

# 2023 Spring Forum



April 25, 2023

Waltham Woods Conference Center



# SAVE THE DATE

## Healthcare Innovation Summit

Thursday, November 2, 2023  
Boston, MA

ACHE of MA invites you to an interactive day of cross-sector thought leadership, networking, and knowledge exchange.

*Patient + Provider + Payer + Policy +  
Producer + Promoter = Progress*

Leaders from across the healthcare ecosystem: health systems, health plans, life sciences, healthcare technology/start-ups, and universities will share insights and innovation to solve for some of healthcare's key challenges.



# Thanks to our Chapter Sponsors





# Thanks to Our Chapter Sponsors



# An ACHE National Update

ACHE of Massachusetts

Spring Forum: The Evolving Healthcare Landscape

April 25, 2023

[ACHE.org](https://www.ache.org)








# My Leadership Journey



Michael Givens, FACHE  
COO/Administrator  
St. Bernards Healthcare

Governor with ACHE, District 1

# Outline for Today

-  ACHE: For Leaders Who Care
-  Catalyst
-  Connector
-  Trusted Partner
-  Leading Together for the Future

# ACHE: Strength in Numbers

**48k**

Members

**76**

Chapters

**194k**

Hours of Education

**8.8m**

Web Visitors

**170k**

Social Media  
Followers

**191k**

Podcast  
Plays

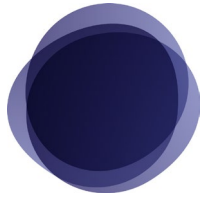
**35k**

Media  
Mentions



# For Leaders Who Care

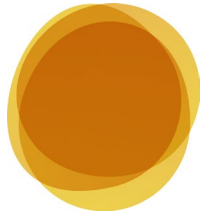
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## VISION

To be the preeminent professional society for leaders dedicated to advancing health.

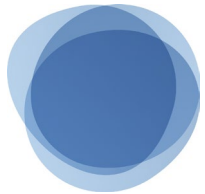
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## MISSION

To advance our members and healthcare leadership excellence.

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## VALUES

Integrity, Leadership, Lifelong Learning,  
Diversity and Inclusion

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**Vision**  
To be the preeminent professional society for leaders dedicated to advancing health

**Mission**  
To advance our members and healthcare leadership excellence

**Core Values**  
Integrity • Lifelong Learning  
• Leadership •  
Diversity and Inclusion



**Catalyst**

As a Catalyst, achieve our highest calling to advance health by leading through the lens of equity.



**Connector**

As Connectors, grow our professional community of leaders across the healthcare continuum by leveraging our partnerships with chapters and other organizations.



**Trusted Partner**

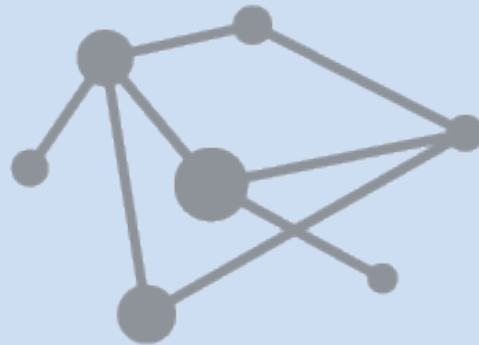
To expand our role and influence as a Trusted Partner to help leaders reach their highest potential to lead.



**CATALYST**

**CONNECTOR**

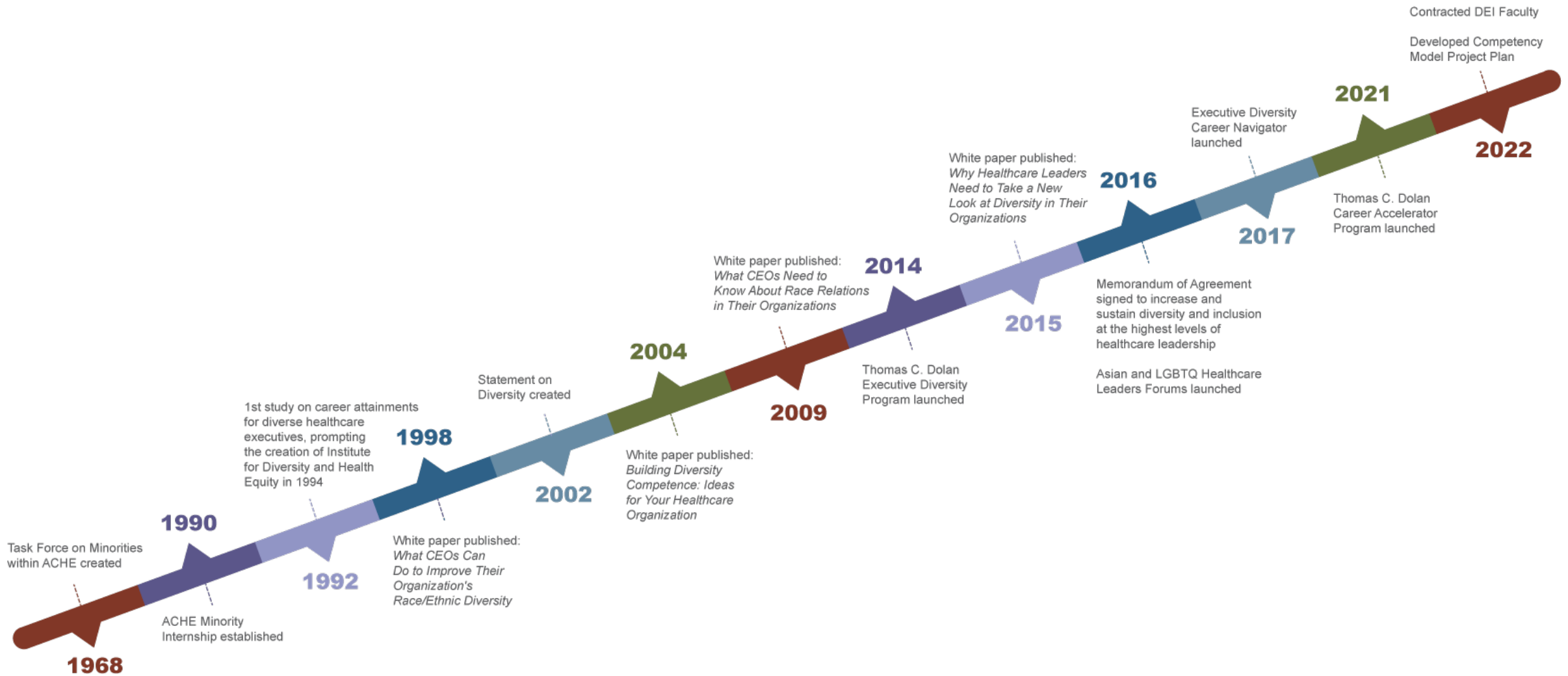
**TRUSTED PARTNER**



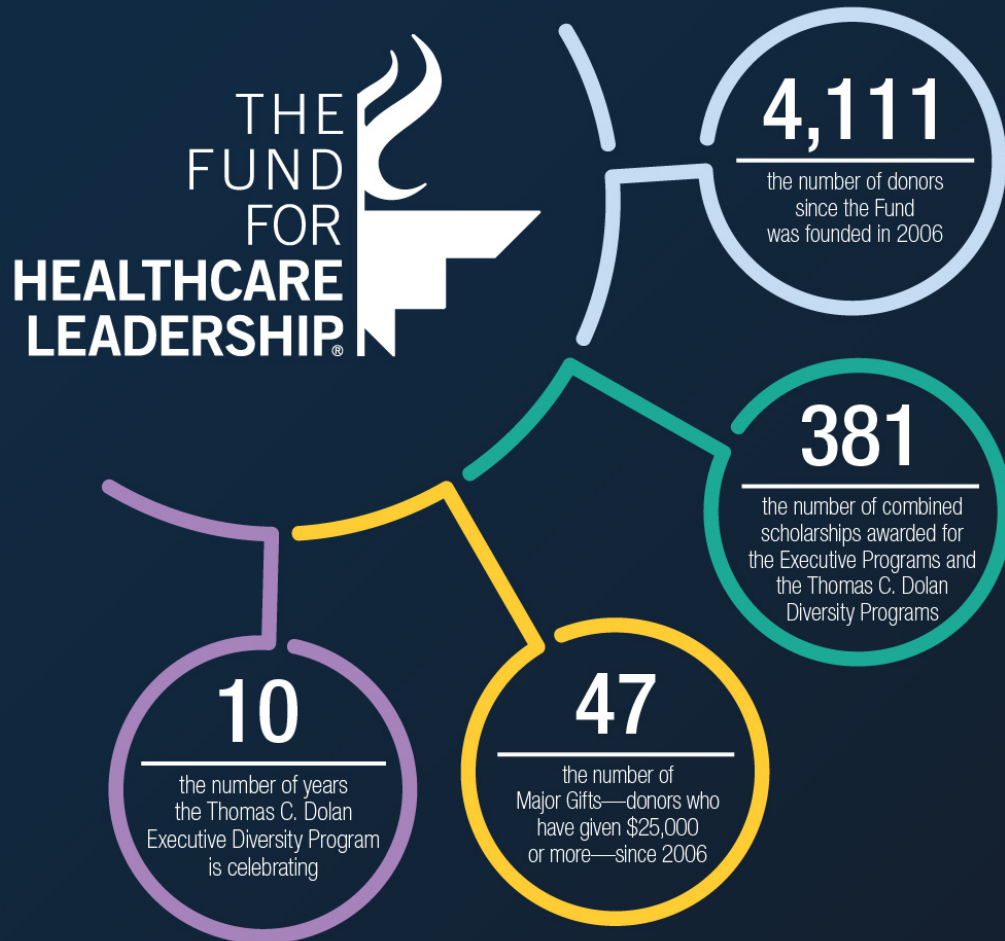
**Catalyst**



# Leading in Diversity and Inclusion for Over 30 Years



# Fund for Healthcare Leadership



“We all know that many people who have the right leadership qualities can grow in their positions, but participating in programs like the Dolan Executive Diversity Program help us to do it more efficiently, accelerating our ability to grow, innovate, participate and contribute to overall healthcare.”

**Rahnia J. Boyer**

*Thomas C. Dolan Executive Diversity Program Scholarship Recipient*

# Partnering to Advance Diversity and Inclusion

The Equity  
Collaborative



**Institute for Diversity  
and Health Equity**

*An affiliate of the American Hospital Association*



American College of  
Healthcare Executives®



NATIONAL ASSOCIATION OF  
LATINO HEALTHCARE EXECUTIVES

**LGBTQ+ Healthcare  
Leaders Community**



# Leading for Safety

## Driving Toward Zero Preventable Harm

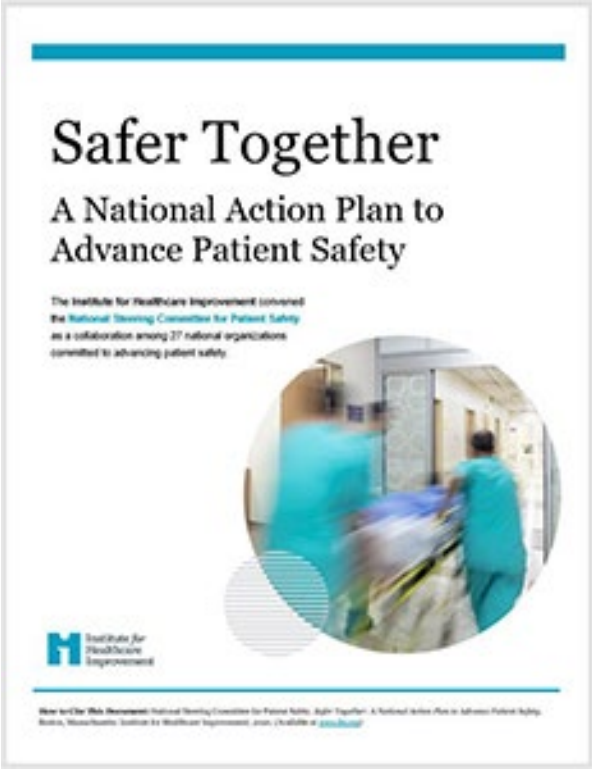
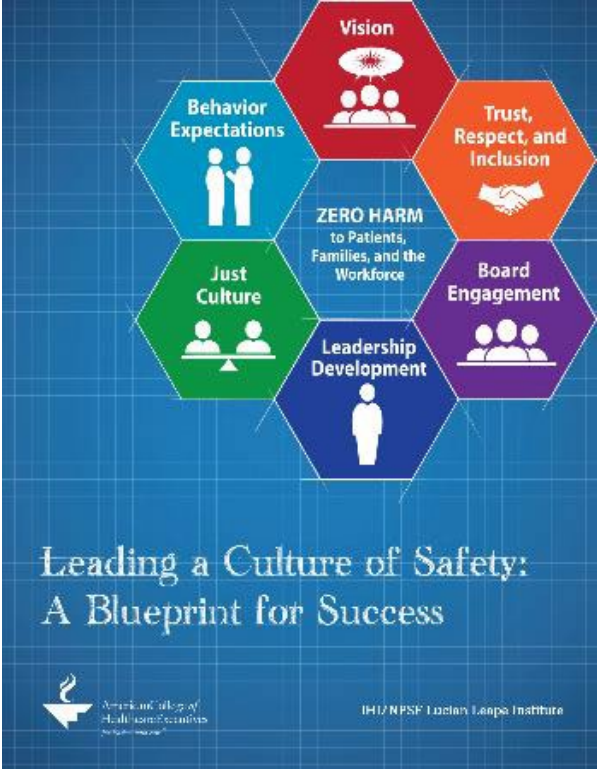


American College of  
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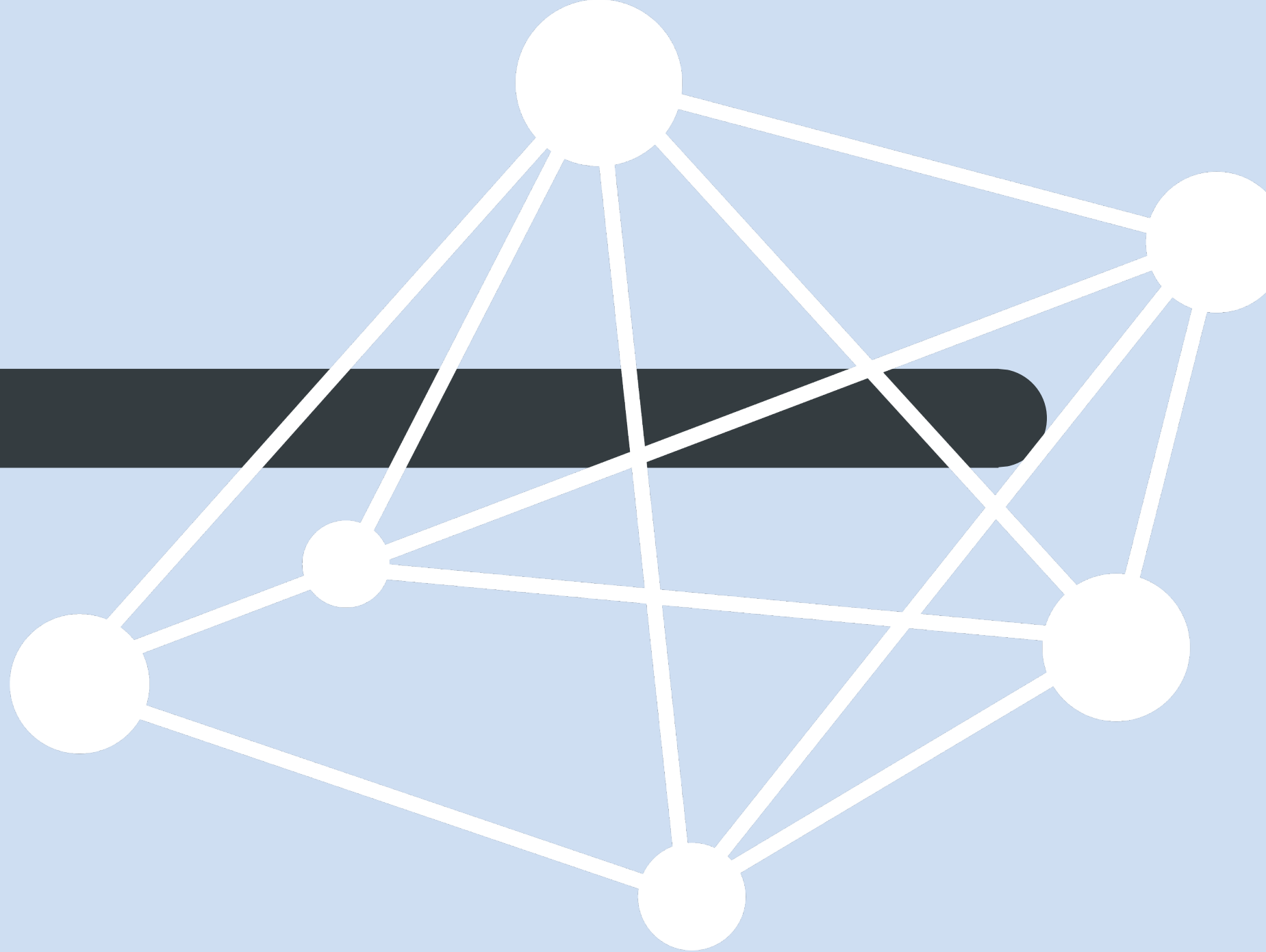
Institute for  
Healthcare  
Improvement

[ache.org/Safety](http://ache.org/Safety)





**Connector**



# Connecting with Colleagues



Members are connected to a network of healthcare leaders across the country and around the world.

# Connecting Locally



Chapters



Events



Attendees



Attendee Hours

# Connecting Through Collaborations



Improving outcomes for patients is an important bond we share with our clinical partners.

- American Academy of Physician Assistants
- American Physical Therapy Association
- American Society for Anesthesiologists
- American Society of Health-System Pharmacists



JOINTLY ACCREDITED PROVIDER™  
INTERPROFESSIONAL CONTINUING EDUCATION

**Trusted Partner**



# Your Partner in Learning



Foremost provider of continuing education and publications for healthcare management and leadership:

- More than 300,000 hours of education delivered nationally, locally and virtually.
- New in 2023: Free webinars

[ache.org/Education](https://www.ache.org/Education)

ACHE Virtual  
**Leadership  
Symposium**

**Tuesday–Wednesday**  
**May 9–10, 2023**



Foundation of the  
American College of  
Healthcare Executives®

# Your Partner in Learning: FACHE



[fACHE.org](https://fACHE.org)

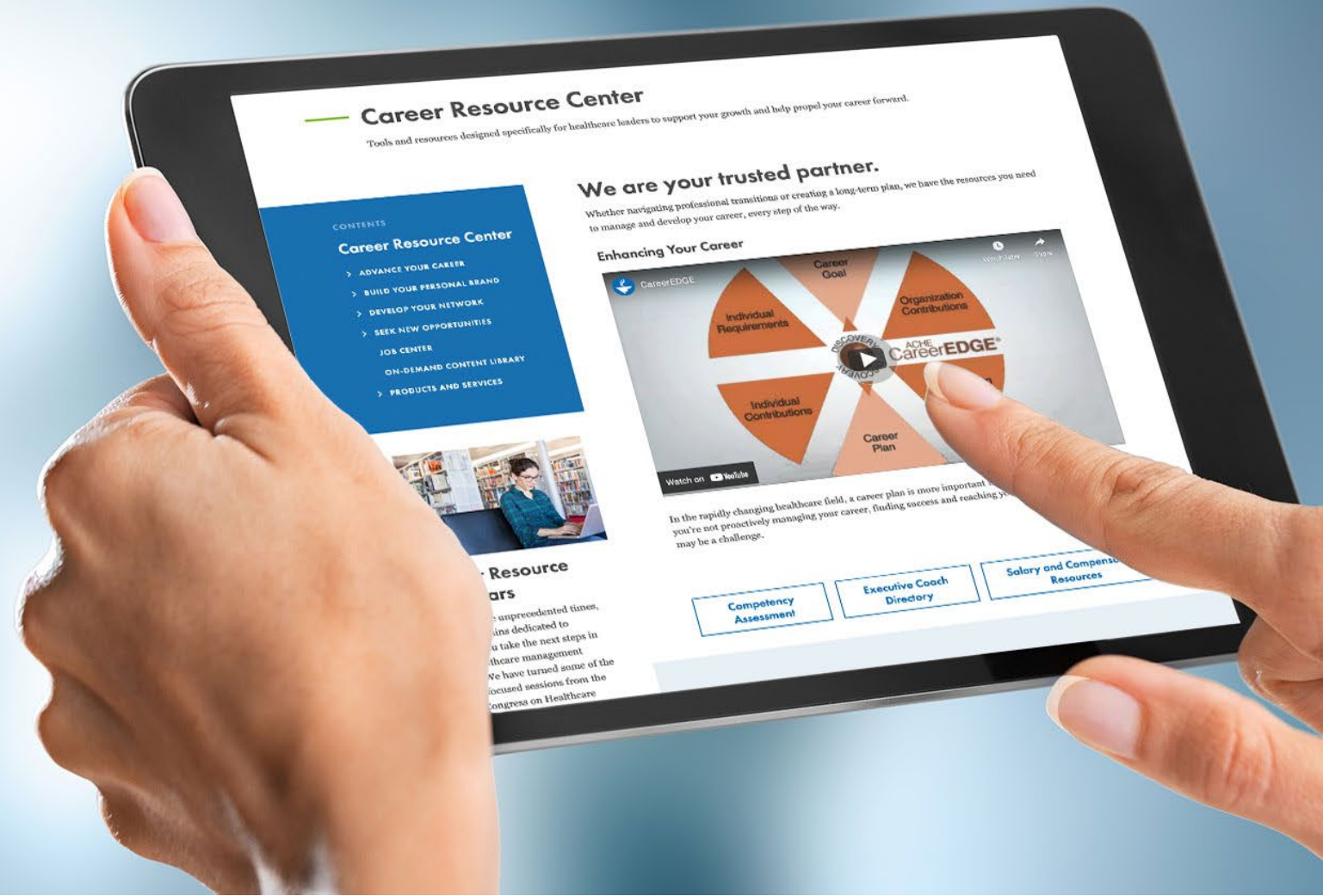
**FACHE**  
Fellow of the American College of Healthcare Executive  
*The Distinction of Board Certification*



# Your Career Resource Partner

Helping members navigate career development and professional transitions every step of the way.

[ache.org/Careers](https://ache.org/Careers)



# Your On-Site Learning Partner

**Invest in  
professional  
development  
tailored  
for your  
organization**

Let us bring our experts to you.



**Choice.**

- Content and format tailored to your organization's needs.
- Delivered on your organization's schedule.
- Option to include skill-based assessments for individuals and teams.
- ACHE Face-to-Face Education and Joint Accreditation credit (MD/DO, PA, RN, PharmD).

# Supporting Our Mission

# ACHE Premier Corporate Partners

**CHANGE**  
**HEALTHCARE**

Insight. Innovation. Transformation.

**EXACT**  
**SCIENCES**

**INTUITIVE**

 **LeanTaaS**

 **Quest**  
Diagnostics®

**Thank you**

# PANEL DISCUSSION



An Independent Chapter of

American College of  
Healthcare Executives

*for leaders who care*®



# THE STATE OF HEALTHCARE ACHE OF MASSACHUSETTS

**April 25, 2023**

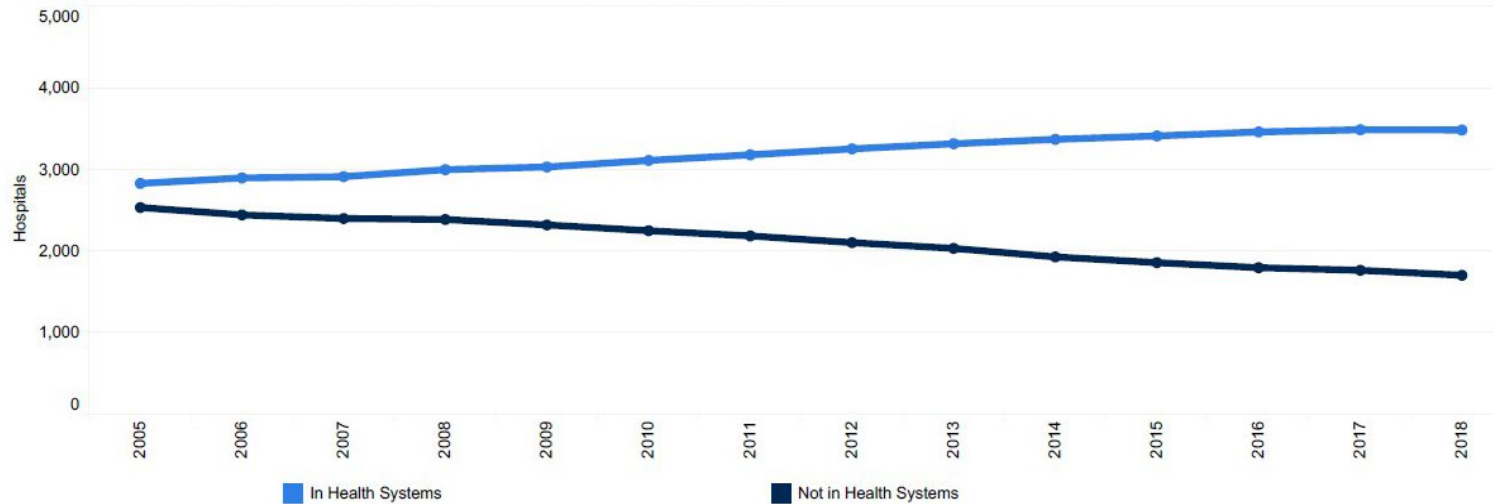
Charlie Buck

**McDermott  
Will & Emery**

# BACKGROUND

Source: AHA TrendBook 2020 - Steady Rise of the Number of Hospitals in Health Systems  
**As of 2022, 67% of Hospitals are already system affiliated.**

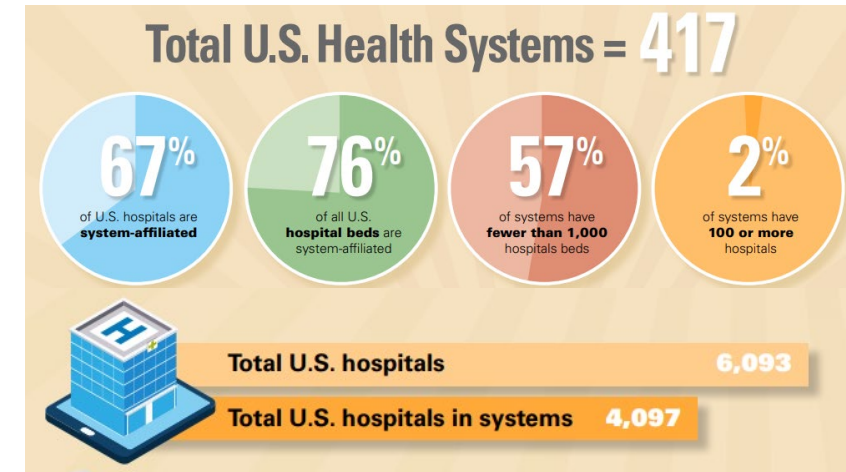
Chart 2.4: Number of Hospitals in Health Systems, 2005 – 2018



Source: Analysis of American Hospital Association Annual Survey data, 2018, for community hospitals.  
 (1) Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.



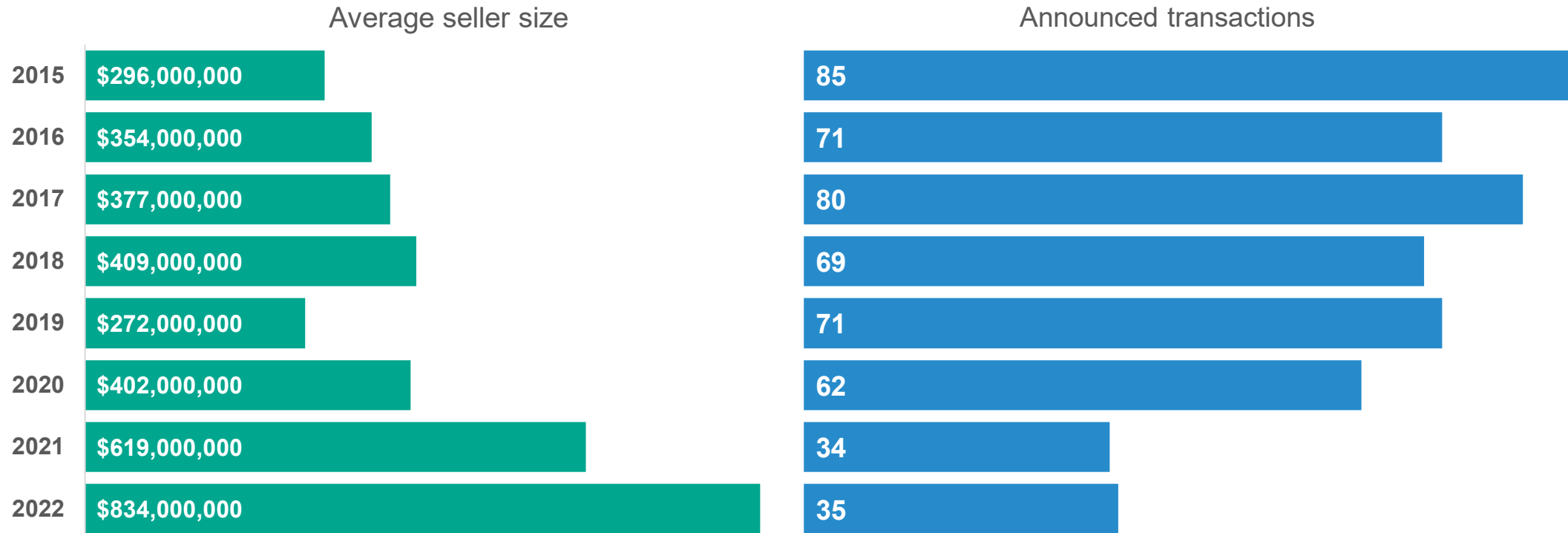
## 2022 FAST FACTS





# BACKGROUND

## HOSPITAL M&A DEALS ANNOUNCED THROUGH Q3 OF 2022



Source: [M&A Quarterly Activity Report: Q1 2022 | Kaufman Hall](#); [M&A Quarterly Activity Report: Q2 2022 | Kaufman Hall](#); [M&A Quarterly Activity Report: Q3 2022 | Kaufman Hall](#)

# TRENDS IN THE INDUSTRY

## Factors Impacting Industry Trends

- Macroeconomic and Pandemic / Endemic Effects
  - General inflation exceeding medical inflation; supply costs
  - Physician aging / workforce shortages; cost of labor
  - Lower volumes and revenue loss; push to diversify
  - Supply chain
- Increased Regulation and Enforcement
  - CMS/HHS
  - FTC – Antitrust
  - States. In Massachusetts – Health Policy Commission
- Payment Shifts
  - CMS payment cuts
  - Insurance / managed care pressures to manage risk (e.g., bundled payments, total cost of care)

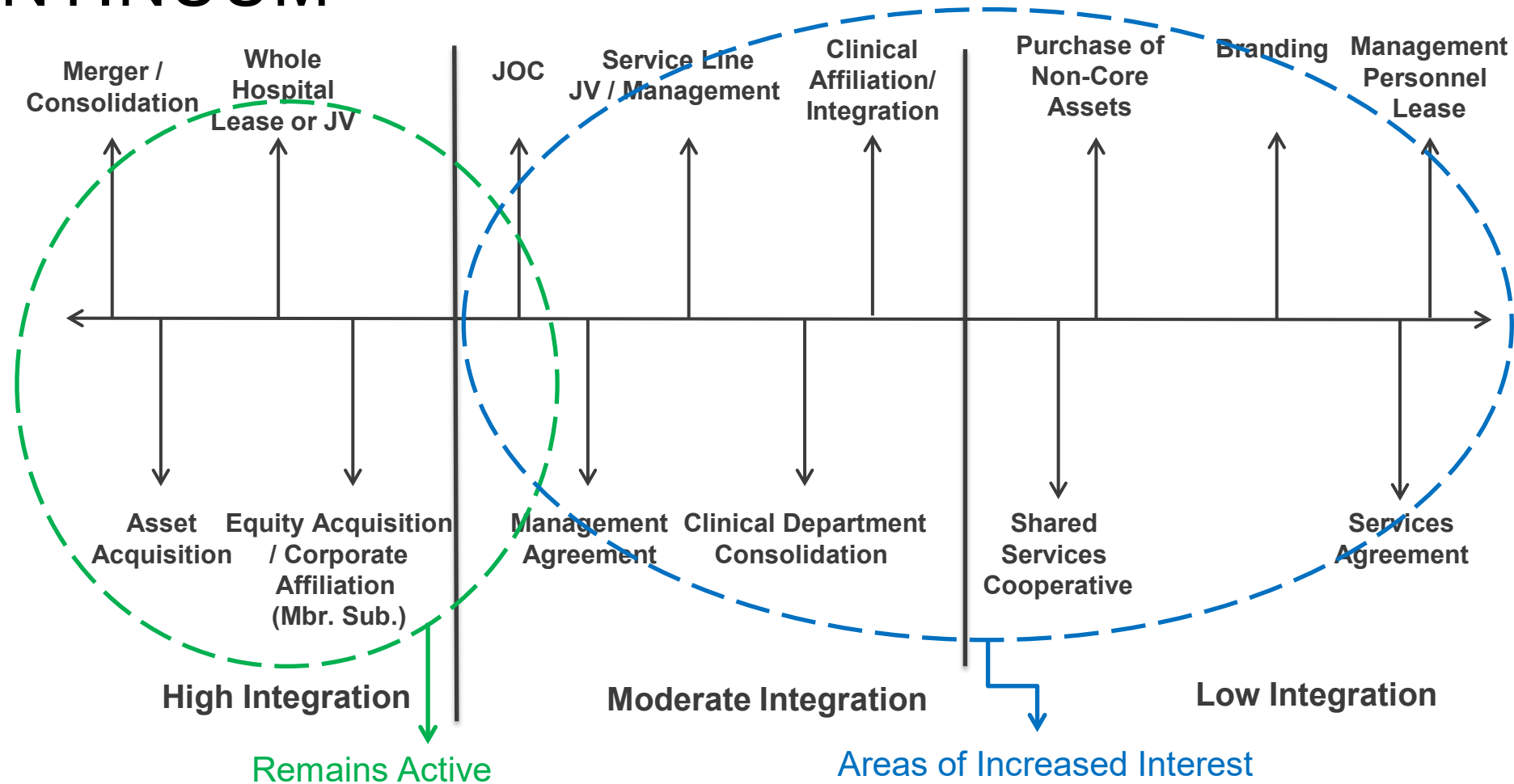
# DEAL TREND #1: MERGER OF EQUALS

- Large, financially well-positioned health care systems across the country are increasingly pursuing “mergers of equals”
- Unique set of transaction issues, including:
  - Governance
  - Management
  - Headquarters
  - Cultural Fit

## DEAL TREND #2: MERGER LITE

- “Less Integrated” Provider Transactions
  - Continued interest in affiliations and collaborations among health systems involving moderate clinical, financial and operational integration between the parties, with no change of control of either party
  - These transactions include “service line” joint operating arrangements creating a shared bottom line and clinical integration arrangements with the parties maintaining separate bottom lines
  - These “less integrated” models can create meaningful relationships with other systems in pursuit of each system’s long-term strategic goals

# SELECTING A STRUCTURE: INTEGRATION CONTINUUM



# DEAL TREND #3: RISE OF INNOVATION INVESTMENTS

- More health systems are embarking on efforts to formalize and centralize their innovation efforts through an “innovation center,” whatever form that may take, to be a key and growing part of their strategy
- Through innovation centers, health systems are partnering with industry partners to achieve goals of transforming healthcare
- By leveraging unique resources, innovation investments can further a health system’s overall mission and vision, build and maintain its organizational reputation, and generate growth opportunities outside core business lines
- Investment opportunities vast
  - digital health
  - administrative functions (e.g., RCM)
  - private equity collaborations
  - start-ups
  - new clinical models (e.g., hospital at home)

## DEAL TREND #4: “PAYVIDERS”

- Payors becoming providers, providers becoming payors
- Competition to health systems on physician practice acquisitions
- Health plan joint ventures between payors and providers
- Health systems building (or buying) infrastructure to better engage in the continuum of value based opportunities and pursue more of the premium dollar

# DEAL TREND #5: DISTRESSED TRANSACTIONS

- Pre-COVID, bankruptcy filings in the healthcare industry had been on the rise despite an otherwise generally healthy economy
- Exacerbated by COVID, “stressed” hospitals have become “distressed”
- Closure remains last option, so repurposing facility can be viewed as success



# CONSUMERIZATION OF HEALTHCARE



# THE CONSUMERIZATION OF HEALTHCARE AND CHANGING MODELS OF CARE

- Provider organizations were almost entirely brick and mortar, focused on episodic, in-person encounters
- The hub of healthcare is shifting to the home
- Massive expansion in telehealth
  - Regulatory flexibility during PHE expanded reimbursement, permissible providers and services
  - Increased deployment in DTC telehealth offerings, behavioral health and substance abuse, remote patient monitoring, mail order pharmacy, diagnostic testing, chronic care support, etc.
- Evolving regulatory landscape will continue to shape coverage policies and contractual relationships between payors and providers
- Current reliance on employer-based coverage is likely to continue to be questioned
  - Higher unemployment to leave more individuals without healthcare coverage
  - Widespread changes in employment status result in “churn” (*i.e.*, the movement between different types of healthcare coverage and uninsured status) and gaps in care, changing networks and interruptions in patient-provider relationships



MASS **ADVANTAGE**

Plan to love your plan.

# Value-based care as a vehicle to make change!

*Heather Trafton PA-C, MBA*

*CEO and President, Mass Advantage, LLC*

# Who is Mass Advantage?

## Company Overview

Founded in 2021, Mass Advantage is a **provider-affiliated Medicare Advantage** organization, offering a superior experience for patients. In 2021, we launched our first partnership and Medicare Advantage products with UMass Memorial Health Care in Central Massachusetts.

We serve ~2k members today after leading our market in back-to-back enrollment periods. We are executing on product expansion and new partnerships in Massachusetts while building a pipeline to launch in new markets in 2024+.

## Our “Advantage”



**Deeply integrated and aligned with health systems**, including the largest academic health system in Central Massachusetts



Integrated model and benefit design provide the unique ability to **manage TME effectively with minimal admin burden**



We provide **personalized care navigation** for members for **seamless access to care**

## UMass Memorial Health: Our anchor health system

- **Largest** health system in Central Massachusetts
- **1.7k** medical staff
- **46k** member ACO
- **1,100+** licensed beds
- **220k** annual ED visits



## Investors



**Eric Dickson, MD,**  
**MHCM, FACEP**  
President & CEO of UMass  
Memorial Health

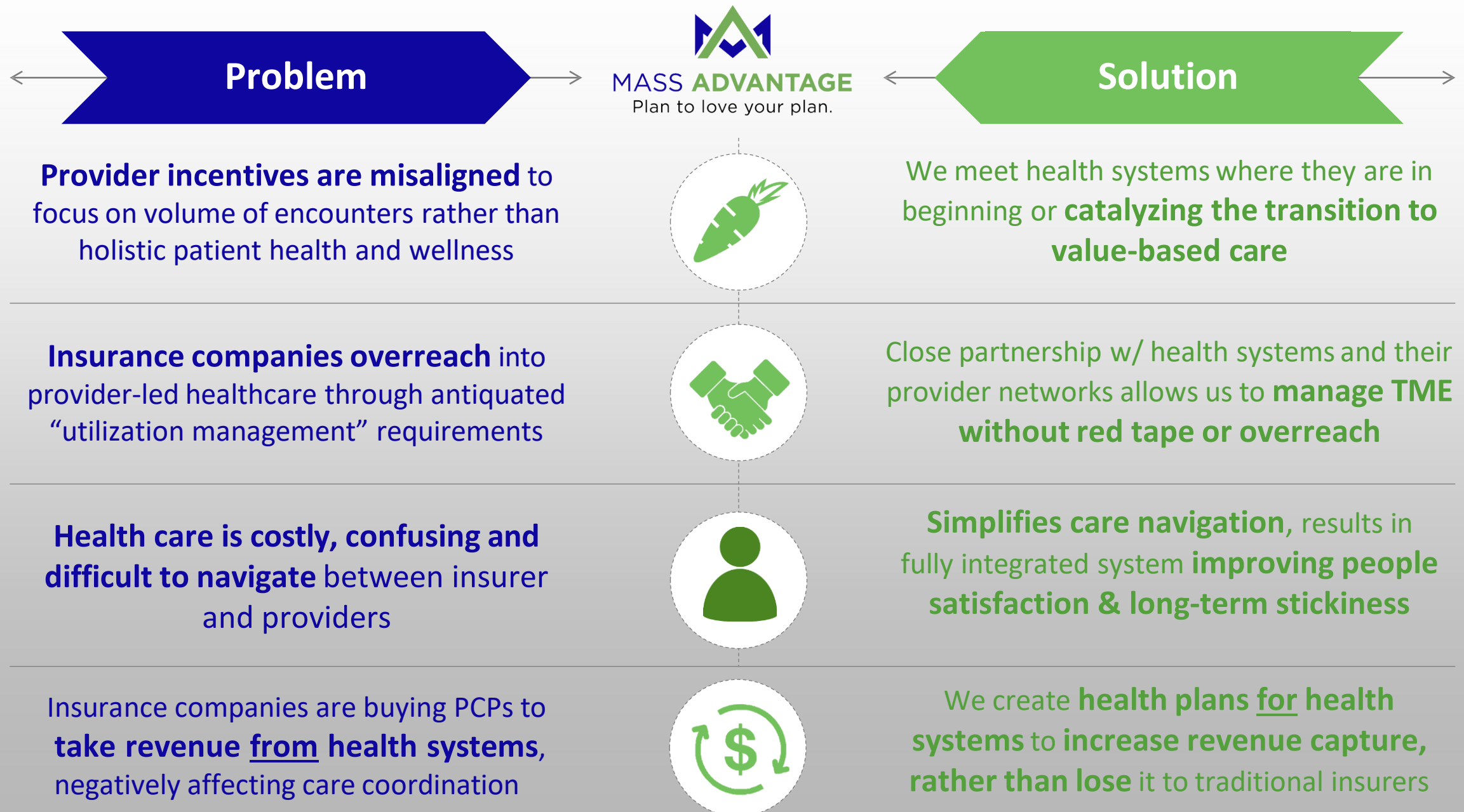


**Jack Shields**  
CEO, Shields Health  
Innovations; Founder,  
Shields Health Solutions



**Thomas Scully**  
General Partner, Welsh,  
Carson, Anderson & Stowe;  
former CMS Administrator

# We built Mass Advantage as a payvider to solve critical challenges in healthcare



# Fully integrated plan and provider input result in differentiated products

## Differentiation through UMMH affiliation



We're committed to getting members into a PCP or specialist **within 10 days** of contacting our Love My Service team



We'll cover non-emergency **transportation**, in addition to **free parking** (via flex card) including at UMMH facilities



UMMH providers have a **direct line to our CEO**, Chief Medical Officer, and Provider Relations team, which all receive rapid, personalized responses



All diabetic members will have access to the UMass **Diabetes Center of Excellence**



**Access to in-home care** through UMass Hospital at Home, and potential future in-home care via UMass Mobile Integrated Health



We continue to identify new ways to **reduce administrative burden** (incl. reduction of prior auths) for providers and care teams



Integration of care mgmt. (incl. pop health, risk adj., quality mgmt.) with UMass (e.g., Office of Clinical Integration) allows us to **simplify & streamline for providers**

## Built with UMMH providers for their community

### UMMH provider feedback

### Mass Advantage product response



Build in flexibility for providers to guide patients in care mgmt

Flex wallet built into all plans



Enable PCPs to guide patients to pre-diabetic nutrition counseling

Partnered w/ local vendor and enabled payment through flex wallet



Make parking free for members

Free parking (via flex card) for SSBCI-eligible members



Add in-home support and / or caregiver respite

Added trial offering to HMO plans



Create a snowbird network

Created a snowbird provider network (limited counties in FL & AZ)



Incentivize value-based behaviors

Established rewards & incentives program across all plans

# Value-based Care: A Vehicle for Change in Healthcare Delivery

$$\begin{array}{c} \mathbf{V} \\ \text{(value)} \end{array} = \frac{\mathbf{Q} \text{ (quality)} + \mathbf{E} \text{ (experience)}}{\mathbf{\$} \text{ (cost)}}$$

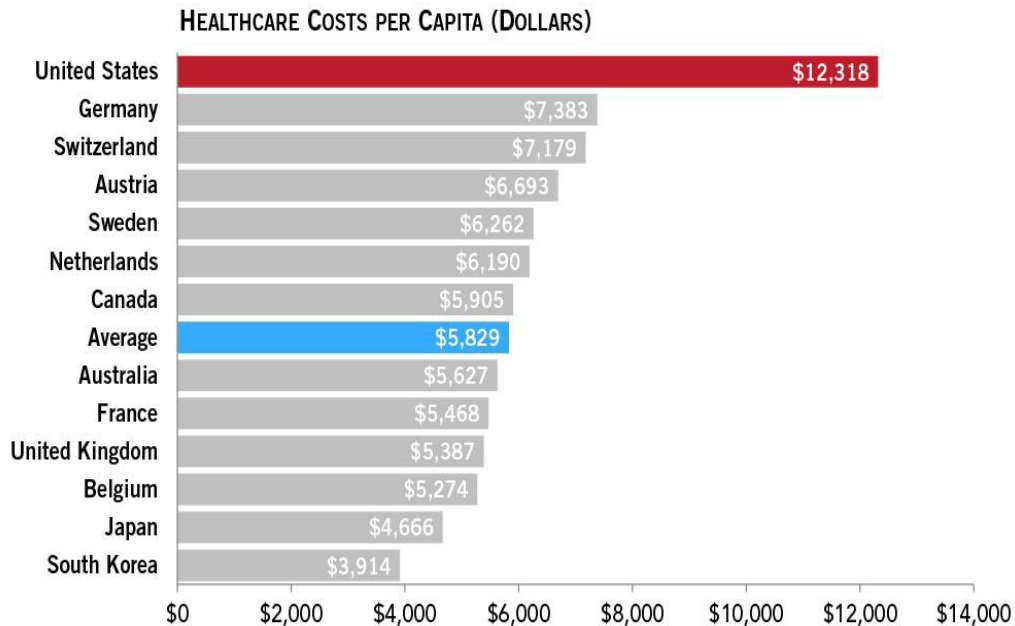
# Today's healthcare is NOT delivering value as a whole

*The trust fund for Medicare Part A benefit reserve will be depleted after 2026*

**Per capita spending is not sustainable....**



**U.S. per capita healthcare spending is over twice the average of other wealthy countries**



SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2022*, July 2022.  
 NOTES: Data are latest available, which was 2019, 2020, or 2021. Average does not include the United States. The five countries with the largest economies and those with both an above median GDP and GDP per capita, relative to all OECD countries, were included. Chart uses purchasing power parities to convert data into U.S. dollars.

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PGPF.ORG

**...and outcomes rank among the lowest!**



**Although the United States spends more on healthcare than other developed countries, its health outcomes are generally not any better**



SOURCE: Organisation for Economic Co-operation and Development, *OECD Health Statistics 2022*, July 2022.  
 NOTES: Data are not available for all countries for all metrics. Data are for 2020 or latest available.

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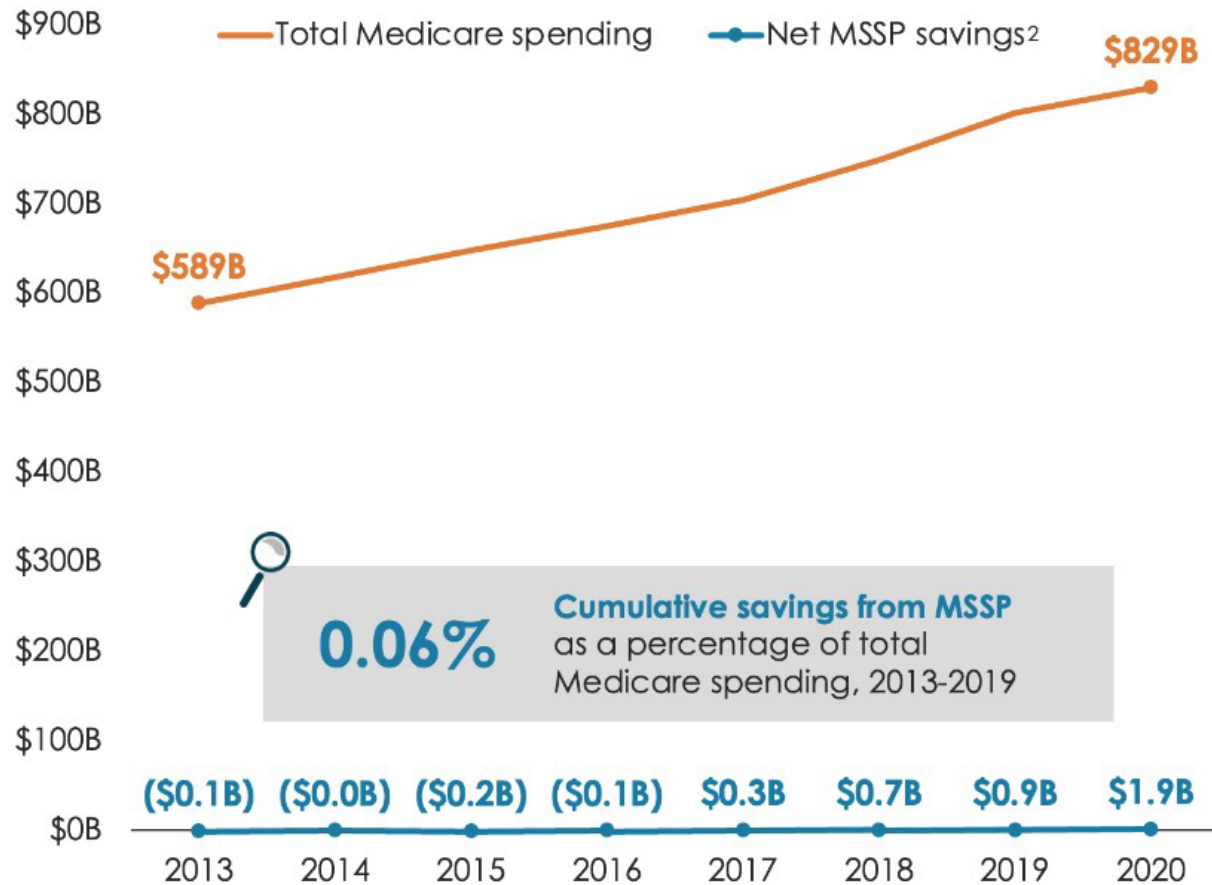
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# We're in the "1st inning" of volume-to-value transition

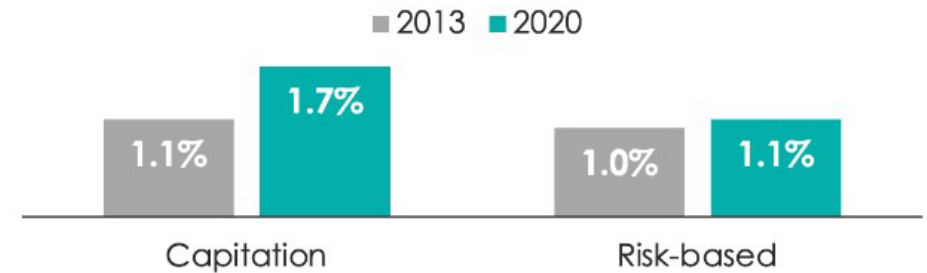
Current value-based spend and savings represent a small fraction of total medical spend.

### Total Medicare Spending and MSSP<sup>1</sup> Performance, by Year



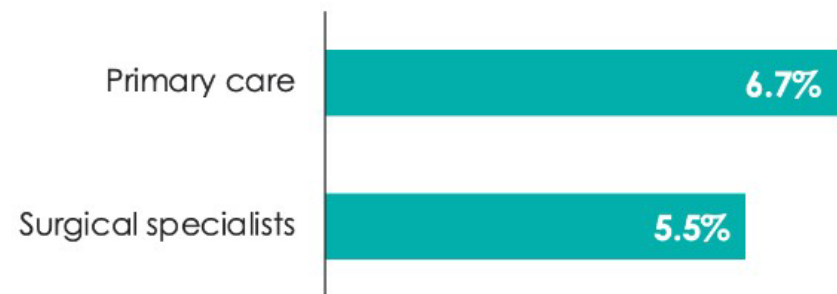
### Select Health System Reimbursement Methods, by Median Percent of Net Patient Revenue<sup>3</sup>

n = 259 health systems



### Percentage of Revenue Tied to Value-Based Contracts by Provider Type, 2021

n = 2.3K physician groups



Notes: <sup>1</sup> Medicare Shared Savings Program; <sup>2</sup> Savings to Medicare after bonus payments; <sup>3</sup> Median values calc'd separately for each metric (full profile doesn't sum to 100%)

Source: Gist Healthcare

# Using Medicare Advantage as a proxy to evaluate outcomes under full risk

*When comparing Medicare Advantage outcomes to MSSP outcomes, MA delivers lower cost and better quality*

## Comparing rates of avoidable hospitalizations by high-cost, high need group

Measure	Disabled <65			Frail Elderly			Major Complex Chronic			Overall Population		
	Medicare Advantage (%)	Traditional FFS Medicare (%)	Diff	Medicare Advantage (%)	Traditional FFS Medicare (%)	Diff	Medicare Advantage (%)	Traditional FFS Medicare (%)	Diff	Medicare Advantage (%)	Traditional FFS Medicare (%)	Diff
<i>Number of beneficiaries</i>	252,820	252,820		94,832	94,832		233,572	233,572		1,262,180	1,262,180	
Avoidable Hospitalizations - Acute Conditions	Not Applied			4.5	8.1	-45%	2.0	4.7	-57%	2.3	4.7	-51%
Avoidable Hospitalizations - Chronic Conditions	Not Applied			19.9	28.7	-31%	10.4	19.0	-45%	12.1	20.0	-40%
Avoidable Hospitalizations - Any Condition	Not Applied			23.2	35.9	-35%	11.9	22.9	-48%	13.3	23.2	-43%
All-Cause Readmissions	11.8	12.0	-2%	12.3	12.6	-3%	7.7	8.8	-12%	10.4	11.0	-5%
Physician Office Visit Within 14 Days of Discharge	68.4	54.2	26%	73.9	51.9	42%	69.8	66.7	5%	69.9	57.6	21%

Data: Centers for Medicare and Medicaid Services 100% Medicare Part A/B FFS Claims and 100% Part D Prescription Drug Event Data (PDE); Inovalon's Medical Outcomes Research for Effectiveness and Economics Registry (MORE2 Registry\*)  
 Note: Calculations may differ due to rounding

**Average PMPY spending was 22% to 26% higher for MSSP ACO compared to risk adjusted MA beneficiaries**

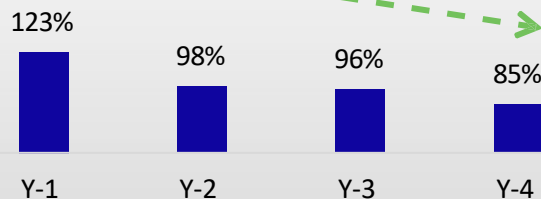
**Higher MSSP ACO spend associated with higher outpatient and inpatient spending across 4 disease-specific cohorts**

# Investors are betting on the business models under risk: early data suggests they are right

*Business models vary (partner, acquire, or build), but the outcome is the same: Lower MLR and increased profits*

## Oak Street

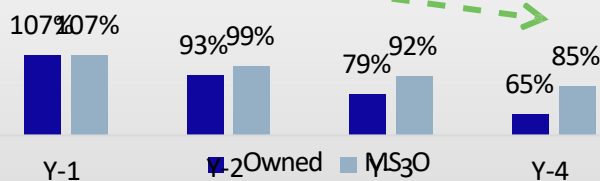
*(38)% center-level cost improvement*



■ 2015

## CareMax

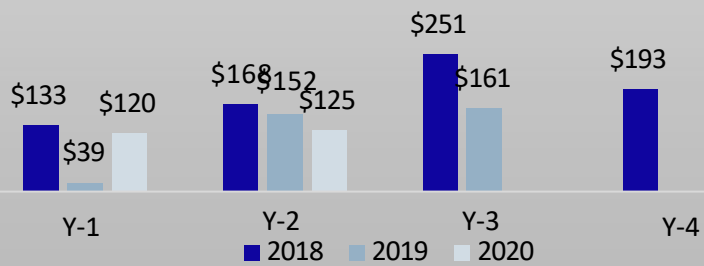
*(32)% Avg. MLR improvement*



## Agilon

Medical Margin PMPM

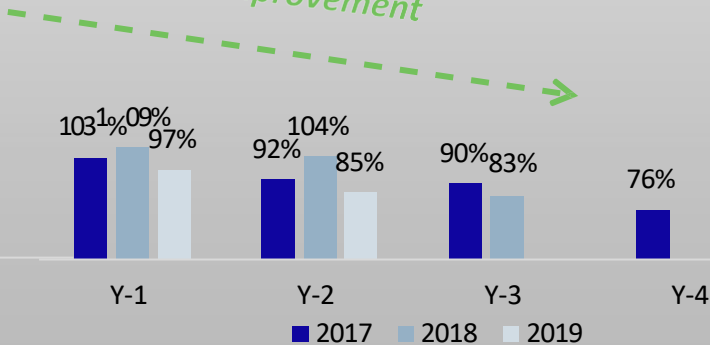
*Y-4 PMPM Medical Margin +45%*



■ 2018 ■ 2019 ■ 2020

## Iora

*(27)% MLR improvement*



■ 2017 ■ 2018 ■ 2019

## Investor research is bullish on enablement

- Enablement capabilities have the power to help all health care stakeholders: payors (multiple lines), patients, physicians, **health systems**, & communities (especially underserved)
- Over the next decade health insurers will increasingly become financing mechanisms for the delivery of healthcare (think life insurers), **moving out of the way for physician to manage the providers with “enablement capabilities” to manage the health of Americans**
- There will be losers as enablement expands, most notably inefficient sites of care but **physician enablement is about the optimization of resources & moving the economics of value to the providers**
- “We would go so far as suggesting that **this sector has the opportunity to create more value for shareholders than any subsector we have seen in the past two decades...**”

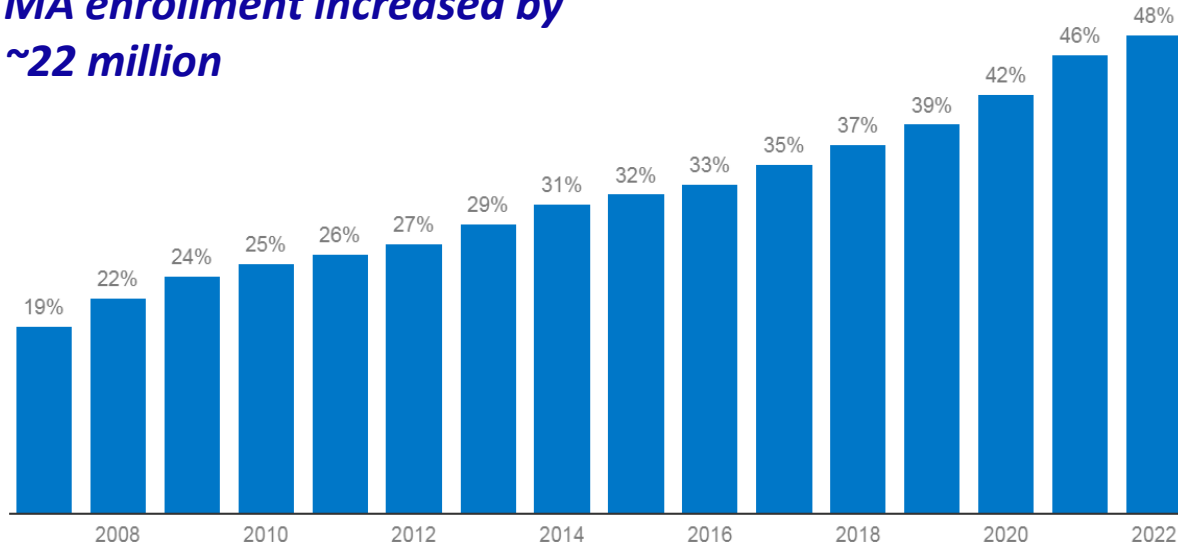
# The growth trajectory & economics of full risk in Medicare Advantage create significant opportunities for market disruption

*Growth trajectory of Medicare spend in Medicare Advantage is staggering; there is a race to control and capture the spend of Medicare \$*

**63M Medicare eligible; with some counties > 60% MA penetration**

Figure 1  
Total Medicare Advantage Enrollment, 2007-2022  
Medicare Advantage Penetration Medicare Advantage Enrollment

**MA enrollment increased by ~22 million**



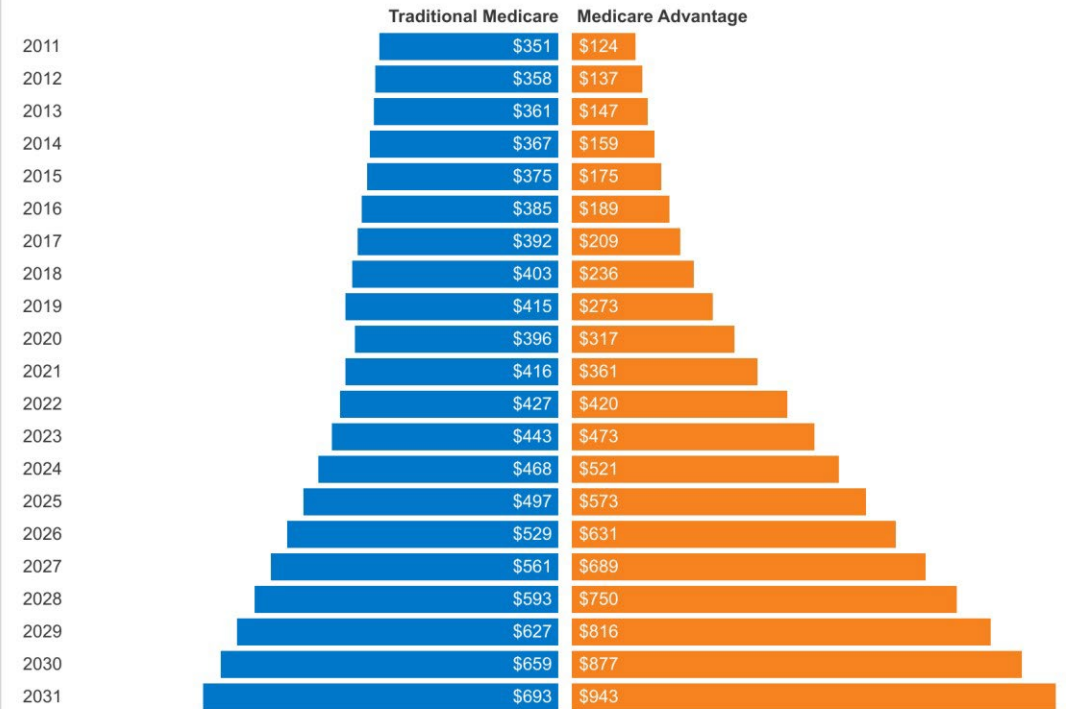
NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020, and Medicare Enrollment Dashboard 2021-2022. • PNG



Figure 5  
Payments to Medicare Advantage Plans for Part A and Part B Benefits Nearly Tripled Between 2011 and 2021 from \$124 Billion to \$361 Billion and Are Projected to Increase to \$943 Billion in 2031

Spending (in billions) on Part A and Part B Benefits in:

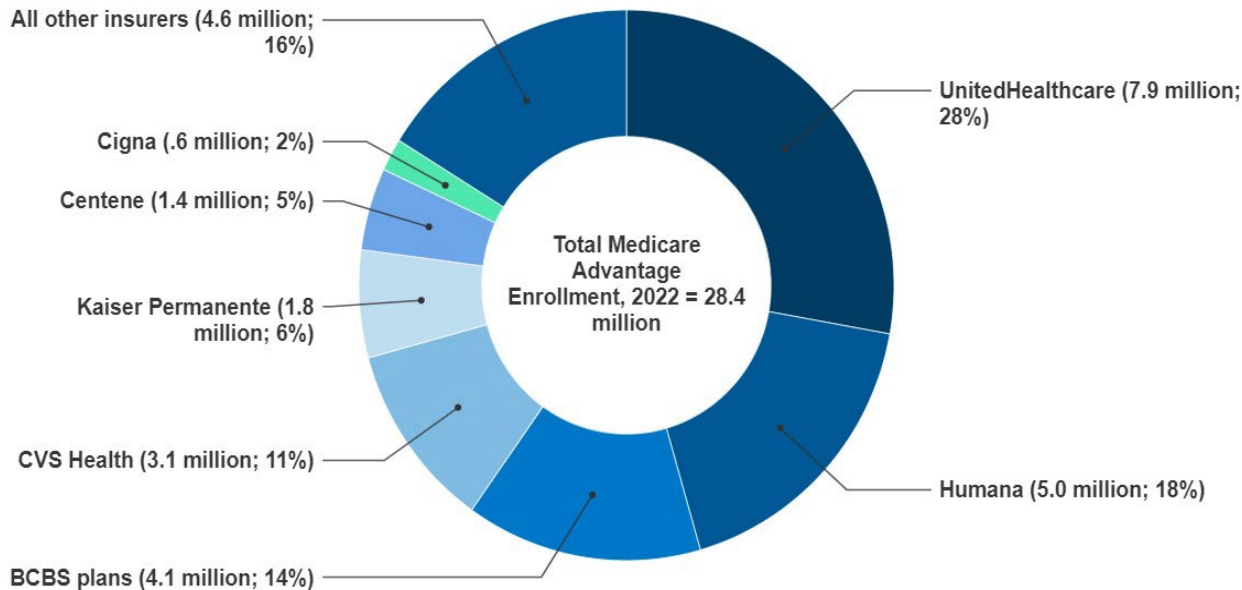


SOURCE: KFF analysis of Medicare spending data from the 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.



# Who has the market share of Medicare \$ through MA and what does this mean for health systems?

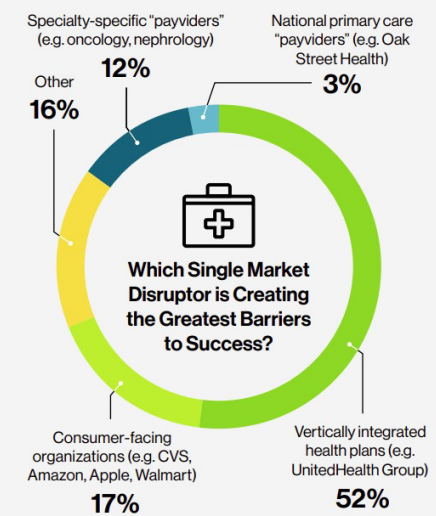
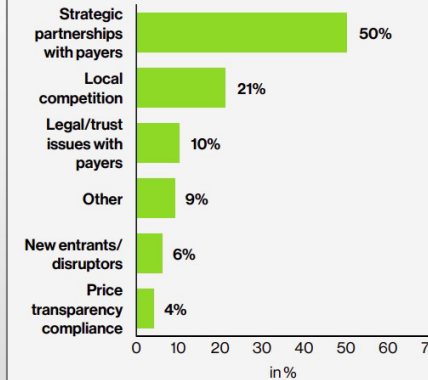
Figure 8  
Medicare Advantage Enrollment by Firm or Affiliate, 2022



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are about 2% of total enrollment.  
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022. • PNG



What is your top external challenge with pursuing payvider models or increased levels of risk/capitation/joint venture arrangements?



Guidehouse (HFMA survey): 2021 Risk-based Healthcare Market Trends

**Meet America's largest employer of physicians: UnitedHealth Group**  
Jakob Emerson - Updated Thursday, February 16th, 2023

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The largest employer of physicians — it's UnitedHealth Group

With 70,000 employed physicians, UnitedHealth Group cemented itself at the top of the list. In comparison, *Bloomberg* reports that HCA has 40,000 physicians, HCA has 40,000 physicians.

**Optum quietly buys New York physician group**

Jakob Emerson - Monday, April 10th, 2023

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Optum has purchased Middletown, N.Y.-based Crystal Run Healthcare, a multispecialty physician group with over 400 providers across more than 30 locations.

# Billions invested in covered lives through primary care and provider acquisitions

*Health systems and academic medical health systems can't compete with these investments!*

*Transformational leadership and strategic planning is necessary to protect providers and covered lives. PCP and Patient retention strategies are a priority with the goal of developing P&L services lines outside the four walls of traditional facilities. Losing PCPs and covered lives will result in the loss of control and input into how health care dollars are spent.*



VALUE-BASED CARE

**Humana, WCAS Throw \$1.2 Billion into CenterWell Senior Primary Care Expansion**

By Joyce Famakinwa | May 16, 2022


**Walgreens Boots Alliance Makes \$5.2 Billion Investment in VillageMD to Deliver Value-Based Primary Care to Communities Across America**

**CVS closing in on deal to buy Oak Street Health to expand primary care footprint: WSJ report**

By Heather Landi • Feb 6, 2023 10:02pm

# Models vary, but similar end-goal: improve care and align incentives

There are a wide range of business models that are addressing these issues. Models vary by method of approach, but they all work to address the same underlying issues

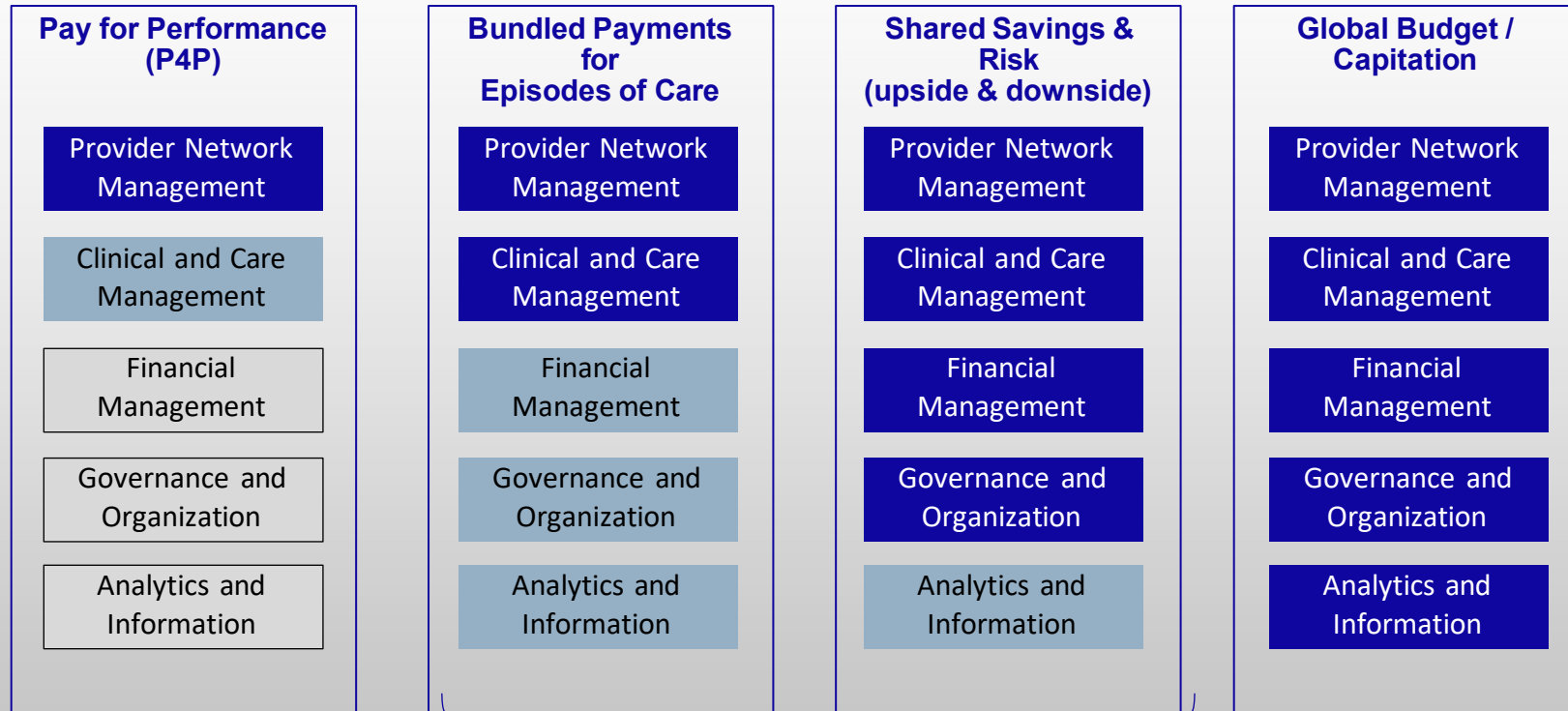
	Privia	One Medical / Iora	Evolent Health	P3 Health Partners	Agilon	Apollo Medical	Oak Street Health	Alignment Healthcare
								
<b>Primary Focus</b>	All payers			Medicare Advantage (MA)		All payers		Medicare Advantage (MA)
<b>Risk Model:</b>	Various (Some shared-savings, some downside, some upside only). Limited full risk, but moving toward higher risk models.	100% of risk with Iora VBC lives, FFS for rest of business. No risk for core One Medical annual membership fees	Majority of lives full-risk Pathways to Success (CMS) is full risk program.	100% of risk, fully delegated services model for majority of business; some sub-capitated risk agreements with Specialists	100% of risk	Various (mix of full-risk, shared savings, FFS)	100% of risk (for MA population); some novel sub-capitation models with New Century Health (Evolent)	2/3 of lives under full risk, 1/3 of lives sub-capitated to other risk based organizations
<b>Primary Care Center model:</b>	No ownership in physical sites, provider partners own real estate.	One Medical/Iora Offices in urban locations. Typically 7-8 provider offices per location.	No ownership in physical sites, provider partners own/rent real estate	No ownership in physical sites, provider partners own/rent real estate	No ownership in physical sites, provider partners own real estate	No ownership in physical sites, provider partners own real estate. Company owns some ancillary services sites.	OSH centers with treatment rooms and social activity center. Leased centers, not owned.	No ownership in physical sites, provider partners own real estate.
<b>Care model:</b>	IT-enabled (partner with athenahealth), partner PCP led with some specialist providers too	IT-enabled internal care team, PCP led.	IT-enabled (Identifi platform): enables high ROI based on prioritized interventions. Internal care team; partner PCP-led	IT-enabled (partner with athenahealth), partner PCP led with embedded care teams, develops a network of specialty Providers	IT-enabled, partner PCP led with agilon embedded teams	IT-enabled (EHR agnostic), partner PCP led with embedded care Teams	IT-enabled (OSH Canopy) internal care teams (employed providers and social workers)	IT-enabled (AVA platform), PCP contracted network + internal team for at-risk patients (Care Anywhere)
<b>Employed Providers?</b>	No	Yes	No	No	No	No	Yes	No
<b>Detailed Overview</b>	Partnered groups (indep. or hospital owned / affiliated doctors) move to a single Privia tax ID in each market; annual evergreen relationships. PCPs get 60% of residual income in Medicare risk business.	Employed doctors, expand number of providers per center as local membership expands.	Grown rapidly from inception in 2020 to 100k+ lives / \$1.1B+ premium under management in 2022	Affiliate model. PCPs receive P3 team/tech to enable VBC. PCPs get same FFS rates plus financial upside from increased patient access and improved outcomes. 50% share in residual income from MA business.	20-yr partnerships with independent PCP group anchors. Typically a 50%/50% share in residual income in MA risk business	Affiliate model where PCPs receive benefit of AMEH team/tech to enable VBC. PCPs receive same FFS rates plus financial upside from value-based bonuses.	Employed providers, typically 6 care teams per center (one PCP, one NP, one scribe, one other medical practitioner per team)	Employed providers (to manage care coord. for highest risk members); also network of contracted providers (typical managed care groups of in-network, contracted providers)

# Transitioning FFS to Value: What does it take?

## Capabilities required under common value-based risk models:

### Organizational Commitments:

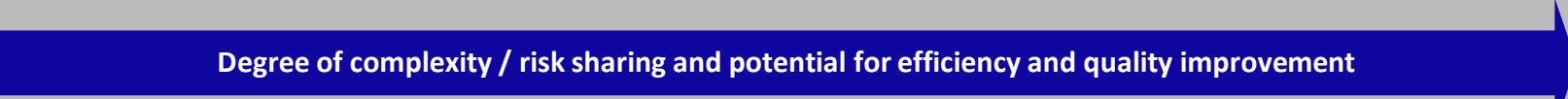
1. Different but integrated Infrastructure
2. Transitional Leadership
3. Accountable leadership with P&L responsibility for value
4. Established aligned incentives
5. Focus on Primary Care innovation
6. Care outside the 4 walls but captured revenue for the system



Level of risk can vary depending on arrangement



Note: \*Shared savings arrangements with lower levels of risk may require fewer capabilities.





**Be the disruptor**

**Let VALUE be your target**

Thank you,

Heather Trafton, PA-C, MBA

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# Changing the Paradigm

**Creating a virtuous cycle  
for employees and physicians**

Jessica Dudley, MD  
Chief Clinical Officer, Press Ganey



# A vicious cycle is upon us



# Paradigm Shift with Focus on Solutions

**Burnout -> Engagement**

**Hiring -> Optimize**

**Individual -> Team**

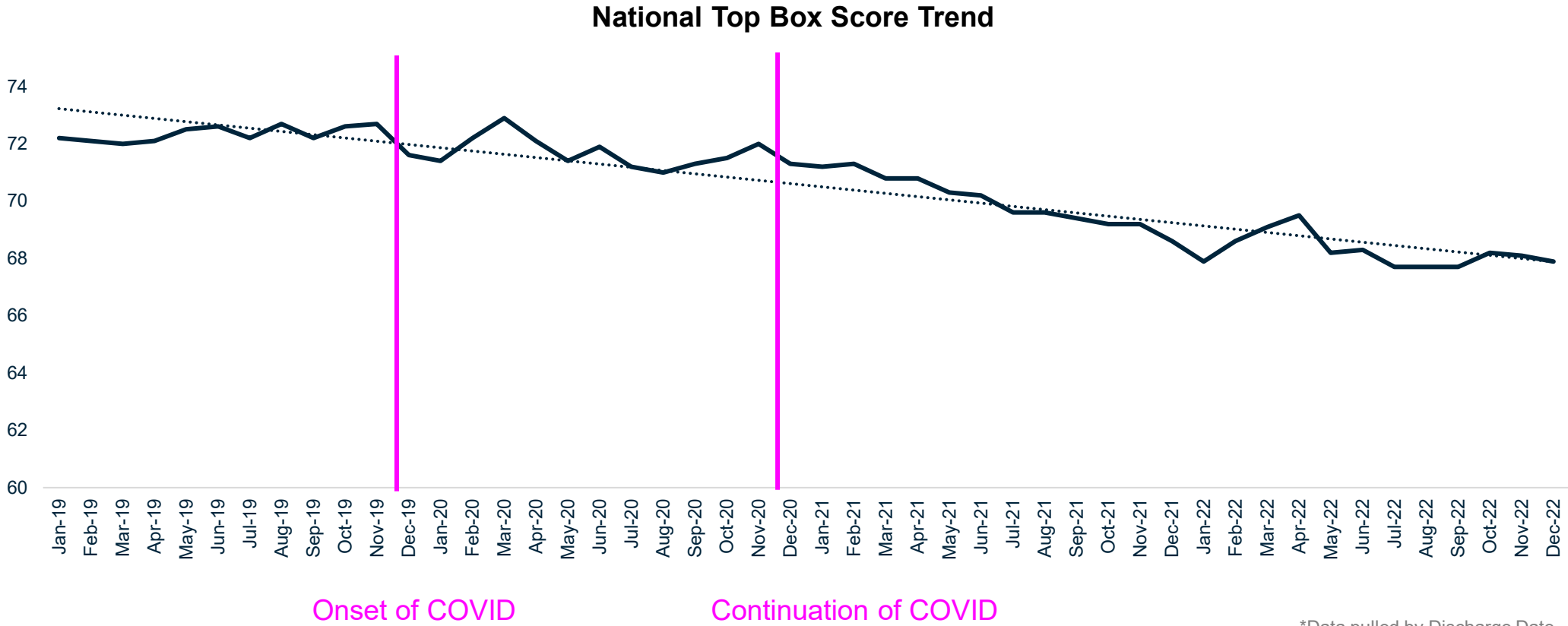
**Survey -> Listen**

**Silo -> Integrated**

# National Trends in PX

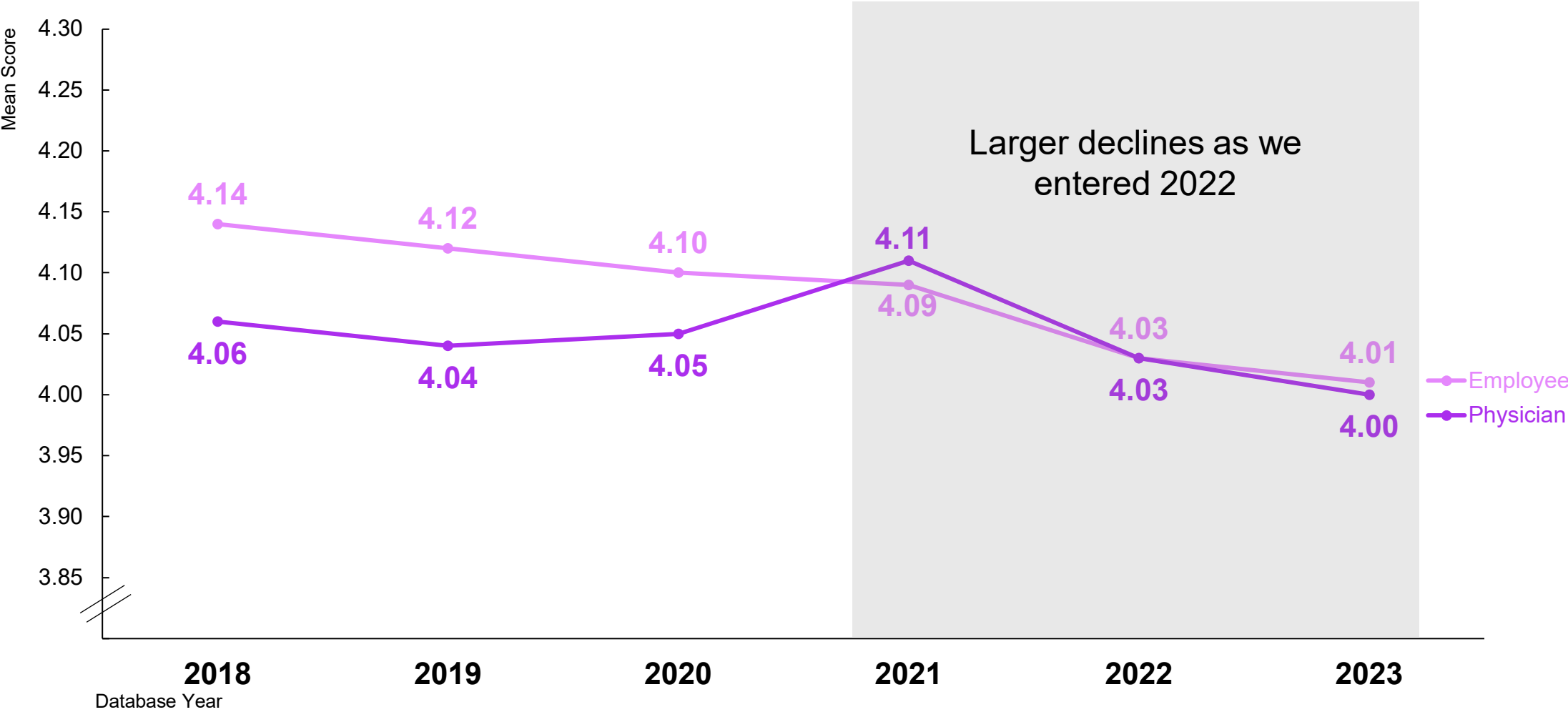
## HCAHPS RECOMMEND THE HOSPITAL

- For inpatient, there has been a downward trend in LTR the hospital.



\*Data pulled by Discharge Date.

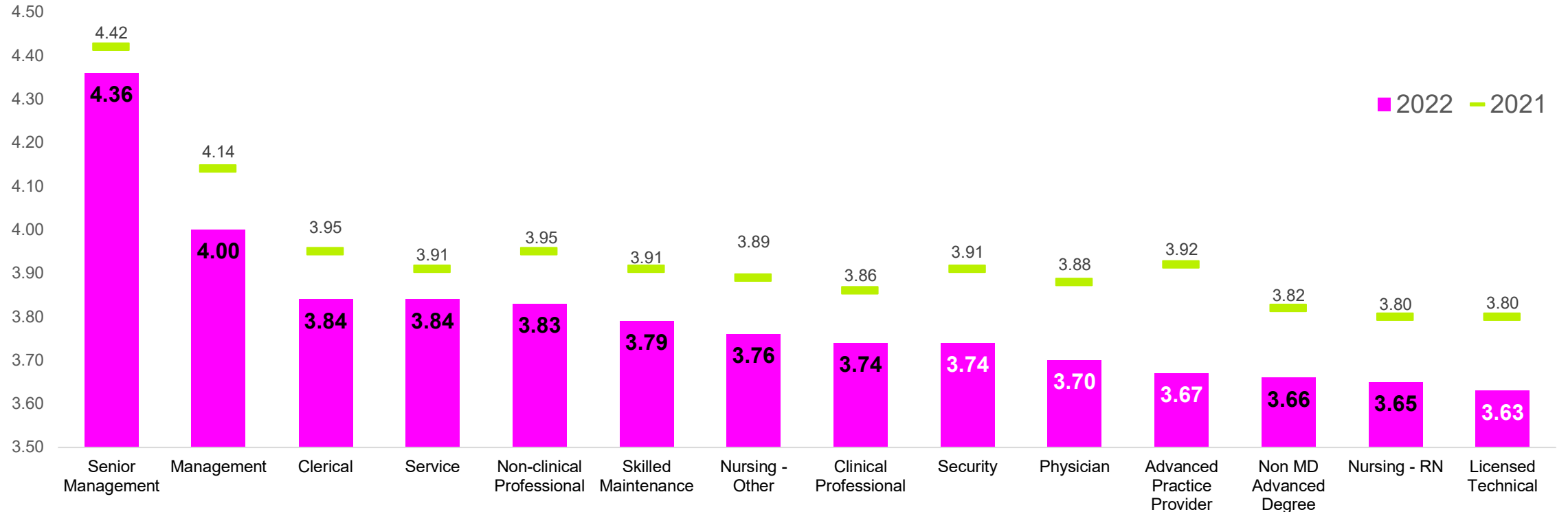
# National Caregiver Engagement Trends



# “I Would Stay With This Organization if Offered A Similar Position Elsewhere” By Position

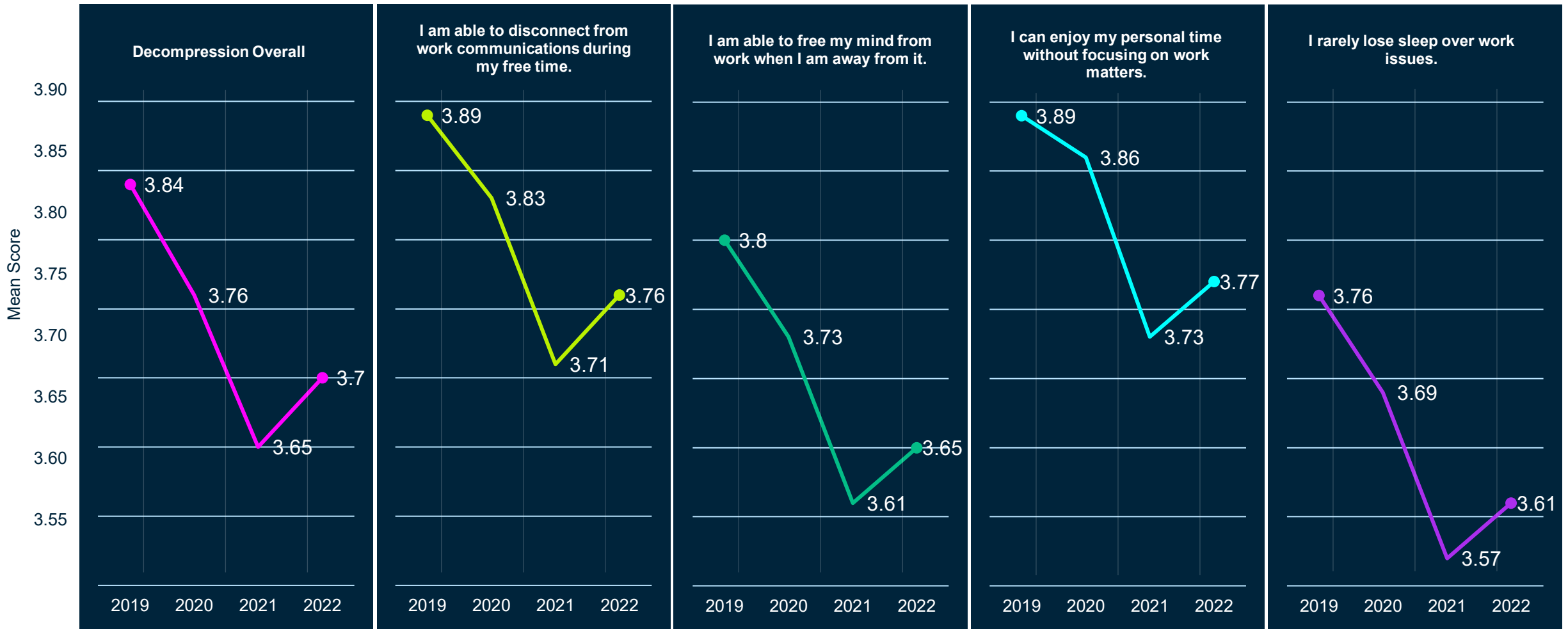
## Key Takeaways

- In the last year, greatest declines are seen in Advanced Practice Providers and Physicians
- Management, Licensed Technical, and Security declined more than we have seen in prior years
- Senior Management is the least impacted group



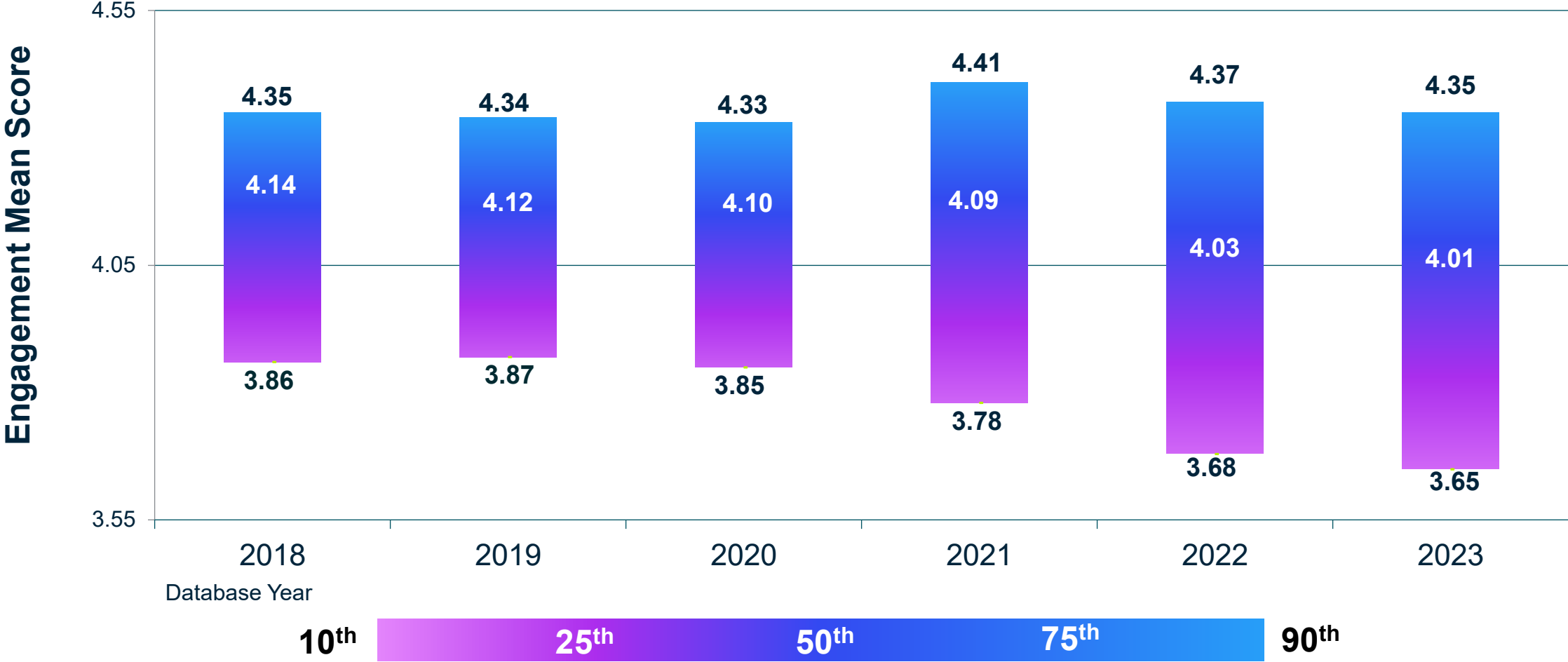
# RN Decompression

YEAR OVER YEAR DECLINES 2019 – 2021 WITH HOPE ON THE HORIZON





# National Healthcare Avg Trending - ENGAGEMENT

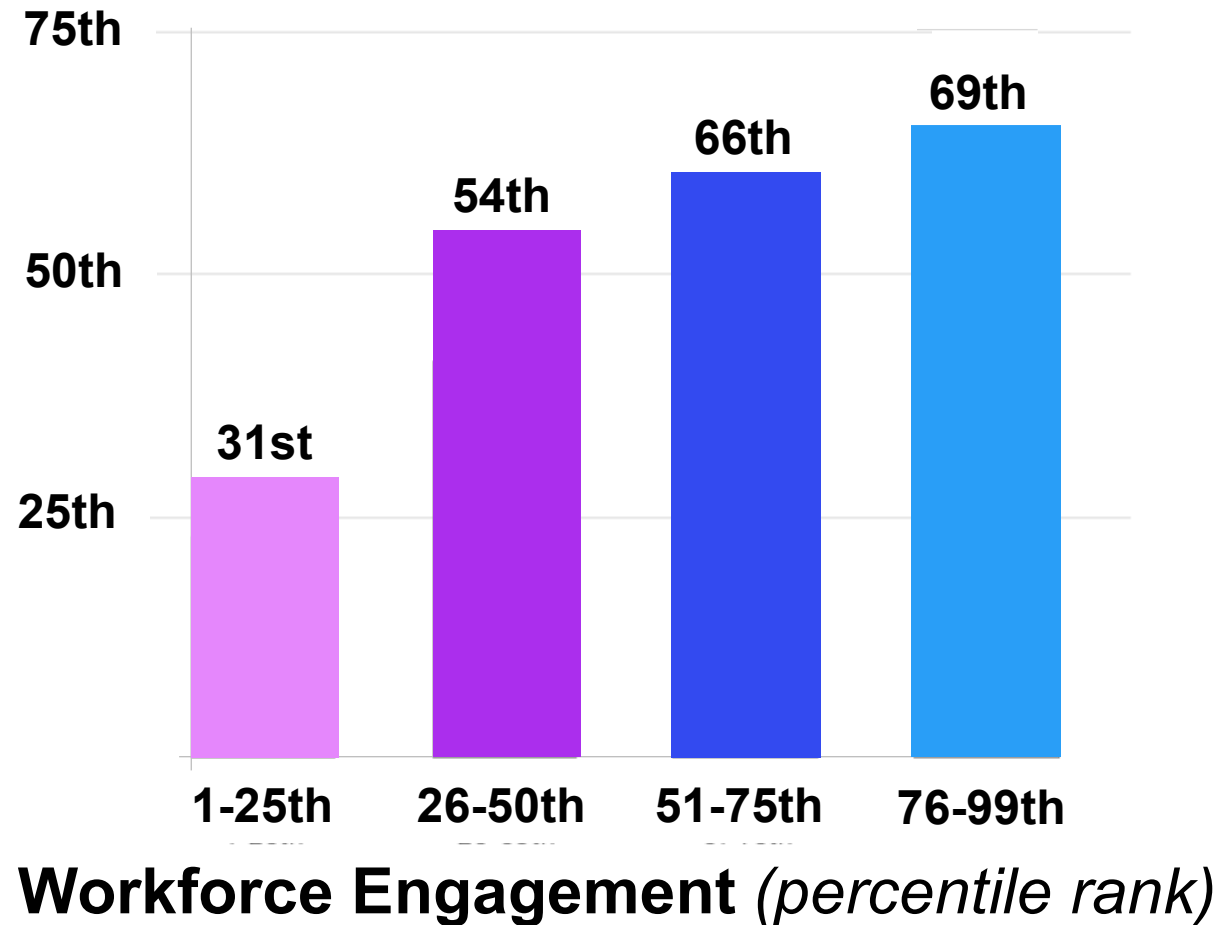


Note – National Healthcare Average based on Press Ganey’s six (6) Engagement items . Employee respondents 2023 (1.52M), 2022 (1.5M), 2021 (1.64M), 2020 (1.87M), 2019 (1.61M), 2018 (1.42M).

# Why Engagement Matters

Patient Experience Performance is Higher at Facilities with Stronger Workforce Engagement

**Inpatient Experience  
Likelihood to Recommend**  
*(percentile rank)*



# Top Decile Performers Do Better



Senior Leadership



Listen & Respect



Meet Employees' Basic Needs



Safety Focused

# Specific Tactics for Improving Engagement

1. Senior Leadership Commitment
  - Accountability
  - Continuous Listening
2. Support the individual
  - De-stigmatize self-care
  - Respect and Recognition
  - Peer Support & Build Community
3. Build the Teams/Train the Leaders
  - Psychological Safety
  - Invest in leader development
4. Fix the systems
  - Optimize what you have
  - Engage frontline in solving and prioritizing

# Thank You!

[Jessica.Dudley@pressganey.com](mailto:Jessica.Dudley@pressganey.com)



# National Efforts

2022

## CONGRESSIONAL ACTION

- Dr. Lorna Breen Health Care Provider Protection Act

## SURGEON GENERAL

- Addressing Health Worker Burnout

## NATIONAL ACADEMY

- National Plan for Health Workforce Well-being

<https://drlornabreen.org/about-the-legislation/>

<https://www.congress.gov/bill/117th-congress/house-bill/1667>

<https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html>

<https://nam.edu/initiatives/clinician-resilience-and-well-being/national-plan-for-health-workforce-well-being/>