Section I Demographic: The following items must be completed by each respondent. Organization type (practice, association, health plan, consumer organization, etc.), name of organization, mailing address, phone number, fax number, and name and email of designated point of contact (POC). Respondents are required to provide a summary of their experience related to practice transformation. Clinical Practices must identify themselves as specialty, primary care or mixed (including both primary and specialty). Clinical Practices are required to also provide practice size including number of providers and size of patient population.

CHE Trinity Health is the second-largest Catholic healthcare delivery system in the nation, serving people and communities in 20 states from coast to coast with 82 hospitals, 88 continuing care facilities, and home health and hospice programs that have more than 2.3 million visits annually. With annual operating revenues of about $13.3 billion and assets of over $19 billion, the new organization returns more than $800 million to its communities annually in the form of charity care and other community benefit programs. CHE Trinity Health employs nearly 86,000 people. CHE Trinity Health is currently participating in 5 Shared Savings Plan (SSP) ACOs and was part of one Pioneer ACO that withdrew from the Program.

CHE Trinity Health is committed to helping practices transform, including those that are part of our group of 3,200 employed physicians as well as 21,600 affiliated physicians serving a combined population of 18 million people in our communities. Whether owned or affiliated, we provide our practices across 20 states with resources and support toward becoming clinically integrated networks, including examples such as analytics, support staff roles dedicated to population health management, and research on the similarities and differences in staffing to support patient-centered medical homes (PCMHs) as a type of practice transformation within primary care. Integration of care management is a significant component of these practice transformation efforts. This PCMH work has included our leadership in the statewide Michigan Primary Care Transformation Project (MiPCT), the three-year multi-payer project to improve health, to make care more affordable, and to strengthen the patient-care team relationship. Several other CHE Trinity Health markets have also advanced the PCMH model of care, including Columbus, OH; Boise, ID; throughout the state of Iowa; Albany, NY; Camden, NJ; Southeastern, PA; Langhorne, PA; Fort Lauderdale, FL; and Springfield, MA.

A. Practice Transformation Strategies, Resources and Opportunities

1. Based on your organization’s experience and understanding, what does a transformed clinical practice look like?

In our experience, a transformed practice can be identified by the existence of leadership, teamwork, strong communication and performance metrics. The
identification of a transformed practice cannot be determined by fancy office space and technology. Those are not indicators of patient-centered care. However transformation can be seen if a practice is achieving the triple aim, and it can demonstrate such with outcomes.

The most important characteristic of a transformed practice can only be determined by asking the patient using questions like these: Are we centering care delivery around you? Are we meeting your needs?

We agree with the Kevin Taylor, MD practice transformation model, which provides a framework for a team approach of caring for patients.

2. Clinical practice transformation can occur through many forms and avenues. When you think about clinical practice transformation, what forms and avenues do you think it should take? Which avenues would you find most valuable and would maximize quality and outcomes?

No answer

3. What are the existing sources of national, state and local expertise available to assist with leadership development, clinician engagement and overall transformation? What gaps can CMS help to close to build upon these efforts?

While there are several well-known national experts, most clinicians prefer and trust state or local experts, because their expertise is based upon the reality that the clinicians face each day.

State and County Medical Societies may be leveraged in some locations- especially where membership is large and there is support for practice transformation.

4. What should CMS consider if it were to organize a program of technical assistance to support the transformation of clinical practices and to prepare for effective participation in value-based payment? What should CMS consider to ensure local on-the-ground support to practices? In such a program, what if any role by the state would be useful?

CMS should consider the varied needs of physician practices. Any on-the-ground support should be able to address a multitude of challenges where transformation is taking place. Any on the ground support should be well qualified- with constant feedback back to CMS to gauge the effectiveness of such assistance and to avoid any program integrity issues.


5. **What key areas of practice transformation require attention?**

HIT infrastructure;
Financial(budgeting acumen);
Frontline staff engagement;
State specific regulations around credentialing, supervision, scope of practice
Disparities in payment for primary care and specialty care services (our payment models currently undervalue primary care)

We encourage CMS to build upon the success it has already achieved in the Advance Payment ACO model where you used the CMMI Section 3021 authority to test prepayment of savings to ACOs in the MSSP ACO models. CMS could extend this approach to prepay all ACOs care management fees of $10 PMPM. This approach would also be consistent with and a test of the approach of CMS to move toward care management fees for high-risk enrollees in 2015.

Clinically integrated networks that are part of an SSP ACO would then have predictable financial support to invest in care management, which would advance clinical transformation.

6. **What policies or standards should CMS consider adopting to ensure that groups of solo, small practices and rural providers have the opportunity to actively participate in practice transformation?**

We think it is very important to support solo and small practices in their desire to stay independent, while assisting them to become an integrated part of the work around population health management. In order to be part of population health management efforts, the small and solo practices need to be actively participating in clinically integrated networks. Additionally, any policies or standards CMS adopts around clinical transformation should be embracing and inclusive of solo and small practices.

Solo and small practices are often lacking in the infrastructure to undergo wholesale and rapid change. The Physician Quality Reporting System (PQRS) could be used as a means of helping smaller providers become more aware of their population’s needs and may represent a simpler approach. Right now, PQRS is being used as a way to collect and display clinical data for practices. We believe that if the PQRS process could be simplified and shortened to provide more actionable, timely data, then solo and small practices may be more likely to use this as a means of understanding their population and their practice.
7. **What practice transformation strategies, resources, and tools are most needed to prepare smaller practices to successfully participate in private and public sector pay for value arrangements?**

Smaller practices need simple, low or no cost tools, easily accessible and digestible in small chunks. With small practices already overwhelmed and resource deprived, asking them to make wholesale changes should be approached on a smaller and slower scale. We also believe that practice transformation requires a coordinated approach between primary care and specialty care.

8. **Are there private sector organizations interested in providing practice transformation support if matching federal dollars were available?**

We believe there are private sector organizations interested in providing this type of transformation support, however we are concerned that short-term players could be enticed in by federal dollars and offer solutions that are not sustainable. These short-timer vendors could disrupt more sustainable efforts with partners (local market partners) that will remain engaged for the long haul.

9. **What should CMS consider as it relates to beneficiary and caregiver experience of care when practices transform?**

Appropriate metrics and metric collection processes regarding beneficiary and caregiver experience are difficult to develop and sustain. Any efforts must be credible, validated and reflect the voice of the beneficiary and caregiver.

It is important to clearly describe the way the metrics were developed and how they are to be used. This communication to providers is an important component of gaining traction as a metric.

10. **Which existing educational and assistance efforts might be examples of “best in class” performance in spreading the tools and resources needed for practice transformation? What evidence and evaluation results support these efforts?**

No answer

11. **How useful is the rapid sharing of results in facilitating practice transformation and improving health outcomes?**

Rapid sharing of results in very useful, to the extent that they can be used consistently and continuously for improvement. The timeliness of the data is critical as our experience has showed us that old data kills the conversation.

12. **What general quality improvement strategies should practices employ to build a**
sustainable continuous quality improvement program (e.g., programs that rely on input and involvement from patients and staff, proven improvement processes and performance measures)?

It is imperative that practice transformation be approached in a way that advances clinical integration which includes both primary care and specialty care.

13. How are practices using Health Information Technology (HIT) and Electronic Medical Record (EMR) technology to improve patient health outcomes? How have various organizations supported HIT integration in practice transformation?

Currently, we believe the meaningful use program could be improved if it focused on functionality and improving care. We suggest that improvements be made in the following areas:

Functionality – the technology needs to operate in such a way that it enhances a provider’s ability to manage a complex patient

Interoperability – we believe that additional rigor needs to be place on EMR vendors so that they are more accountable for ensuring their products will work smoothly with the products of other vendors.

Patient-centeredness - the requirements for the patient portals should focus more on the patient. We prefer measurements that will ensure that the tool is driving more enhanced collaboration and coordination. Simply providing a patient access to their health data, without providing a connection mechanism to the caregiver to provide context to test results, etc, can actually be extremely harmful.

The use of analytical tools, such as population health management software systems, (e.g. care evolution) have proven successful for CHE Trinity Health, to understand a population. We recommend encouraging use of registries, and population health management software, through use of incentives to further assist practices in the transformation.

We would like these products to aid us in our abilities to do medication reconciliation, but they cannot in their current state. A critical component to medication reconciliation is getting at the best source of the medications that a patient is currently taking. We believe the best way to assure this happens would be to have some form of linkage to the Pharmacy Benefit Manager.

Right now EMRs focus on replacing a paper document, particularly as it pertains to billing and coding. EMRs are lacking in decision support mechanisms that could really drive change in the delivery of care.
14. How are practices addressing race, ethnic, primary language, and disability status health disparities in their work to improve patient health outcomes? How have organizations leveraged practice transformations to support reduced racial and ethnic disparities?

Practices should be encouraged to use race, ethnicity, language preferences and disability status/health disparities as a critical component of practice transformation. However, many practices do not currently collect, or if collected, do not use this data. It is our strong belief that data is only valuable if it prompts you to do something different with it.

Practices should be educated that these are important parts of understanding a practice population and that better understanding leads to better outcomes.

Not mentioned in the list are the challenges around educational level and the significant determinant that has on a patient’s willingness and ability to comply.

15. How are practices using population-based strategies to improve patient health outcomes? How have organizations supported population-based strategies in practice transformation?

No answer

B. Challenges and lessons learned in Practice Transformation engagement.

16. What are the most significant clinician challenges and lessons learned related to transforming a practice and what solutions have been successful in addressing these issues?

Significant challenges related to transforming a practice include:

Believing that there is a “silver bullet” or one-size-fits-all solution
Our experience has demonstrated that merely implementing an EMR or participating in a LEAN initiative will not result in transformation. Both EMR and LEAN can be part of transformation. What is really needed is the right clinical champion who understands how to align transformation with practices goals. To be successful, transformation needs to be linked to 2 of the 3 following things. Transformation needs to improve financial performance, demonstrate better patient outcomes and improve clinician productivity (make their day easier). And, it is critical that transformation initiatives provide flexibility for different practices to achieve a goal in the varied world they live in.

Age of the clinician (close to retirement, mid-career, early career). Those physicians close to retirement often lack the motivation to create or initiate any kind of
transformation. Thus, changes will take place gradually, over time as these clinicians retire and close practices.

17. What are the operational challenges, lessons learned, and successes in developing an infrastructure to support transformation?

In our experience the following have been helpful in achieving success with practice transformation:
Using front-line clinicians to change practice;
Redefining the role of the front-line workers;
Establishing clear criteria to measure success;
Allowing the clinicians a voice to figure out how to achieve the goal; and
Working with the practice management and administration to create greater efficiencies in order to allow clinicians to practice taking care of patients as opposed to paperwork.

Challenges with differences in federal and state laws and state-by-state variation in laws continue to impede our transformation efforts, particularly as it pertains to:
Laws that address board specialty;
Credentialing and licensing for all professionals; and
E-prescribing laws.

18. How can physician/clinician affinity groups be leveraged to strengthen the care process and for improve patient outcomes?

We believe that affinity groups can be leveraged as partners in delivering a message and in seeking feedback. The groups would need to see value in engaging its members in such discussions and would need toolkits to be provided. Peer groups are good for sharing and driving health competition. In our experience, clinicians want to deliver good care and don’t want to be viewed as “less than” a colleague.

We have found that when we bring practice leaders together to discuss their improvement efforts, that much discussion ensues and it can be a very significant motivating force for resisters to begin transformation.

19. What are the essential lessons learned from other industries where best practices on systems transformation and learning culture have been adopted?

The banking industry is one where transformation of practice to become automated and mobile happened rapidly. One disruptive innovation (ATMs) began the transformation of the industry.

20. What challenges that have not been successfully addressed to date need to be addressed to achieve desired outcomes in health, healthcare, and more affordable care?
Because many physicians are not focused on the mechanics of financially running a practice, they are often unaware of the type of payer contracts they hold or which payer programs they are participating. This lack of knowledge and understanding can contribute to outcome benchmarks being missed, thus preventing the practice from achieving the “upside” of improvement. Or, even worse, unknowingly being hit with “downside” implications of missed measurements.

21. What information privacy challenges are anticipated or have been experienced in the transformation of practices? How have these challenges been addressed? What specific local, state or federal requirements presented these obstacles?

No Answer

C. Engagement, Partnership and Continuous Learning in Practice Transformation.

22. What should CMS consider when spreading innovations through learning systems?

CMS needs to consider the wide range of skill sets and resource availability of the audience. What may be simplistic to one audience may be too complicated for another. CMS should consider learning and diffusion for at least 2 types of audiences: those with some skills, and those who do not have any knowledge of the subject..

23. What should CMS consider regarding how QIOs, Regional Extension Centers, States and other existing entities can support practice transformation?

No answer

24. What should CMS consider when working with private payors in practice transformation?

CMS should use its muscle to advance consistency and standardization in working with private payors.

CMS should also leverage private payers ability to analyze data as well as their actuarial bench strength and expertise in the commercial space. This type of data could be useful to practices if presented in an easy to understand manner. Additionally, CMS should use program framework such as the Comprehensive Primary Care Initiative or CPCI, but on a smaller scale to make success easier to attain.

CMS may also consider payment incentives to reward health plans for sharing their data with practices/providers. Oftentimes, health plans have the actuarial expertise that could aid practices in exploring innovative payment models.
25. What should CMS consider as it works with States in practice transformation?

Differences in federal and state laws and state-by-state variation in laws challenge or impede our transformation efforts, particularly as it pertains to:
Laws that address board specialty;
Credentialing and licensing for all professionals; and
E-prescribing laws.

We believe that CMS can drive change in this area. We encourage CMS to work with the Administration to raise these issues with governors. We think that by sharing stories about how these variations are effecting citizens of their states, we can incent them to work together to improve the situation.

26. What should CMS consider when aligning public and private clinical transformation efforts?

CMS should reduce constraints in collaboration with industry constituents by allowing more flexibility in the working relationship and means/mode of collaboration. CMS should encourage collaboration that fosters respect and transparency. CMS should allow the public and the industry to see the clinical collaboration efforts applied to large and small physician practices for clinical transformation.

27. How has the use of knowledge management systems facilitated effective communication in learning environments (i.e., through sustainable sharing of improvement results, providing virtual technical assistance, interactions amongst large communities of practice, and the provision of on-line resources and tools)?

Knowledge Management system such as MLN Matters as well as the framework established by MSSP (ACO Spotlight/webinars/etc) are helpful in distributing information. These systems are on-demand, updated regularly, and provide easy to understand and useful information for participation in MSSP as well as other programming.

28. What would motivate clinicians to participate in any potential future initiatives relating to practice transformation and value-based purchasing?

Clinicians are motivated by payment incentives commensurate with the promise of improvements in practice. Additionally, practice transformation and value based purchasing initiatives need to be initially upside without being punitive. Penalties can be phased in as they were with PQRS, eRX and other programming. Efforts can’t be overly complex initially, or clinicians will not engage. In some geographies, having a physician champion (from the community) may be a way to garner support from other physicians---you may consider testing this as a way to potentially engage physicians in all types of practices.
29. What would motivate new partners to enter the field of practice transformation as a prime contractor, subcontractor, or consultant?

No answer

30. Are there other successful mechanisms that support engagement in practice transformation that could be considered?

No answer

D. Current Engagement in CMS Models

31. What is your current relationship with CMS initiatives related to practice transformation (e.g., Accountable Care Organizations (ACOs) participating in the Shared Savings Program or the Pioneer ACO model, and the State Innovations Models (SIM))?

CHE Trinity Health is currently participating in 5 Shared Savings Plan (SSP) ACOs and was part of one Pioneer ACO that withdrew from the Program. We are committed to developing more ACOs over this year.

32. In your transformation efforts, have you seen any program integrity issues and if so what strategies did you use to assure that your transformation efforts did not foster program integrity problems?

CHE Trinity Health places an emphasis on program integrity. Integrity is one of our organizations 5 core values. We assure that our transformation efforts remain consistent with our values and align our incentives in such a way not to conflict.

33. Even if you did not see any program integrity problems or issues during your transformation efforts, did you actively design strategies to mitigate any such issues? What were the mitigation strategies?

No answer

34. Are there particular program integrity issues that you think you need to address as you pursue transformation? What are these issues? What barriers do they pose to successful transformation?

No answer

35. How could CMS possibly use patient satisfaction surveys or report cards regarding practice transformation?
Patient surveys can be used as one metric, to the extent that they apply to that specific physician’s patient panel- and that is important to point out. If the survey does not apply to that physician’s practice, it will be disregarded. CMS has already developed reporting around the physician value based modifier, so there is potential to use that type of reporting capability.