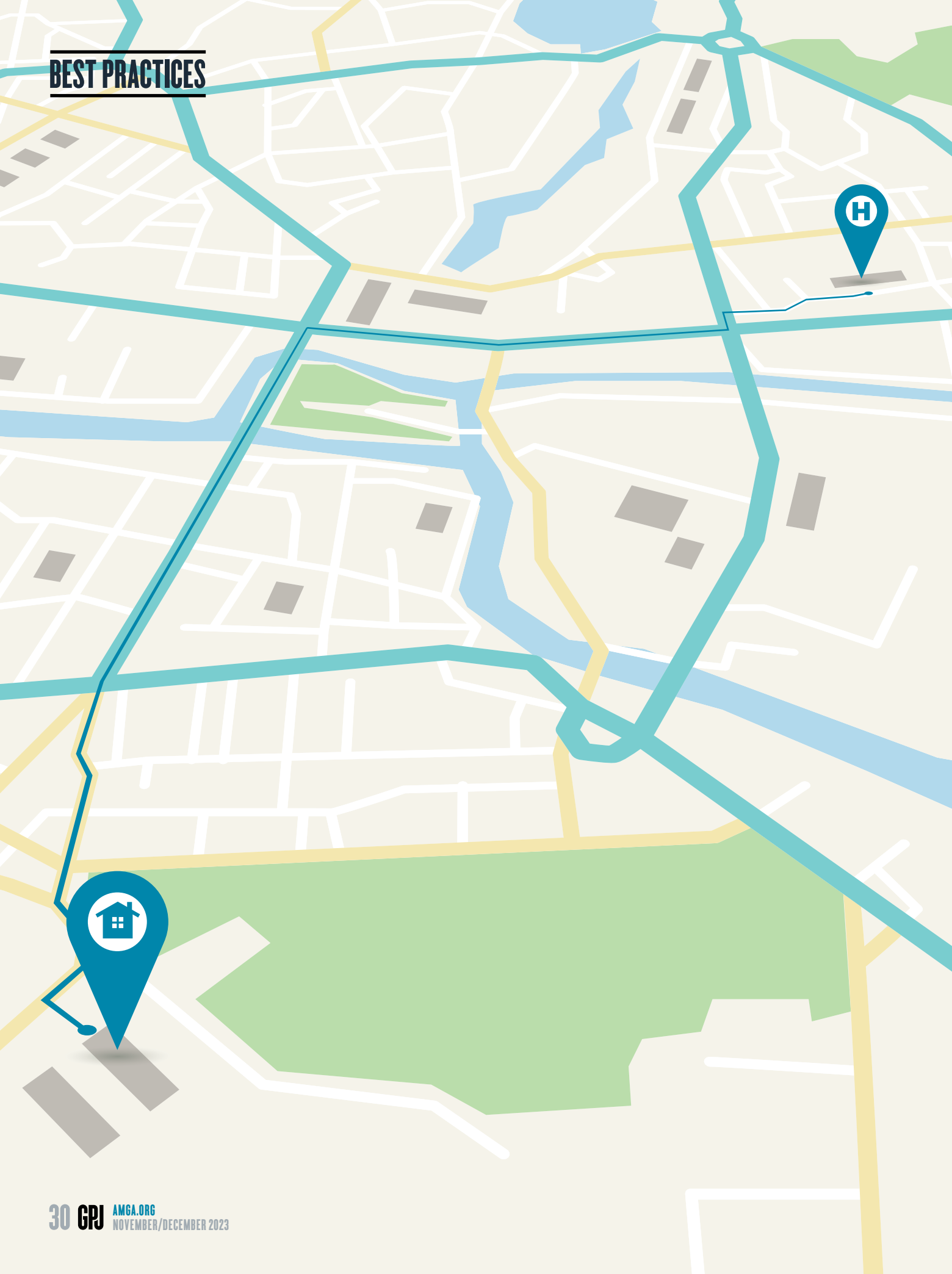
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Right This Way

Strengthening group practice patient connection and supporting new revenue opportunities

By Tina Graham

The Centers for Medicare and Medicaid Services (CMS) recognizes the critical importance of providing deeper interactions and activations of patients with multiple chronic diseases.[1] For years, CMS have been trying to encourage primary care physicians to engage in chronic care management (CCM) practices that are likely to help these vulnerable patients avoid further health deteriorations that require costly hospitalizations. The current reimbursement opportunities for CPT® codes specific to CMM offer new revenue avenues for physicians on the front lines with these patients and can help primary care and principal care physicians support their success in value-based contracting arrangements.

In particular, primary care providers and a number of specialty practices—such as oncology and rheumatology practices—serve as an important connection point for patients who are eligible for CCM. However, whether patients can fully benefit often depends on the practice's ability to allocate the time and focus of its physicians and clinical staff in order to coordinate care within the standards of CCM delivery. Given all of the demands facing a group practice, it is sometimes challenging to carve out the necessary resources to provide CCM interactions.

Nevertheless, considering today's emphasis on value-based care, meeting patient CCM goals is most certainly in the best interests of practices. The ability to deliver improved outcomes is more directly tied to reimbursement and incentive revenues based on quality metrics, patient experience, and satisfaction scores, as well as advancing health equity priorities. At some point, group practices will have to find supplemental ways to participate in CCM programs.

Care Guidance Solution

One way to respond to the needs of patients in CCM is to partner with an outsourced care guidance service that goes beyond the scope of lay navigation and extends support to clinical staff. By leveraging technology, workflows, and highly trained personnel provided by care guidance services, practices are finding new value in CCM with efficient results.

Table 1
Requirements and Components for CCM and Complex CCM

Documentation	**CCM services that must be documented in the electronic health record (EHR). Covered services include, but are not limited to:** ▶ **Management of chronic conditions** ▶ **Management of referrals to other providers** ▶ **Management of prescriptions** ▶ **Ongoing review of patient status**
Non-complex CCM (CPT code 99490)	**Requirements:** ▶ **Two or more chronic conditions expected to last at least 12 months (or until the death of the patient)** ▶ **Patient consent (verbal or signed)** ▶ **Personalized care plan in a certified EHR and a copy provided to patient** ▶ **24/7 patient access to a member of the care team for urgent needs** ▶ **Enhanced non-face-to-face communication between patient and care team** ▶ **Management of care transitions** ▶ **At least 20 minutes of clinical staff time per calendar month spent on non-face-to-face CCM services directed by physician or other qualified health care professional** ▶ **CCM services provided by a physician or other qualified health care professional are reported using CPT code 99491 and require at least 30 minutes of personal time spent in care management activities**
Complex CCM (CPT code 99487)	**Shares common required service elements with CCM, but has different requirements for:** ▶ **Amount of clinical staff service time provided (at least 60 minutes)** ▶ **Complexity of medical decision making involved (moderate to high complexity)**

Source: The American Academy of Family Physicians Foundation. 2023. Chronic Care Management. AAFP.org.

Care guidance service partnerships help improve patient satisfaction and retention and improve overall health outcomes. As a patient activation solution, the primary objective of care guidance programs is to promptly identify and resolve a patient's disparity-driven barriers to accessing, receiving, and adhering to care before nonclinical issues become clinically problematic and costly.[2] The addition of a care guidance program provides group practices and healthcare organizations with a truly effective support service by freeing up labor, time, and resources so that clinical staff can focus on high-value tasks within their scope.

How Care Guidance Works

The success of a care guidance program rests largely on specially selected and tech-enabled "care guides" who work to establish a peer-to-patient connection with patients and their families. This human-led approach builds trust, enhances a patient's ability to communicate, and helps to uncover issues that pose barriers to care. Care guides then work to resolve these issues and assist patients in the ongoing process of their care.

Optimally, care guides are equipped with scalable technology platforms that provide structured workflows and use evidence-based disease- and condition-specific protocols to proactively identify and resolve practical and nonclinical barriers experienced during care. With this technology support, care guides ensure that nonclinical issues are promptly resolved and clinical issues are immediately escalated to proper clinical care teams.

The human element of care guidance is important, as automated technology cannot be a replacement for the human aspect of patient interaction. This is especially true considering the limited abilities certain patients have in accessing digital health technologies and potential use impairments among disabled, disadvantaged, and senior populations. The right mix of integrated human and tech elements supports personalized and meaningful peer-to-patient relationships and personalized communication in providing patients and their families with the connected support they need to stay on track and engage in the management of their condition throughout their care continuum.

Billing and Reimbursement: New Revenue Opportunities

CCM services usually qualify for reimbursement through government-managed care programs and are provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months. As these programs have the ability to garner additional revenue streams, group practices must understand the billing and reimbursement procedures to ensure proper compensation for the services provided.

Since the introduction of reimbursement for CCM, CMS have consistently increased payment rates to advance this important aspect of connected care for patients experiencing multiple complex conditions. CPT code 99490 covers noncomplex CCM, paying an average reimbursement rate for

20 minutes of service provided by clinical staff (per patient per month) to coordinate care across providers. Providers are also permitted to bill CPT code 99439 up to two times (per patient per month) as an add on code, paying a reimbursement rate for each additional 20 minutes of service provided by clinical staff.[3]

Care guidance programs support a range of additional care management models, including:

- Principal care management (PCM)
- Annual wellness visit (AWV)
- Remote patient management (RPM)
- Total care management (TCM)

A growing number of providers are electing to participate in arrangements that link payments to measured health equity improvements and overall quality performance indicators. A CMS initiative that helps advance health equity is the introduction of the Quality Payment Program (QPP) as a value component to the accountable care organization (ACO) model.[2]

For providers exploring options to participate in CMS programs with the support of care guidance to supplement clinical protocols with social determinants efforts, there are a number of choices. No matter which program a provider is considering, the common element is the need to better identify, document, and resolve barriers embedded in social determinants of health (SDoH) and drivers of disparities, and advance health equity for all patient populations.

Addressing and Resolving Nonclinical Care Barriers

Patients in CCM benefit from a holistic, personalized, proactive, and preventative care approach. However, some patient populations find it more difficult to access, receive, and adhere to chronic care because of the socioeconomic conditions that drive disparities underlined by nonclinical factors. These patients typically require amplified levels of activation, coordination, support, and monitoring that challenge group practices and hospitals within their health systems. These problems are compounded by the clinical and financial impact of the national nurse shortage.

Nearly 80% of overall health and health outcomes are tied to nonclinical, social determinant factors.[4] Left unresolved, nonclinical issues may create barriers to care delivery and transitions, treatment adherence, and medication compliance, and hinder a patient's ability to perform self-care. These barriers potentially lead to health deteriorations and rehospitalizations that complicate CCM, require additional healthcare service utilization, and financially burden group practices.

There is growing recognition throughout healthcare of the struggles patients in CCM face to overcome disparities attributed to SDoH, the conditions in which patients live that affect a wide range of their everyday functions, and typically fall outside of a group practice's visibility and control. SDoH are categorized by socioeconomic, educational, cultural, and environmental domains shown to perpetuate health disparities and widen health inequities among patients, especially affecting those with chronic health conditions.[5]

Figure 1

Patient Navigators in Cancer Care: Across the Care Continuum

Source: "What are patient navigators and how can they improve integration of care?" Policy Brief, No. 44.; Budde H, Williams GA, Scarpetti G, et al; based on Freeman & Rodriguez

Evidence

According to a policy brief issued by a partner of the World Health Organization (WHO), there are rising rates of chronic diseases, long-term conditions, and multimorbidity, with patient health care needs becoming increasingly diverse and complex.[6] Many patients in CCM repeatedly have to transition between inpatient and ambulatory care, as well as different providers, and they often need support in coordinating care.

A systematic review observed that patients with chronic diseases experience barriers to managing their diseases and accessing available health services.[7] The investigators recognized that patient-navigated programs are increasingly used to help patients with chronic diseases navigate and access health services. Findings indicate that these programs improve processes of care and clinical outcomes and reduce costs.

Extended and Expanded Support

Healthcare experts highlight the need for an extended and expanded support solution that has capabilities to address the operational challenges group practices commonly face to manage patients in CCM and lower the cost of delivering care efficiently and effectively.

Collaboration among hospitals, providers, and care guidance teams create a triad of care coordination and management. Hospitals and their

clinical staffs receive the extended support they need from a dedicated care guidance service by:

- Reaching and managing more patients, maintaining their continuity of care
- Removing nonclinical tasks from the workloads of nurses and clinical staff
- Performing follow-ups and monitoring, conducting follow-up tasks, and ensuring potential issues and barriers are proactively identified and resolved
- Scheduling appointments, screenings, preventive care, and annual wellness visits
- Ensuring compliance, adherence, and medication management
- Reducing unnecessary service utilization and avoidable readmissions

A Higher Level of Personalized and Preventive Care

Care guidance supports CCM by helping at-risk patients navigate the complex healthcare landscape. This renders a higher level of personalized and preventive care to improve the provider's ability to deliver patient-centered care and generate the best possible health and wellness outcomes with a return to a normal degree of function and quality of life. Hospitals and their clinical staffs receive the extended support they need to advance health equity and deliver care that optimizes patient experience and satisfaction.

Care guidance assists with a number of CCM tasks, such as facilitating referrals to specialists, scheduling follow-up appointments and therapy, arranging transportation, and helping patients and their families access social service resources, support groups, and financial assistance. One of the key components of CCM is patient education. Care guidance helps patients ensure they understand the information pertaining to their conditions, prescribed treatment, and medication plan. As managing chronic conditions is often influenced by lifestyle factors such as diet, exercise, and stress, group practices can work with care guidance partners to implement strategies that encourage lifestyle modifications and empower patients to take a more active role in their everyday self-care.

Technology Integration

Group practices can incorporate technology to support CCM to capture strategic insights and data analysis. This information is used to assess patient outcomes and utilization of services, and identify trends, gaps in care, and areas needing improvement in the CCM program.

An effective care guidance platform should capture SDoH data and disparity-related barrier resolution to supplement electronic medical records (EHR) systems, some of which are not specifically designed to facilitate the kind of workflows needed when addressing health equity and SDoH issues. For example, upon patient intake, care guides conduct assessments to identify the patient's social needs and concerns. Data from these screenings provide key insights to identify probable SDoH risks. Led by this intelligence, care guides can then promptly resolve nonclinical issues and promptly escalate clinical issues.

Value of a Care Guidance Partnership

Care guidance is becoming a "must-have" addition to the service line portfolio of health systems, hospitals, and provider organizations. It is at the nexus of CCM and managed care priorities where care guidance represents an innovative approach to connected care, advancing heath equity, and delivering high-value, high-quality care. A partnership with a dedicated care guidance provider with a portfolio of available services can be a highly effective strategy, rather than attempting to allocate internal resources to perform the tasks that dedicated resources can provide more efficiently and with lower overall cost.

An outsourced care guidance program that is scaled and well designed offers a truly cost- and time-effective connected care solution. Providers receive extended clinical and nonclinical support in the context the "triple aim" of improving the care experience, advancing population health, and reducing total cost of care. Patients receive equitable and personalized care, clinical staffs are freed to focus on the tasks within their scope, and hospital administrators have an opportunity to improve financial and operational performance. This is where care guidance presents the most value to all shareholders. GPJ

Tina Graham *is COO of Guideway Care.*

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John Heilemann (far left) is editor-in-chief and cofounder of Recount Media; creator and host, *The Circus* on Showtime; National Affairs Analyst, NBC News and MSNBC; and coauthor of *The New York Times* Bestsellers *Game Change* and *Double Down*.

Mark McKinnon is creator, executive producer, and cohost of Showtime's *The Circus*; cofounder of the bipartisan group No Labels; and former chief media advisor to George W. Bush and John McCain.

Complete session descriptions and continuing education information is available at: **amga.org/AC24**

Agenda at a Glance (Subject to Change)

Monday, April 8

12:00 pm – 5:00 pm	AMGA Board Meeting

Tuesday, April 9

8:00 am – 5:00 pm	Leadership Council Meetings **($)***
5:30 pm – 7:00 pm	Leadership Council Reception*
7:00 pm – 9:00 pm	Distinguished Leaders Dinner (invite only)

Wednesday, April 10

6:30 am – 1:00 pm	AMGA Golf Classic **($)**
7:00 am – 12:00 pm	Women in Leadership Meeting **($)***
8:00 am – 10:00 am	AMGA Foundation Board Meeting
10:30 am – 12:30 pm	Chronic Care Roundtable (invite only)
2:00 pm – 4:00 pm	Exhibit Hall and Poster Session Preview
1:30 pm – 5:00 pm	Immersion Sessions **($)**
5:00 pm – 5:30 pm	Spotlight on Membership Reception (invite only)
5:00 pm – 7:00 pm	Welcome Reception
6:00 pm – 7:00 pm	HPPE Reception (invite only)

Thursday, April 11

7:00 am – 8:00 am	Networking Breakfast in Exhibit Hall
8:00 am – 9:30 am	Opening General Session: *Carla Harris, Senior Client Advisor, Morgan Stanley* ***The Dr. Scott Hayworth and the Honorable Dr. Nan Hayworth Lecture***
9:30 am – 10:15 am	Exhibit Hall Refreshments/Networking
10:15 am – 11:15 am	Peer-to-Peer Breakouts
11:30 am – 12:30 pm	Peer-to-Peer Breakouts
12:30 pm – 1:30 pm	Exhibit Hall Lunch/Networking
12:30 pm – 1:30 pm	Past Leaders Luncheon (invite only)
1:30 pm – 3:30 pm	AMGA/Janssen CV19 Health Equity Workshop
1:45 pm – 2:45 pm	Industry Partner Sponsored Breakouts
2:45 pm – 4:00 pm	Refreshment Break in Exhibit Hall with Poster Presentations
4:00 pm – 5:00 pm	Peer-to-Peer Breakouts
5:00 pm – 6:30 pm	Happy Hour in Exhibit Hall
6:30 pm – 7:30 pm	AMGA Value Pathways Reception (invite only)
7:00 pm – 8:30 pm	AMGA Foundation Celebration (invite only)

Friday, April 12

7:00 am – 8:00 am	Networking Breakfast
8:15 am – 9:45 am	General Session: *Jeremy Gutsche, CEO of Trend Hunter and* New York Times *Bestselling Author and Speaker*
10:00 am – 11:00 am	Networking Discussion Groups
11:30 am – 12:30 pm	Closing General Session: *John Heilemann, Editor-in-Chief and Cofounder, Recount Media,* and *Mark McKinnon, Creator, Executive Producer, Cohost of Showtime's* The Circus
12:30 pm – 2:00 pm	Closing Reception

*For AMGA member medical groups only. **($)** Indicates additional registration fee required.

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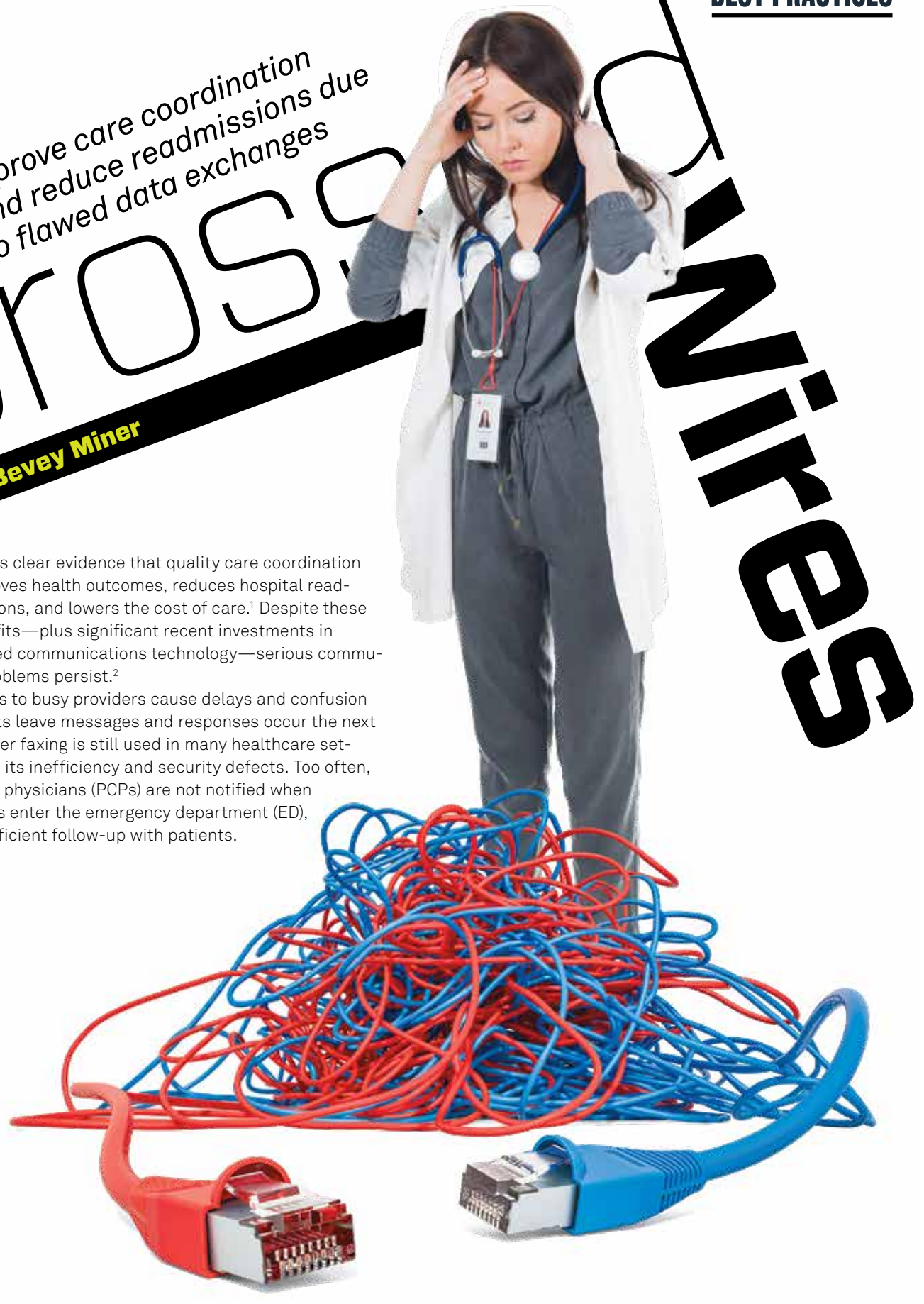
Crossed Wires

Improve care coordination and reduce readmissions due to flawed data exchanges

By Bevey Miner



There is clear evidence that quality care coordination improves health outcomes, reduces hospital readmissions, and lowers the cost of care.[1] Despite these benefits—plus significant recent investments in health-related communications technology—serious communications problems persist.[2]

Phone calls to busy providers cause delays and confusion when patients leave messages and responses occur the next day, and paper faxing is still used in many healthcare settings despite its inefficiency and security defects. Too often, primary care physicians (PCPs) are not notified when their patients enter the emergency department (ED), impacting efficient follow-up with patients.

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Efficient workflows combined with advanced technology create a virtuous circle in which clear communication leads to quality care coordination, which leads to improved outcomes, few avoidable admissions, and decreased clinical burnout. This process, in turn, lowers patient and payer costs and helps providers comply with the 21st Century Cures Act.

Automation Reduces Handoff Errors

Patient transitions (also called "handoffs") remain a significant issue in healthcare five years after the Joint Commission issued a *Sentinel Event Alert* on the subject. "Potential for patient harm—from the minor to the severe—is introduced when the receiver attains information that is inaccurate, incomplete, not timely, misinterpreted, or otherwise not what is needed," the alert asserts.[2]

The alert suggests actions to improve handoffs, including culture changes and focusing on improving the organization's systemic approach to handoffs (rather than singling out individual errors) and standardizing critical content to be communicated during a handoff. The alert also advocates for monitoring the success of interventions to improve handoff communication and using lessons learned to drive improvement.

Technology is another suggested action item for improving patient handoffs, with the alert calling for the use of clinical content standards such as the Consolidated Clinical Document Architecture (C-CDA) and other technologies to streamline hand-offs. "Facilitate ongoing communications and feedback loops between senders and receivers by providing as much critical information as possible," the alert states.[2]

Upgrade Eliminates Manual Work, 150 Daily Phone Calls

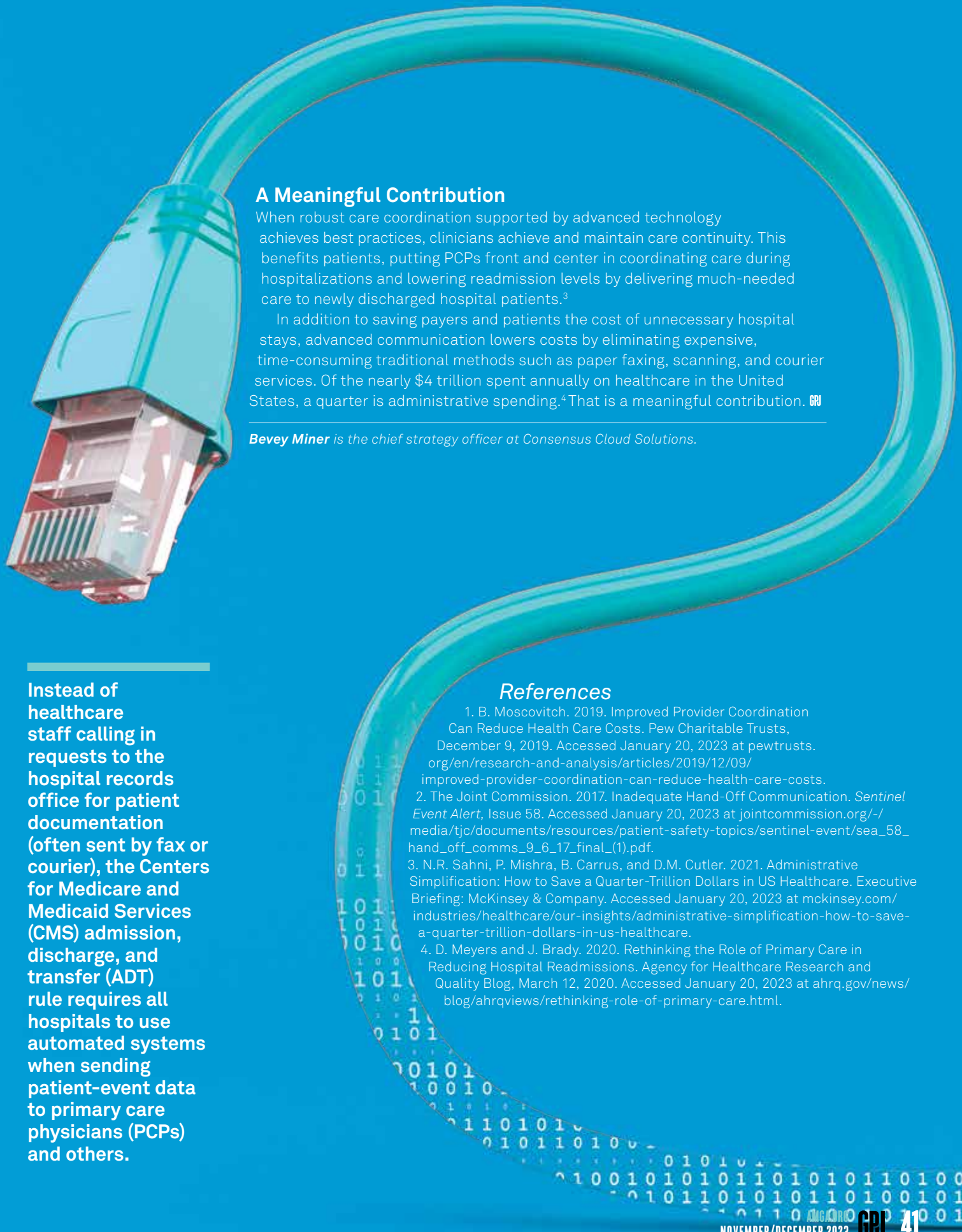
As recommended by the Joint Commission, today's clinical data exchange platforms are changing the way hospitals communicate with clinics and other providers in their community, both in and outside of network. Instead of healthcare staff calling in requests to the hospital records office for patient documentation (often sent by fax or courier), the Centers for Medicare and Medicaid Services (CMS) admission, discharge, and transfer (ADT) rule requires all hospitals to use automated systems when sending patient-event data to PCPs and others.

For example, a 200-bed community hospital in California replaced its manual processes with an advanced clinical data exchange system that provides on-demand, 24/7 access to patient records. The system's rules and integration engine, along with account and subscription verification capabilities, ensure that correct patient information is securely delivered to the correct provider in a timely manner. The platform gives community providers data access without allowing full electronic health record (EHR) permissions while ensuring that all processed data are automatically encrypted to Health Insurance Portability and Accountability Act (HIPAA) standards.

Within a month of going live on the platform, the hospital had connected 315 area providers and was successfully receiving notifications and corresponding documentation. This eliminated around 150 phone calls and paper faxes daily from the hospital's health information management (HIM) department. In less than a year, the hospital delivered more than 1.4 million event and reporting notifications and shared more than 70,000 ED encounters, 57,000 outpatient encounters, and 50,000 pre-admit and admit encounters.

The hospital now experiences the following system benefits:

- Care managers are immediately alerted that a high-need patient presented for care in the ED or was in transition from acute care, enabling providers to engage the entire care team in an intervention plan.
- PCPs and all care team members are immediately alerted to patient events, improving post-discharge follow-up care.
- Patient-centric care team communication results in increased collaboration, reducing the number of patients that slip through care delivery gaps.
- Labor-free processing of patient records lowers traditional faxing and mailing costs.
- The burden on HIM staff to manage high volumes of phone calls is reduced in favor of a streamlined, secure approach to exchanging patient data.
- Delivery and read receipts are used, where applicable, to ensure key stakeholder engagement. The audit trail is used to track provider responsiveness and identify gaps in care delivery.



A Meaningful Contribution

When robust care coordination supported by advanced technology achieves best practices, clinicians achieve and maintain care continuity. This benefits patients, putting PCPs front and center in coordinating care during hospitalizations and lowering readmission levels by delivering much-needed care to newly discharged hospital patients.[3]

In addition to saving payers and patients the cost of unnecessary hospital stays, advanced communication lowers costs by eliminating expensive, time-consuming traditional methods such as paper faxing, scanning, and courier services. Of the nearly $4 trillion spent annually on healthcare in the United States, a quarter is administrative spending.[4] That is a meaningful contribution. GPJ

Bevey Miner *is the chief strategy officer at Consensus Cloud Solutions.*

Instead of healthcare staff calling in requests to the hospital records office for patient documentation (often sent by fax or courier), the Centers for Medicare and Medicaid Services (CMS) admission, discharge, and transfer (ADT) rule requires all hospitals to use automated systems when sending patient-event data to primary care physicians (PCPs) and others.

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Engagement is key to better care and health outcomes

Knowledge Is Power

By Peggy Chou, MD, MBA

Managing the care of high-need patients, particularly those with chronic diseases like diabetes, heart disease, or obesity, is taking a toll on clinicians and medical groups that are already operating on lean budgets with limited staff and resources.

Engaging these patients between medical appointments with digital health platforms overseen by trained and certified health coaches can help solve this problem, particularly when paired with an existing medical group. Experience proves that this solution results in better outcomes for patients and improved efficiencies for clinicians. It also creates more opportunity for medical groups to focus on core operations, patient growth, and new revenue sources.

Engagement is key. Engaged patients are more successful in managing their medical condition and more profitable to healthcare organizations. Clinicians who are more engaged are more effective and less likely to suffer from burnout.

Here are three example cases to demonstrate what engagement looks like.

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1 Overcoming Work Conditions

Patient S. is a 56-year-old landscaper with diabetes who wasn't able to check his sugar levels while working. There was no safe, clean way to do so, and he didn't understand the importance of monitoring these levels throughout the day. This is where Stability Health played an important role. Susan MacLean, a registered dietician and certified diabetes and care education specialist (CDCES), is an integral part of the Stability Health team. She discovered the patient wasn't taking his insulin at lunch, identifying this problem through attentive listening and active conversation.

S., who is Hispanic, also struggled with the English language, complicating the care process. However, once MacLean identified that he wasn't properly monitoring his sugar levels while at work, she came up with a solution and discussed it with S.'s doctor. She got him on a continuous glucose monitor (CGM) in order to read his blood sugar levels and a patch pump that holds three days of insulin, which could be strapped to his abdomen away from the dirt and grime of his job. Now S. is able to safely check his sugar levels using his phone, eliminating concerns about cleanliness. His progress is monitored by his health coach and shared with his physician. Once he started to feel better and fully understood the cause and effect of his choices and actions, S. made remarkable progress. His A1C history went from >15.0% in February 2022 to 7.3% a year later, and his LDL improved from 98 to 77 mg/dL within the same time period. With very little change in his medication management, most of S.'s improvement came from four key areas. With the help of his coach he: (1) better understood his condition; (2) started properly using his medication; (3) continued regular check-ins with his health coach, who in turn reported everything to his primary care physician (PCP); and (4) assumed more accountability for making better lifestyle choices.

2 Addressing a High-Need Patient

Patient R. is a 51-year-old Black male who had an amputation and uses a wheelchair to get around. He, too, has diabetes and was taking 150 units of insulin a day to manage his glucose but still had a significantly elevated A1C level. He was also a strain on his healthcare team, as he was consistently reaching out to his providers with questions, complaints, and medical complications.

Jennifer Newman, RD, LDN, CDCES, clinical team leader at Stability Health, managed his care. She supported him by helping him understand the diabetes disease process and the need for lifestyle changes, including healthy eating and exercise. Newman encouraged the patient to participate in wheelchair exercise. Simultaneously, Stability Health's diabetologist recommended his PCP adjust his medication beyond a further increase of his already high insulin dose.

As a result of these interventions, R. slowly and safely de-escalated his insulin dose to 5–10 units/day and lost 50 pounds. Once he started feeling better, his exercise activity increased, and he became much more engaged in his healthcare. These improvements freed up the previous involvement of his clinical team to focus energies and efforts on other patients and organizational needs. R.'s need for attention diminished as he started to feel better.

3 Culturally Appropriate Recommendations

Patient L. is a 61-year-old South Asian woman with a 15-year history of type 2 diabetes complicated by micro-albuminuria. Initially, she was hesitant to work with her coach. It took a while for Newman to gain her trust. But in time she did, because Newman helped her in a culturally sensitive manner and tailored recommendations to her food and cultural preferences.

After four months of engagement with Stability Health, L.'s A1C went from 9.2% to 5.8%. Much of this decrease was associated with weight loss and a 10% reduction in her insulin dose. Her time in range, reflected by a Dexcom CGM device, improved from 45.9% to 82.9%. Her diet also improved dramatically, with the patient consuming three balanced meals each day with more vegetables and salads.

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An All-Around Win

According to MacLean, "It is so gratifying to develop a rapport and work with patients on lifestyle and behavior change. The results from the patient's efforts alone are remarkable, but being able to support their provider as well, with updates and recommendations, takes the progress to a whole new level. It's an effective, collaborative model that empowers the patient and supports the provider. It makes me feel great at the end of the day. A win/win/win!"

"It is so gratifying to develop a rapport and work with patients on lifestyle and behavior change … It makes me feel great at the end of the day. A win/win/win!"
—Susan MacLean

Although all these examples are specific to diabetes management, Stability Health's tech-enabled engagement platform is easily adapted to other chronic conditions. We started with diabetes management because of its significant impact on medical groups.

Currently, 1.4 million Americans are diagnosed per year with the disease (the number is rising), and medical expenditures are 2.3 times higher with diabetes.[1] Patients with diabetes comorbidity represent 34% of in-hospital admissions.[2] It is not usually the primary or even secondary diagnosis, but it factors into length of stay and workload of discharge planning. In addition, patients with diabetes are a significant part of a PCP's workload and of an organization's quality metrics for Healthcare Effectiveness Data and Information Set (HEDIS) scores. Furthermore, now that hospital admission rates have become a quality metric for value-based programs, such as Primary Care First and ACO REACH, mitigating the burden of diabetes care on the system is imperative.

Touch Points and Outcomes

Newman believes that touch points have a direct impact on the quality of care she can deliver and subsequently improve patient outcomes. She said, "The ability to have more frequent touch points with patients helps them feel more supported." She goes on to explain that she was led to this profession because of what she observed when her father had a heart attack and died. She felt that he didn't get the personal support that he should have received and believes that affected his quality of care.

In a collaborative white paper published by Stability Health and Penn Medicine, Penn's partnership with Stability Health demonstrated that the care model of supporting and engaging patients and clinicians produced clinically significant outcomes.[3] The care model, which combines elements of the Chronic Care Model with newer technology and a health coach, creates an expanded care team with

the ability to frequently connect with patients, helping them adhere to treatment and improve self-management.

Stability Health's own internal data aggregated across all its medical group partners show high patient engagement rates—up to 80% in the ambulatory outpatient setting. Specific to diabetes, this high level of patient engagement translates into clinically significant reductions in A1C in as little as four months.

How Stability Health Works

The success that Stability Health is having working with medical groups and their clinicians is attributed to its transformative care model, its care team, and its success with patient and clinician engagement.

The foundation of its transformative care model is the proprietary technology platform. The platform contains a rules engine that embeds evidence-based standards of care from a variety of professional organizations, such as the American Diabetes Association and Association of Certified Diabetes Care and Education Specialists. The platform is able to ingest data from a variety of devices so that patients can be monitored when they are in their usual routines. The rules engine and the information collected through detailed patient assessment are used to create a comprehensive care plan. This plan supports patients in making lifestyle changes, and it delivers specialist expertise to their clinical care teams so they make optimal clinical decisions for medications and devices.

Technology alone is insufficient to create engagement. Stability Health's transformative care model supports patients with a human coach they connect with virtually using whatever technology they are most comfortable with: email, text, or video chat. As shown in the stories of S., R., and L., coaches work with patients on goals that are meaningful to them. Each patient also has access to CDCES and registered dieticians to support more intensive education when needed, or requested—occurring at a time and cadence that is convenient for them. Diabetologists oversee and ensure care plans, and recommendations are appropriate for each patient. In this way, the entire care team, supported by the platform that standardizes ideal care, provides care individualized to each patient.

Conclusion

Engagement of patients and clinicians is essential for developing and maintaining longitudinal relationships, which are at the heart of what patients want from their doctors and the reason clinicians go into primary care and medical specialties. Engagement happens when patients are supported to reach goals that are meaningful to them. Engaged patients have stronger bonds with their clinical care teams and are more satisfied with their care. Supporting clinicians to leverage their training by providing the most up-to-date recommendations tailored specifically to their patients helps to improve clinician satisfaction with their practice and prevent burnout.

This patient and clinical engagement is key for helping medical groups improve patient satisfaction and retention, operational efficiency, and ultimately clinical outcomes and financial performance. The challenge is that most medical groups operate with a very slim margin, and the human capital required to adequately staff health coaches and clinical specialists is not practical. The challenge is magnified by today's environment, in which there are 1.9 million open healthcare positions.[4]

It is for this reason that Stability Health was founded. It can help medical groups scale services for medically complex patients at lower cost, in turn improving patient outcomes and reducing demand and stress on clinicians. It also assists administrators with financial challenges and improved operational goals. GPJ

***Peggy Chou, MD, MBA**, is chief medical officer at Stability Health.*

***To learn more about Stability Health, contact Dr. Peggy Chou at* peggy.chou@stabilityhealth.com *or visit* stabilityhealth.com.**

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Weight Time

Roundtable tackles the obesity epidemic

The 2023 Fall Chronic Care Roundtable (CCR) took place on November 8, 2023, at The Ritz Carlton, Pentagon City, VA. At this meeting, we took a closer look at the comorbidities associated with obesity—such as diabetes, cardiovascular disease, and kidney disease—to help our AMGA member medical groups and health systems ensure equitable access to obesity and chronic disease care. The meeting included the following speakers, breakout presenters, and panelists:

- Christopher Still, DO, FACN, FACP, FTOS
  Director, Geisinger Obesity Institute; Medical Director, Center for Nutrition & Weight Management
- Patricia Nece, JD
  Counsel for Regulations and Legislation at U.S. Department of Labor (ret.); OAC – Past Chair
- Sandra J. Taler, MD
  Consultant, Division of Nephrology/Hypertension, Professor of Medicine, College of Medicine, Mayo Clinic
- Brian C. Jameson, DO
  Endocrinologist, Geisinger Health System
- John Clark, MD, PhD
  Associate Professor, UC San Diego Health

For more information about CCR, please contact Grante Wright at **gwright@amga.org**.

AMGA Member Groups Administer Nearly 12 Million Adult Vaccines!

Rise to Immunize® (RIZE) participants administered or documented nearly 12 million routine vaccinations to adult patients in the first two years of the campaign. The hard work of AMGA member groups participating in RIZE is helping to protect more patients from vaccine-preventable diseases. In fact, approximately 105,000 *additional* adults aged 66+ received comprehensive immunization care (vaccinated for influenza, pneumococcal, Td/Tdap, and zoster) throughout Years 1 and 2 of the campaign when compared to the baseline period.

Campaign participants are working together to reach the campaign goal of administering or documenting 25 million vaccines by 2025. Three AMGA member groups received "RIZE to the Challenge" awards for their commitment to the campaign and impressive data achievements during Year 2: UC San Diego Health; McFarland Clinic, PC; and Summit Medical Group, PLLC. All three organizations realized impressive progress on campaign measures and are continually making strides to leverage campaign activities and resources.

Congratulations to all RIZE groups on their accomplishments as part of the national campaign!

To join the 80+ AMGA member groups involved in this national immunization campaign, visit **RiseToImmunize.org** *or contact us at* **RiseToImmunize@amga.org**.

FOUNDATION FAN

"AMGA Foundation collaboratives have been instrumental in pinpointing significant health issues and provide the expertise to bring evidence-based guidelines into clinical practice. The ability to provide data, clinical expertise, networking, and implementation support is essential to make substantial advances and to sustain those efforts. Our support to the Foundation ensures that this work will continue to improve healthcare both in our community and on a national scale."

—Mary Laubinger, RN, MSN, VP, Population Health, Mercy

rise to immunize

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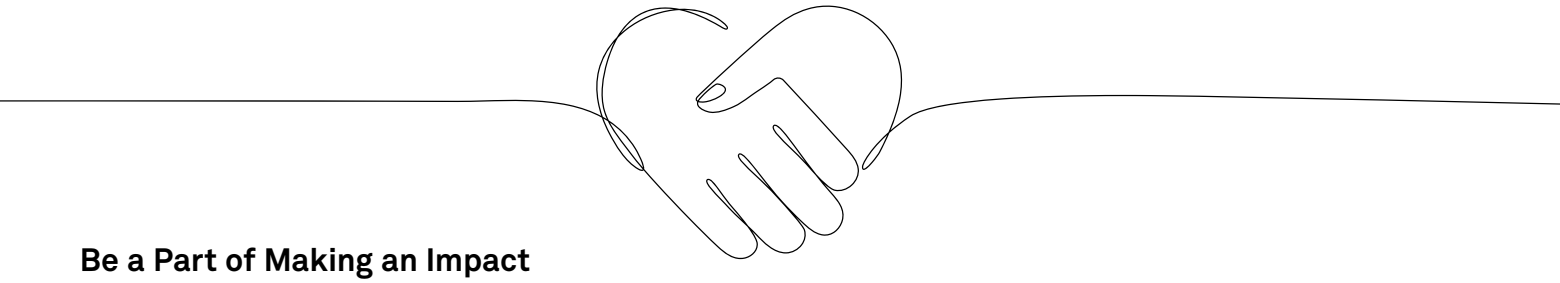

Be a Part of Making an Impact

AMGA Foundation's innovative population health and quality improvement initiatives and campaigns have reduced costs, increased efficiencies, and helped deliver better patient care. The guidance, tools, resources, and benchmarking we provide have allowed us to accomplish the following:

- Administer more than 12 million adult vaccines
- Develop strategies for the secondary prevention of ASCVD
- Develop a model of care for implementing adult obesity programs
- Enhance colorectal cancer screening for earlier detection and treatment
- Reduce fracture rates among patients with osteoporosis
- Include health equity metrics in all of our initiatives

AMGA Foundation has improved care for more than 40 million patients by working closely with members and focusing on health equity and the development and sharing of best practices for care delivery. We need partners like you to help us continue to have an impact. Your support helps us change the trajectory of chronic disease in communities across the country.

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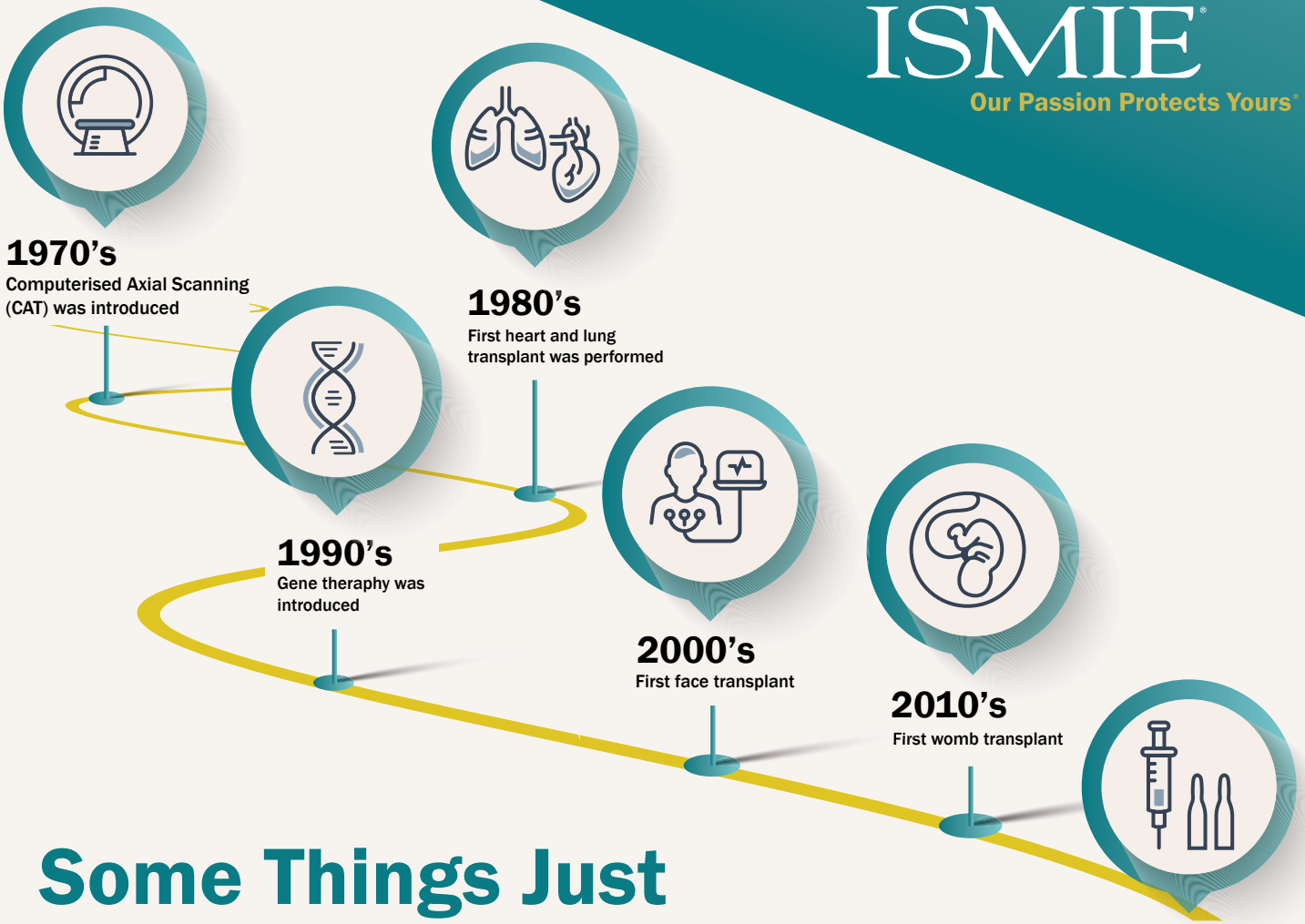

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