RowdMap's
Institute for the Delivery of High-Value Care
May 17th - 18th - Louisville, KY
Summary Notes

WEDNESDAY, MAY 17TH - Best Practice Vignettes to Learn from Your Peers

The Mandate: Payment vs. Know-How
David Wennberg, MD; Steve Ondra, MD & Josh Rosenthal
Healthcare leadership has a Know-How Problem that has historically blocked the delivery of High-Value Care. A lack of reliable data and financial incentives are easy to point out and solid gains have been made on these fronts. But the business and management skills necessary to face down tough cultural resistance and nurture high-performing teams are the focus here.

Summary: The challenges to the delivery of high-value care no longer include whether or not low-value care exists or if the data can illustrate that, but the fact that our system is built around optimizing fee-for-service. Providers are incentivized to get good outcomes no matter the cost. With the recognition of the impact of low-value care on payers, providers and consumers comes strong cultural resistance. As Dr. Wennberg said, "The question is no longer whether variation exists, it's what to do about it."

Clinician to Clinician, Part 1: A High Value Conversation
Matt Collins, MD; Julie Blehm, MD; Lisa Faust, MD; Robert Del Junco, MD & Eric Andreoli
How to Talk to Clinicians about High-Value Care, from a Clinician's Perspective. Tips, tricks and techniques for avoiding pitfalls and having a high-value conversation with a Clinician.

Summary: Assume there is good intent. Don't lead with dollars and cents, but start with the data and then move on to discuss population health. Focus on improving the experience for our patients. Do not go with data that you can't support, but rather understand the data and be able to answer questions. In many cases, physicians haven't seen this information before. Don't get bogged down in the minutiae, but look at the bigger picture, asking "Do you want to know if you're going to succeed in pay-for-value? Do you want to see this data?"

- *Question from audience: When you work on changing physician behavior, do you have the information and granularity to help them change?*
- *Answer: It's too new right now. But when we show a physician a 'report card' they immediately want to improve it. When they see how they compare to the peer group, they will begin to self-correct.*

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System Frenemies? Hospitals vs. Groups

Cathy Mesnik; Niki Balginy; John Stites; Kevin Manemann; Kristie Genzer & Ashley Distler

Challenges, ideas and successes in building and aligning infrastructure, between Hospitals and Groups, around High-Value Care to sustainably deliver it at scale. Tips, tricks and techniques for talking about high-value care from a Hospital's, vs. a Group's, perspective with keys to facing down cultural resistance in each context.

Summary: Have executive teams on both sides with goals and incentives tied to high-value care and understanding that it's the community of physicians driving the results at the hospital. It's important to set expectations within the organization. As hospitals and groups are extending partnerships, it is important to understand what it means to be clinically integrated and what is does not. A challenge that can arise is having lower-value physicians who bring in significant revenue.

What are toxic topics around transition to high-value care?

- *The "r" word - referrals. Legacy of physician ownership versus partnership. The volume conversation, as 50% of business is still in fee-for-service (FFS).*

How do you avoid discriminating against populations based on payment model?

- *Key is taking advantage of opportunities CMS is providing (CPC+, etc.) Rally around members and see them as individuals. We need to do the right thing for the patient, regardless of payer mix. Bid out care management to make it competitive. Work to create more value-based contracts.*

Flowing Downhill: PCPs vs. Specialists

Tim Rodgers; Robert Del Junco, MD; Thomas Groves; Dave Janiec; Greg Downing, DO & Ryan Melander

Challenges, ideas and successes in building and aligning infrastructure, between Primary Care Providers and Specialists, around High-Value Care to sustainably deliver it at scale. Tips, tricks and techniques for talking about high-value care from a PCP's, vs. a Specialist's, perspective with keys to facing down cultural resistance in each context.

Summary: It is important to align the payment models/incentives between Primary Care Physicians and Specialists so that everybody has something to gain through population health. Use report cards to see referrals per 1,000 to show cost of care to physicians that they refer to. The multitude of payment arrangements adds to the complexity, and you must figure out what things you don't have to do. PCPs are very early in cultural change and are therefore, serving two masters – "feed the beast" and population health. Previously there was not any real clinical data to help PCPs make referral decisions, essentially just because the specialist was able/willing to see the patients and the patients were satisfied. Now, we can use RowdMap to help with these decisions. Data is often shared in a one-off situation. The fee-for-service (FFS) model makes it very hard to do any sort of value-based models as there is no incentive to do or change anything.

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West Coast vs. Fly-over Country

Elizabeth Curran; Kent Cerneka; Sean Nyhus & Bryant Hutson

Challenges, ideas and successes in building and aligning infrastructure, between Diverse Regional Markets and Delivery System Geographies, around High-Value Care to sustainably deliver it at scale. Tips, tricks and techniques for talking about high-value care from a West Coast, vs. a Fly-over Country, perspective with keys to facing down cultural resistance in each context.

Summary: We try to meet providers where they are. In urban areas, this may mean integrated networks with sophisticated infrastructure. In rural areas, this may mean starting with upside, and identifying barriers to access. Where we lack scale for meaningful value-based models, we have to get creative. When contracting in urban areas, there are many options for systems and group partners, so we can figure out the right arrangements and risk for different partnerships. In rural areas, there may only be a single option. In terms of value-based models, urban providers are in more sophisticated systems/Clinically Integrated Networks (CINs) and we try to provide them with supplemental and helpful data. As for rural areas, they don't have the infrastructure so we try to provide assistance on things like barriers to access. But in all, the goal is ultimately to move the provider to value-based models. Approximately 70% of spend is across 6 healthcare systems. Many of them are beginning to purchase community hospitals and care centers in order to encourage referrals. In rural settings, the proposition of high-value care originates at the primary care level. Also, alternative care models are beginning to be offered in rural settings – i.e., virtual care or clinics within large employer settings. In urban centers, we have found the high-value specialists for high-cost procedures and are steering members to them, which has been vastly successful.

WEDNESDAY, MAY 17TH - Interactive Games-Based Workshops to Practice Skills

A – Moneyball: An MBA for Healthcare

Jodie Uhl; Sean Nyhus; John Stites; John Bulger, MD; Alex Brayton & Mac Davis

An interactive workshop focusing on the concept of high-value care using analogies from other industries (aka sports) examining the economic fundamentals, systemic pressures and market and geographic forces driving or inhibiting the delivery of High-Value Care.

Summary: Oakland A's changed baseball by throwing out traditional baseball statistics and using data to determine what players were most likely to contribute to wins. They decided that you win baseball games by getting players on base (OBP = on base percentage). By finding players who got on base, and were undervalued in the market, they were able to win the same number of games as the New York Yankees, but for far fewer dollars per win. Support your unique thinkers by pulling them into the room, giving them as much runway as you can, and encouraging them to speak their mind. You don't always want your healthcare organization to be the first person through the door, since they "always get smashed and beaten by everyone else," but we do want to be at the tip of the arrow and an early adopter. "The power of Billy Bean is that he decided to make a fundamental change, and then he went

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full tilt. We know what the right thing to do is, but we often don't execute because we see barriers we don't want to tackle. When was there ever something worth doing that was easy?"

H – Comm. 101 – Culture and Consensus

John Smith, MD; Troy Smith; Mark Werner; Lisa Faust, MD; Julie Blehm, MD; David Wennberg, MD; Rachel French & Ashley Herbison

An interactive games-based workshop focusing on how to achieve consensus and create a culture that values and works towards delivering High-Value Care. Tips, tricks and techniques for making progress, answering objections and turning the tide.

Summary: Consumers may not understand low-value care, but they do understand economic distress. Value does not equal cost. A proactive care model prevents hospitalizations, but requires sufficient supply of primary care. Physicians have practiced in a relatively data-free environment. For behavior change, we have data, we have incentives, what's missing to create change? We need to take advantage of physicians' competitiveness. "It's human nature to want to understand how we're different."

B – Behind Closed Doors – Clinicians to Clinicians

David Wennberg, MD; Greg Downing, DO; Matt Collins, MD; Robert Del Junco, MD; Jay LaBine, MD; Eric Andreoli & Ryan Melander

An MD-only interactive workshop focusing on the art and science, and the reality of the delivery of High-Value Care. You must know the secret handshake to get into this workshop and be prepared to keep your oath of secrecy.

On transitioning to value-based payment

- *"I want to land on the other shore and burn the boat."*
- *"It sounds like you need a hydrofoil rather than a rowboat."*

Summary: There will only be deflation, there is no more money going into the healthcare delivery system. It's hard to get physicians to understand when they're paid not to. Care models are built based on the payment model. Most health systems don't know how much a procedure actually costs them. The public over assumes the analytical thought patterns for referral patterns. If physicians don't understand value-based care, they can't help shape the future of their profession as we shift away from volume to value. Physicians often practice in a feedback free environment.

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D – Comm. 101 – Talking to Physicians

Sean Nyhus; John Smith, MD; Justin Schulte & Kelly Krawiec

An interactive games-based workshop focusing on how to talk to Physicians about High-Value Care, exploring how to communicate the strategy and tactics for its delivery for Physicians, the opportunity and advantages for Physicians, and ideas for answering objections and breaking down roadblocks from Physicians.

Summary: The correct approach and cadence in talking about high-value care to physicians is different, it's not a "one size fits all" approach. When discussing high-value care, you must focus on creating and developing the proper dialogue with physicians. Once a dialogue is opened, high-value care can be discussed in parallel with improving patient lives. Creating and developing the proper dialogue with physicians, rather than the health plan forcing it down their throats, is the key.

C – Translation – Talking to Clinicians

Steve Sternberg; Lisa Faust, MD; Julie Blehm, MD; Rehan Waheed, MD; Eric Andreoli & Ashley Distler

An interactive games-based workshop focusing on how to talk to Clinicians about High-Value Care, exploring how to communicate the strategy and tactics for its delivery for Clinicians, the opportunity and advantages for Clinicians, and ideas for answering objections and breaking down roadblocks from Clinicians.

Summary: Conversations with clinicians can sometimes go awry, but that doesn't always have to be the case. Understanding the physicians' perspective can help lead to more productive conversations. In this session, our white-hats identified a few methods for gaining physician buy-in and encouraging productive action:

- *Explain how the information helps patients. Physicians are focused on patient care and they will be more likely to listen if they understand how low-value care adversely affects the lives of their patients.*
- *Stress that imperfect data is still incredibly useful. There is no such thing as a perfect data set, but that should not be a barrier to action. Instead of focusing on statistical details, focus on conclusions and action items.*
- *Approach the conversation with a discrete goal. Physicians are bombarded with data. The conversation will not go anywhere if your only goal is to discuss a shiny new data source. Be explicit about why you are sharing this information.*

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E – Comm. 101 – Talking to Actuaries

Gary Stanford; Troy Smith; Alex Brayton; Rachel French & Liz Young

An interactive games-based workshop focusing on how to talk to Actuaries about High-Value Care, exploring how to communicate the strategy and tactics for its delivery for Actuaries, the opportunity and advantages for Actuaries, and ideas for answering objections and breaking down roadblocks from Actuaries.

Summary: When talking to actuaries, they need to hear empirical data and facts. It's tough for actuaries to deal in the "subjective". When applying RowdMap recommendations for things like product pricing, actuaries often will be extremely conservative. The problem with where RowdMap is in its lifecycle, there hasn't been enough time to see the results take effect. Meaning, if we project 5% savings due to network improvement, what is the real savings achieved? If we say 5%, actuaries are going to with 3%.

F - Comm. 101 – Talking to Analysts

Kurt Ringo; Chris Bush; Niki Balginy; Kent Cerneka; Kathleen Murphy; Bryant Hutson & Katie Claiborne

An interactive games-based workshop focusing on how to talk to Analysts about High-Value Care, exploring how to communicate the strategy and tactics for its delivery for Analysts, the opportunity and advantages for Analysts, and ideas for answering objections and breaking down roadblocks from Analysts.

Summary: Serving as a translator between the executive team and analysts, it's important to be able to "code switch" between the two groups. You must be able to take "big picture" ideas and translate them into specific requests. Additionally, there has been some initial resistance to the RowdMap metrics from the analytics team. The analytics team wants to be able to solve these problems and/or answer questions using internal data, rather than RowdMap's; however, it's important to stress that we have not been able to achieve those things with our internal data, and that we need to be open to trying something new, even if it requires some additional work upfront.

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THURSDAY, MAY 18TH - Best Practice Vignettes to Learn from Your Peers

Mandate, Market & Momentum

Paul Diaz, C.R. Burke & Marshall Votta

Healthcare leadership has a Know-How Problem that has historically blocked the delivery of High-Value Care. A lack of reliable data, and financial incentives as well as the business and management skills are all culprits. But payers and providers are making notable gains and gaining Momentum across a wide variety of Markets in doing the hard work to deliver High-Value Care.

Summary: The biggest reason California has been successful in delivering high-value care starts with the letter 'K': Kaiser." In their model, the hospital is a cost center, not a revenue center. The delegated physician organization – physician drives economic engine. To compete in California, you have to know and work with Kaiser. Everyone has own vested interests and we're not moving quickly enough to align interests. We cannot wait thirty years for the rest of the country to catch up with southern California. We need to be faster – we must move past physician order, and needs to move to consumer.

Clinician to Clinician, Part 2: High Value Hang Ups & Solutions

Matt Collins, MD; Beau Raymond, MD; Jay LaBine, MD; Rehan Waheed, MD & Eric Andreoli

How to Talk to Clinicians about High-Value Care, from a Clinician's perspective. Advanced tips, tricks and techniques for crafting an extraordinarily meaningful a high-value conversation with a Clinician.

Summary: One thing missing in this discussion is the consumer perspective. We're all leaders and making decisions on how care is best delivered, but often the consumer is missing from these decisions. There is a disconnect between how MDs are looking toward high-value care and how systems/hospitals are aiming for it. "If we had a design today, how would we design it?" Think of how architects do these things. If we applied this approach to healthcare, it would be very powerful. The biggest challenge we have is that physicians will say, "this is not about quality." Cost standardization and efficiency data often doesn't represent the quality piece as physicians see it. We have to get physicians to buy-in to the fact that the world is changing. This isn't an RVU-driven model anymore. It's often difficult to talk to physicians about performance, when they think of things as only one-on-one interactions with patients. When you show them data about how they aren't taking care of the many other things aside from the patient in front of them, we may get pushback, but data to back up the discussion is very helpful. When you ask a physician their thoughts on whether they are being successful or not, they have 1 of 2 ways of thinking about this. It's either 1) Financial (i.e., did I make more money than I did last year?) Or 2) It's about patient demand (i.e., "Patients want to see me.") When you talk to doctors about doing specific things that would make patients better, they often have the response of "I would do that thing, but you don't pay me for it!"

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Tying the Knot: High-Value Care Model as a Payer Strategic Advantage

John Bulger, MD; Sean Nyhus; Zeev Neuwirth, MD & Justin Schulte

Challenges, ideas and successes in building and aligning infrastructure between a 'High-Value Care Model' and a health 'Health Plan's Strategy', around High-Value Care. Tips, tricks and techniques for talking about high-value care from a High-Value Care Model delivery, vs. a Payer Strategy, perspective with keys to facing down cultural resistance in each context.

Summary: From a strategic perspective, most people don't understand what we mean by "the model" when talking about payment or tactics. Need to have specifics tactics to get the job done - no one understands the meaning around different models - Utilization vs Unit Costs. Unit Cost doesn't mean anything to a provider (which is why you need to boil it down to tactics) – need to translate to a language understood and supported by providers. Data has been the issue (if you give good data to providers, you can start to see social norming). The word "alignment" is a great way to look at it. These things are definitely "misaligned." I believe that the fee-for-service (FFS) model is actually worse than our current opioid epidemic. I think lives lost can absolutely be assigned to the fee-for-service (FFS) payment model. There are financial and actuarial people that are using unit cost exclusively, because that is how they have always done it. The market is 95% FFS with very little risk, so the payment doesn't lend itself to change.

In order to bridge the gap, it's all about payment. You have to start with the engine. The conversation can't begin until you change how doctors get paid. Somebody has to force us into a different model, and then everything else follows. Until you change payment, it's purely an academic conversation. MACRA helps get the engine running, but finding the right provider group and the right leadership in the plan to create a partnership is a way to change. It's very hard to change inefficiencies, but the right partnerships and leadership can make things happen. Foster these relationships based on trust. Providers don't trust the payers. They think that the payers are the ones making all the profit from this change. Providers will continue to delay, delay, delay the transition until they understand that value-based payment (VBP) is financially beneficial for them, as well. Reality is going to set in though, because this is the world we live in. This is a value-based world now. Providers don't want this transition period to last. They want things to just CHANGE. "Let's just go ahead and do it!" No longer keeping one foot on the dock and one on the boat. It doesn't end well.

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Commercial vs. Government Programs

Gary Stanford; Troy Smith; Mark Werner & Rachel French

Challenges, ideas and successes in building and aligning infrastructure, between 'Commercial Individuals' and 'Government Programs Individuals' within the Same Organization, around High-Value Care to sustainably deliver it at scale. Tips, tricks and techniques for talking about high-value care from a Commercial Individual's, vs. a Government Programs Individual's, perspective with keys to facing down cultural resistance in each context.

Summary: From a provider perspective, there seems to be less payer transparency on the commercial side. Historically, plans have wanted to protect competitive advantage, but this is changing. Providers don't see different lines of business; brought two teams together: 1. Value focus 2. Contracting focus - Value is not a standalone component. We are now changing the dynamic to stop when provider calls to look at RowdMap before moving forward with the discussion with the provider. Rather than looking at commercial vs. government, we try to group things together and form strategies and products that work across all lines. In some cases, there really isn't alignment, because there are differences. For example, whether something happens at hospital A vs Hospital B is a big difference in commercial, but not so much in Medicare Advantage (MA). Historically MA folks and Commercial Folks have been very fragmented. Now, we are bringing them together into one holistic experience. Historically plans are much more transparent with government rates and information, whereas things are held closer to the chest and there are more roadblocks to getting information (as a provider) regarding commercial rates. This is about cultural changes. Historically, that unit cost data in commercial was a competitive advantage. But in value-based payment (VBP), that's no longer the case.

The Tactics: Competition vs. Tough Cultures

John Smith, MD; Kristie Genzer; Jennifer Brady, MD; Rachel French & Melanie Rosenthal

Healthcare leadership has a Know-How Problem that has historically blocked the delivery of High-Value Care. Tips, tricks and techniques for cracking the tough nuts around of Tough Cultural Resistance.

Summary: In order to nurture high-performing teams, it's important to get unique perspectives around the table, let go, and let people do their jobs – let it be organic. You should fan the flame when needed, and give it room when needed. In order to nurture change, you must make huge change management efforts. If you are the leader, wrap your head around this concept and understand it – a lot of work is required around provider leadership to work through this information. Also, important to build training on how to have the hard conversations. DATA = directionally right, specifically wrong. For Cultural Transformation, you must ask, does your organization have cultural appetite for change? Have you created that shared vision? What is your real commitment for supporting transition to high-value care? Must make a commitment to the journey and infrastructure cost. Physician leadership is required for driving conversations; created quality counsels to help create guidelines. Typically, financials are siloed and are in direct opposition with one another; align goals and financials. Overcome Cultural Resistance – seek first to understand then to be understood – first, understand what each other does, then once that

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happens you can explain different positions. A lot of resistance comes from not understanding the need to change – need good data, not perfect. Keep in mind that trust is the foundation of any relationship.

THURSDAY, MAY 18th - Interactive Games-Based Workshops to Practice Skills

A – Moneyball: An MBA for Healthcare

John Stites; John Bulger, MD; Alex Brayton & Mac Davis

An interactive workshop focusing on the concept of high-value care using analogies from other industries (aka sports) examining the economic fundamentals, systemic pressures and market and geographic forces driving or inhibiting the delivery of High-Value Care.

Summary: Oakland A's changed baseball by throwing out traditional baseball statistics and using data to determine what players were most likely to contribute to wins. They decided that you win baseball games by getting players on base (OBP = on base percentage). By finding players who got on base, and were undervalued in the market, they were able to win the same number of games as the New York Yankees, but for far fewer dollars per win. Support your unique thinkers by pulling them into the room, giving them as much runway as you can, and encouraging them to speak their mind. You don't always want your healthcare organization to be the first person through the door, since they "always get smashed and beaten by everyone else," but we do want to be at the tip of the arrow and an early adopter. "The power of Billy Bean is that he decided to make a fundamental change, and then he went full tilt. We know what the right thing to do is, but we often don't execute because we see barriers we don't want to tackle. When was there ever something worth doing that was easy?"

K – Healthcare &/vs. High-Performing Leadership

Lisa Brubaker; Marja Wilson; Jennifer Brady, MD; Melanie Rosenthal & Rachel French

An interactive games-based workshop focused on discovering your leadership profile and how to use it successfully delivery High-Value Care. Tips, tricks and techniques to use in healthcare to make tough decisions, take action based on information and build a team and culture to successfully deliver High-Value Care.

Summary: Healthcare is rapidly changing. Healthcare costs are unsustainable, and hard decisions will have to be made to reduce expenditures. Now more than ever, we need cultural change leaders. Leadership that can achieve consensus quickly, and overcome cultural resistance all while nurturing high performing teams. These leaders will be able to make tough, data-driven strategic decisions to evaluate and assess current and future resources. Healthcare is no longer about volume, but value, and the most valuable leaders in healthcare will be the best at creating change.

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J – Hot Takes & Trends – Real vs. Hype

Clese Erikson; Elizabeth Curran; Sean Nyhus & Bryant Hutson

An interactive games-based workshop focusing on telling the difference between hype and real tools and trend to help organizations deliver High-Value Care. Tips, tricks and techniques for discovering what is truly meaningful and valuable for the delivery of High-Value Care.

- *Plan-driven provider behavior change*
    - *Has to be partnership-driven.*
    - *Long-term (5-7 years)*
    - *Big difference between cheap providers and high-value providers.*
- *Custom-built employer Administrative Services Only (ASO) networks*
    - *"Overrated" - employer willingness?*
    - *"Underrated" - employers are coming to us.*
    - *"Underrated" - employers are not a monolithic group.*
    - *"Overrated"- expensive, inefficient*
    - *"Underrated" - competitive differentiator*
- *Patient-Centered Medical Home (PCMH)*
    - *"Underrated"- hasn't gotten enough attention.*
    - *"Overrated"- savings require equal investment.*
    - *Certification "overrated", name-only. - Doesn't have to be targeted toward every patient; best for high-risk cases*
    - *Requires leadership, "intestinal fortitude". - Must become part of fabric of organization.*
- *Primary Care Physician (PCP) shortage*
    - *No one wants to do it - Hard work, little money versus specialists, hospitalists.*
    - *Bubble about to burst - Colleagues considering career change outside of healthcare.*
    - *Requires allocation, aligning physician skill with patient complexity.*

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B – Behind Closed Doors – Clinicians to Clinicians

Greg Downing, DO; Matt Collins, MD; Zeev Neuwirth, MD; Jay LaBine, MD; Gerald Maccioli, MD;
Eric Andreoli & Ashley Distler

An MD-only interactive workshop focusing on the art and science, and the reality of the delivery of High-Value Care. You must know the secret handshake to get into this workshop and be prepared to keep your oath of secrecy.

*Summary: **Note: the format of the session on Thursday changed to list all of the things we should remember when we introduce data to physicians*

1) *Lead with the patient: Don't always focus on the payer or provider. Ask the five why's and for physicians, it always goes back to the patient*
2) *Embrace our objections/resistance: Ask us what we're afraid of - Let people volunteer to be the "control group"- don't force it*
3) *Disarm First - Always lead with the benefit to a patient. "We're in this with you. Wouldn't you like to see what the data says about you?"*
4) *Understand the History and Context*
    - *We're fatigued from all of the Electronic Medical Records (EMR) changes… we call it "false promises" fatigue*
    - *Remember all of the effort we've put forth thus far. Don't put another check box in front of us. Fighter pilot analogy was also used… don't give me a yo-yo and a hula hoop if I'm trying to fly the plane. Don't ask us to be something we're not. Build the infrastructure around us to let us do what we do*
5) *Be Confident, even if it isn't perfect*
6) *Focus on improvement first, accountability (through reimbursement reforms or network decisions) second*
7) *Create the game that makes it easy to play; We're like highly trained athletes*
    - *What do I need to do to play the game? Make it actionable*
    - *Athletes train themselves, they just need to know the rules of the game and they need feedback*
8) *How I'm paid is only one variable (this came from a plan physician)*
    - *Frame the conversation to your audience. Is money the motivator? Maybe it's more time home with my family? Maybe it's less call. Maybe I need a scribe. Maybe it's recognition*
    - *Measure cost as more than just compensation*

"We are a microcosm of our industry in this room. We started with saying that we should put the patient first and we ended up talking about our [providers] needs for the rest of the time. We went straight to solving our problems, not the patients. We need to think about value from a patient's perspective. What is value from a patient's perspective? What are their KPIs? Where is the alignment between all three major stakeholders: payers, providers and patients?"

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I – Comm. 101 – Talking to Your ELT

Marja Wilson; Gary Stanford; Mark Werner; Ryan Melander & Jorge Serrano

An interactive games-based workshop focusing on how to talk to an Executive Leadership Team about High-Value Care, exploring how to communicate the strategy and tactics for its delivery for an Executive Leadership Team, the opportunity and advantages for an Executive Leadership Team, and ideas for answering objections and breaking down roadblocks from an Executive Leadership Team.

Summary: There are many opportunities for discussing high-value care with your executive leadership team and the utilization of RowdMap for that purpose. It was asked how hospitals would actually react and utilize the information that RowdMap provides. A provider explained that they had to introduce the data slowly, but after presenting it in the correct way, which is slowly and by building champions within the organization, they were able to present the information to the chairman of their board, who was a specialist, show him that he was a red dot provider, and then managed to get him excited about the data that RowdMap provides and the prospects of delivering high-value care. Now, RowdMap data is being used to internally tier their physicians and are using it for contracting decisions, as well, and looking forward to expanding the use and the delivery of high-value care.

A question that was posed by a payer to a successful and highly reputable provider-owned health plan was why their hospitals would actually use this info when they are already world renowned. The response was that while there is no threat currently to their reputation and their revenue, value-based payment models are the future and they want to be prepared and ensure that they are still world leaders when it comes to healthcare no matter how it is defined. The delivery of high-value care is important to them and they see RowdMap as a great tool to be socialized within their organizations and with their physicians, not only as a revenue-risk tool, but also as one that allows them to show that they are the best in whatever category someone deems important.

G – Comm. 101 – Talking to Sales

Michael Abate; Ryan Keith; Kip Haffner; Bob Hartman; Thomas Groves; Kristin Senac & Ben Frauhiger

An interactive games-based workshop focusing on how to talk to Sales and Marketing individuals about High-Value Care, exploring how to communicate the strategy and tactics for its delivery for Sales and Marketing, the opportunity and advantages for Sales and Marketing, and ideas for answering objections and breaking down roadblocks from Sales and Marketing.

Summary: It's necessary to tie incentives to sales, providing an incentive to drive members to choose a high-value provider (v. a lower performing provider). Additionally, it is imperative to educate the sales team on what high-value care is, and how the sales team can help maximize the delivery of this high-value care for their members. Health plans should comarket with high-value providers to make them more visible to members.

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L – Pulling This all together – What Are We Doing Here and What Are You Going to Do about It on Monday

Kristie Genzer; Jennifer Brady, MD; Cupid Gascon, MD; Meredith Williams McKiernan, MD;
Melanie Rosenthal & Rachel French

An interactive games-based workshop tying together what an individual and team needs to tactically do to deliver High-Value Care exploring specific steps to take for different contexts.

Summary: It is one thing to discuss what is wrong with the current healthcare system, but it is another to take action on the problems faced today. Instead of walking away from the Institute with only a few new ideas and friends, it is time to reflect on what we will all do 'come Monday.' That is the theme of how to become cultural leaders. "What will you do Monday?" Let's take action on the problems we face to make a cultural shift to deliver high-value care.

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