MEDICAL DIRECTOR MEETING – MINUTES
March 2, 2017

GROUP MEMBERS PRESENT: Alan Abrams, MD; John Barravecchio, MD; Emily Chin, MD; Jatin Dave, MD; David Dohan, MD; Barbara Downey; Leonard Finn, MD; Savitha Gowda, MD; Harold Greenspan, MD; Jevon Thomas, MD; Vinay Kumar, MD; Dennis Markovitz, MD; Patel Kanu, MD; David Pickul, MD; Cynthia Rosenberg, MD; Shah Pramodchandra, MD; Peter Sheckman, MD; Joseph Taylor, MD

WEBINAR: Bashir Bashiruddin, MD; Robert Fraser, MD; David Grace, MD; Douglas Gronda, MD; William Medwid, MD; Sarah Nuciforo, MD; Melissa Rose; Shawn Pawson, MD; Louis Silvagnoli, MD; Kenneth Shamir, MD; Ellyn Davis; Laura Chaves; Laura Ludwig; Mary Mathieu

TOPIC	DISCUSSION/QUESTIONS	**QUESTIONS/ANSWERS/ACTION/ FOLLOW UP**	**WHO**
• Review of February Meeting Jonathan Harding, MD	• PCP Capitation List • Screening for Undiagnosed Asymptomatic conditions: DPN, PVD, spirometry, et. al. Buying or leasing equipment in PCP offices. Significant revenue is at stake. • Custom Care • 10 Day report homework assignment • Custom Care Impact on MD cash flow	• We are taking all SNF rounding codes off PCP capitation list and adding a few other new codes per the minutes/presentation • Let me know how many of which devices or services you wish so I can negotiate volume discounts for you. Or, buy them direct yourself. • Informational, explained impact on physicians • Research and let us know who in your organization gets the 10 day report and paid claims reports and what they do with them.	TMP Groups Groups

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	<table><tr><td></td><td colspan="3">Reimbursement for E&M Services on Custom Care Members</td></tr><tr><td></td><td>PCP with Cap</td><td>PCP without cap</td><td>Specialist</td></tr><tr><td>Capitation</td><td>yes</td><td>No</td><td>No</td></tr><tr><td>Copayment</td><td>No</td><td>No</td><td>PCP copay</td></tr><tr><td>RVU</td><td>No</td><td>Yes</td><td>Yes</td></tr><tr><td>Minus copay</td><td>No</td><td>No</td><td>yes</td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td colspan="3">Reimbursement for E&M Services on all other Members</td></tr><tr><td></td><td>PCP with Cap</td><td>PCP without cap</td><td>Specialist</td></tr><tr><td>Capitation</td><td>yes</td><td>No</td><td>No</td></tr><tr><td>Copayment</td><td>yes</td><td>yes</td><td>Specialist copay</td></tr><tr><td>RVU</td><td>No</td><td>Yes</td><td>Yes</td></tr><tr><td>Minus copay</td><td>No</td><td>yes</td><td>yes</td></tr></table> • Are You Seeing Flu-Related Admission Surge? HF, COPD, Pneumonia, Dehydration • HEDIS • Chart review will ramp up over the next month. o Because our scores have been high, our chart review samples are low. For chart review measures, one or 2 charts not available can pull our score down. o If we can't get records from practices we may ask you to help o Cologuard will now count for Colon Cancer Screening measure		
Enforcing Referral Circles	• We periodically hear from some of you that our CSRs are telling members they can get care anywhere they want as long as their PCP submits a referral • This is a true statement. Our model is PCP dominant. PCPs (or in some groups, the internal referral office in lieu of PCP) have the authority to submit referrals OORC or OON. • It is not the whole truth, however. Our CSRs have been repeatedly instructed NOT to say <u>only</u> this. They have scripts that describe what they should say. • CSRs do have turnover and it is possible some may not follow the script as they are supposed to.	• If a specific member says CSRs at TMP have told them they can go OON or OORC if they have a referral from PCP, send us the member ID and approx. date member says they were told. • We can look up the transcript of the call and in many cases the recording of the call to determine if this happened and take remedial action if it did.	

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	• CSRs have a quality assurance process that includes recording calls and supervisors reviewing and scoring them. Message from the Director of Customer Service to his staff 2/6/17: • We have a periodic problem with an issue that continues to cause confusion, unrealistic expectations, and makes providers feel uncomfortable. • We need to **stop telling members that if they receive a referral from their providers they can see whichever specialist or hospital they choose**, regardless of Referral Circle status. • The process is clearly outlined in our support documentation, which states that members need to work with her PCP directly. He or she will decide if a specialist is needed and which specialist is best to treat the members condition. If the member disagrees with the choice that the doctor has selected, the member has the option to file an Organization Determination (O.D) to get a ruling from the Health Plan. • Training is being scheduled so that all staff, supervisors included, are reminded of the model we work in and how it works. • I have instructed the Quality Assurance department to make note of any staff person telling a member that they can see who they want if the provider gives them referral outside of network. Your call score will receive a **failing grade**, and you will be flagged and sent to me for personal review. I don't want anyone to lose a job because of this, but we continue to put members and providers in these situations, that work against the essence of the managed care model we work in.	• If you are declining to provide a referral because clinically, chronologically, and geographically equivalent in-network /in-circle services are available, keep track of those decisions, their rationale, and research on the request you have done • Keep us informed of the contact info of the person you designate to send us that research if the member should file an OD	
ODs	• Members have the right to request an organizational determination from the Health Plan if they are not satisfied with a decision by the care team to deny a requested services • We deny such services – providing the member with appeal rights – <u>unless</u> the care team has made an error in denying the services: ▪ The alternatives provided by the care team are not capable of providing the services the member needs - Continuity of care required		

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	- Alternatives don't have same training or qualifications as the requested provider - The alternatives are not within a reasonable time or distance ▪ Denied as NACB but recent NCD/LCD shows it's now covered		
Ten Day Report	"Who in your IDN/group/IPA receives the TMP 10 day report, reviews it, acts on it, and submits it back?" Feedback we received so far: • One group told us who reviews, what they do with it, when. They take it seriously. • "What's a 10 Day report? Can you send us one so we know what it looks like?" • IDN says it's done at group, not IDN level, but they don't know if groups actually do it	Please hand in your homework! If this is not being reviewed and returned by someone in your PO, then claims for members who self-refer to OORC specialists are being paid!	
Ancillary Service Referrals	Do you enforce referral circles for • Chiropractic? • Behavioral health [other than psychiatrists]? • PT/OT? Do you have providers in your referral circle for each provider type? If you do not, do you have concerns with allowing members to self-refer for: • Chiropractic care • PT • OT	In discussion several groups do maintain referral circles for these referral types and would not want to see the referral requirement go away, even though chiropractic is small total $ it is highly susceptible to abuse.	

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	• Behavioral Health practitioners (non-MD)? Now (before filing 2018 bid and referral requirements) is a good time to revisit this requirement. Do we want to improve access to services and simplify administrative challenges in maintaining referral circles for these provider types? We can assess other options to manage possible over utilization for therapy and behavioral health; e.g., applying PA after x visits, consistent with commercial plans If you want to keep referrals in place and maintain referral circles, how will you keep THP informed of who these providers are? We do not have chiros, PTs, or OTs in most medical group's referral circles. Managing this process therefore creates manual work on both sides. Management options include: • We require a referral. If claim appears on 10 day report and we get no response from group, we pay (current state) • We do not require a referral; claims would automatically pay even without a referral • We require a referral and if claim appears on 10 day report and we get no response, we deny. THIS PUTS PRESSURE ON YOUR DOCS TO SUBMIT REFERRALS EVERY TIME, and MDs can't decline to issue chiro referrals even if they don't believe in it. • We don't require a referral but require a Prior Authorization from the rendering provider if they want to exceed x visits Do we really want to put a barrier to reduce initial use of PT, OT, BH? Even if we want a barrier for chiropractic, do we care about chiropractic utilization? Data to Influence Decision		

TUFTS Health Plan

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<tr><th>TOPIC</th><th>DISCUSSION/QUESTIONS</th><th>QUESTIONS/ANSWERS/ACTION/ FOLLOW UP</th><th>WHO</th></tr>
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<tr><th>Service</th><th>Allowed payment</th><th>Cost PMPM</th><th># service dates</th><th># of members</th><th>Visits Per member</th></tr>
<tr><td>PT/OT</td><td>$6,538,397.60</td><td>$24.46</td><td>146,555</td><td>6,875</td><td>21</td></tr>
<tr><td>BH</td><td>$3,648,887.62</td><td>$2.61</td><td>46,012</td><td>6,314</td><td>7</td></tr>
<tr><td>Chiro</td><td>$1,146,132.44</td><td>$0.60</td><td>30,671</td><td>3,248</td><td>9</td></tr>
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<tr><td>Accountability

Why focus on it?</td><td>We at TMP are held accountable for achieving several outcomes:
• 5 Star
• Group retention
▪ RBRVS ratio
▪ Medical Trend
▪ Easy to do business with
▪ Revenue targets
• Membership Growth including same group growth
• TMP Margin
Most of these outcomes can only be achieved through our contracted Medical Groups
We do not have direct authority over you
To hold you accountable for your part of these outcomes, we need to understand your accountability systems

In April 2016, small groups of 3-5 participants were asked to discuss their response to questions I posed about accountability. We kept flip chart notes of Group summary presentations, and summarized it again in the presentation slides.

There was not consistency in how different organizations view the definition of</td><td></td><td></td></tr>
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	accountability or in the structures to support lines of accountability that TMP can follow .		
Dustin Straley of Partners in Leadership presented: Creating a Culture of Accountability.	The group defined Accountability as being responsible for one's actions as exemplified by the Patriots football team, discipline, winning. The term tends to comes up when there is a problem; it's often connected to blame, when something happens to "me." In terms of leadership, it focuses on how to motivate and influence people. IBM, GE, Southwest, Google and Disney were companies mentioned for being Accountable: They are known for their strong culture and for doing well. The reality is that culture produces results. **Accountability begins by clearly defining the results.** Often senior management fails to define clear goals. Dustin reported on a survey where only 10 percent of executives were lauded for identifying clear results, 90 percent did not. Hospital staff cannot be accountable for 80 different criteria on a dashboard. Only three to five goals are doable. **A focus on achieving too many results is diluting.** Leadership tends to focus on others. Great leaders look at themselves first. <u>Results Pyramid: 4 layer pyramid</u> .	Are key results clearly defined in your organization? Can the staff name them when asked? Do priorities change frequently, creating confusion around the key results you need to achieve? When you need to achieve results how much of your time is spent on specific actions v. changing beliefs by providing experiences?	Group Medical Leaders

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	 Results or desired outcomes and goals top the pyramid. Actions taken (i.e., reorganize or develop policies and procedures) comprise the second top layer. Beliefs held 3rd layer that determine the list of potential actions Experiences shared 4th foundation layer determine beliefs about actions Activities are actions that people take that lead to results (which are both the desired and undesired outcomes of taking action.) The medical directors cited total medical expense, patient satisfaction surveys and keeping people in networks as examples of desired results. Control what you can control. As Coach Belichick says, "Do your job." Your job is to deliver the results. Know how your job keys to desired results.Many leaders **coerce and compel**, using only the top two layers of the pyramid. Leaders who work the bottom of the pyramid **persuade and influence.** Dustin gave an example of a hospital with a metric of only 42 percent who completed "identify next of kin," which was deemed way too low. Leadership implemented posters and extensive training as action items and the metric went to 47 percent. The belief of staff: This metric is not important. Experiences and stories change a belief. **Actions do not change belief**. Hearing a story about how knowing next of kin would have saved a patient when his daughter, who knew that he was on a new medication, was phoned for additional insights. This		

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	story was an experience that changed belief abou the importance of the result of achieving higher NOK rates. The "identify next of kin" metric then went to 94%. **Compelling stories change beliefs.** Culture comprises the way people think and act in an organization. An example: Meg, a new employee with fresh experiences, asks old timer Nora, "How do things really work around here?" Nora: "Keep quiet, don't speak up. Melvin spoke up and he is no longer here." People are motivated by beliefs, generated by hearing them expressed multiple times, by multiple people. Dustin pointed out, that despite the stories, the reason that Melvin was transferred out was that he was good, not that he spoke up. **Culture shaping stories may not be true!** Another example of culture: "Because we have always done it that way." Good leaders listen and ask for feedback. People don't wake up and say that they are looking to overcome a belief bias. Confirmation or belief bias is when we ignore evidence to the contrary to validate our belief. For instance, Rick is customarily late. Now, he no longer wants to be known as the late guy. He is on time for every day weeks. One day, his car gets a flat tire. Once again, Rick is the late guy. Instead, Rick could have said on day zero: "I own being late. From now on, I am going to be on time. Look for me to be on time." He is giving us and showing us evidence. **The stories we tell create beliefs.** The steps to Accountability: Diverting Accountability starts early. Dustin showed a video of four-year-old Noelle, who was asked if she had used colored pencil to mark the furniture. She claimed multiple times that she did not, saying that Lily had done it. At the end of the clip, the camera moves to show tiny Lily, asleep in a bassinette. He also displayed examples of actual traffic accident reports: "Coming home, I drove into the wrong house and collided with a tree I don't have." "The pedestrian had no idea which direction to go, so I ran over him." "The telephone pole was approaching	Be alert for below the line talk and point it out to the speaker, not that they are bad but that the discussion needs to shift to above the line to achieve results?	

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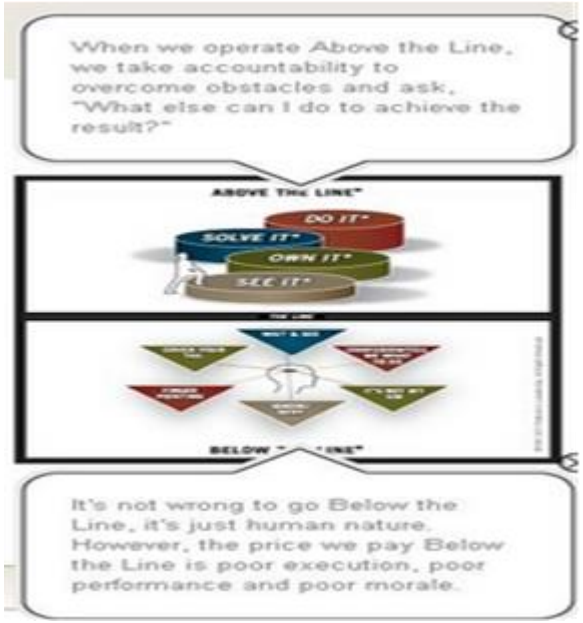
	fast. I was attempting to swerve out of its path when it struck my front end." And he pointed out how often when we know that we are going to be late, we practice our excuse on the way. Denial, finger pointing, diversion are tactics to reject accountability. But they don't get results! Great leaders act Above the Line: See it. Own it. Solve it. Do it. Focus on what you can control.  Below the Line engenders the blame game and can feel safer. But it is frustrating and unproductive to get stuck there. Ways of acting Below the Line include: Wait and See. Cover your Tail. Finger Pointing. Confusion: Tell me what to do. It's not my job. Ignore and Deny.		

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	Examples of going below the line, given by the attendees in the room: "The system is rigged." "The medical assistant will take care of it." "If we get new better patients, we'll get five stars." "The data is not good." "We received flawed information." "Dr. Harding gave us bad instructions." Some leaders say: Let's go below the line for ten minutes to allow for venting and cleansing. Then they say: Now, what are we going to do about it? A common belief about leaders: "You take the credit when things go right and share the blame when things go wrong." Change the belief by changing the experience. Be accountable and **share credit.** Dustin was told: "You never listen to me." A belief is based on experience. To create concrete experiences, reorient. He said, "Look for me to listen more. What would it take? Should I repeat what you say back, nod, stop what I am doing?" Changing a belief involves my willingness to change and your willingness to look for that change. Frame up accountability, which Webster defines as: "the quality or state of being accountable; especially: an obligation or willingness to accept responsibility or to account for one's actions." This sounds like, "Who is accountable for <u>failing</u> to achieve results" Instead, think of it as who is accountable for <u>achieving</u> the results? New definition of Accountability: a personal choice to rise above one's circumstances and to demonstrate the ownership necessary for achieving key results See, Own, Solve, Do it. It's a choice. Seize the power by accepting responsibility.	In your organization is it safe to take blame on yourself? Is it safe to grant credit to others? Or do you need the credit for survival?	

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	And be willing to ask for feedback.		

April Agenda

Member Survey Results: Implications and Opportunities in Medical Practices
Changes to Star Measures: April Call Letter
Pill Dispensing System Options for TMP members*
Last Minute messages to practitioners before the 2017 HOS Survey*
Diabetes Prevention Programs*

Jonathan Harding, MD, Senior Medical Director, Senior Products, Tufts Health Plan

*We will file for CME for these topics