
2023 VIZIENT CONNECTIONS SUMMIT
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SEPT. 18–21, 2023
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# Cardiovascular and Cancer Service Line Executives


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# Agenda

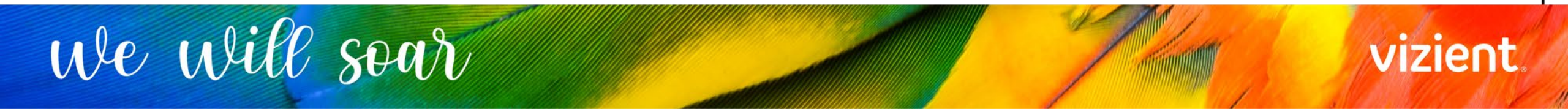
*Combined session with Cancer Service Line Executives (1:00 – 3:00 PM)*

- Service Line Structures and their Financial Implications
- Building an Integrated Profit and Loss Model for Service Lines
- An Innovative, Inexpensive Method to Help Providers Feel Valued
- Wrap-Up

*Join us for Interprofessional Executive Forum Sessions (3:15 – 5:00 PM)*

- Clinical Trial Equity: Achieving Representation and Improving Outcomes for All
- Interdisciplinary Approaches to Service Line Integration and Optimization

# What is a key takeaway from this morning's sessions?



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# Learning Objectives

- Discuss service line structures and financial implications.
- Describe how to develop service line growth goals and project the financial benefits expected to accrue as the result of upfront investments in the service line.
- Identify three high-impact methods of appreciations for physicians and advanced practice providers (APPs).

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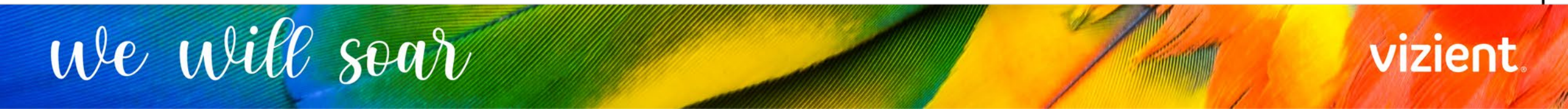
# Service Line Structures and Financial Implications

***Cory Jones,*** *Associate Principal, Sg2*

***Janet Schuerman, MBA****, AVP, Performance Improvement, Vizient*



"We see real differences between our service lines. Some are well developed; some are like herding cats."

—Senior Executive, Northeast

"We still view this as a grand experiment. What we're learning is that this work is really hard. We spend a great deal of time working through the intersections."

—Service Line Leader, Midwest

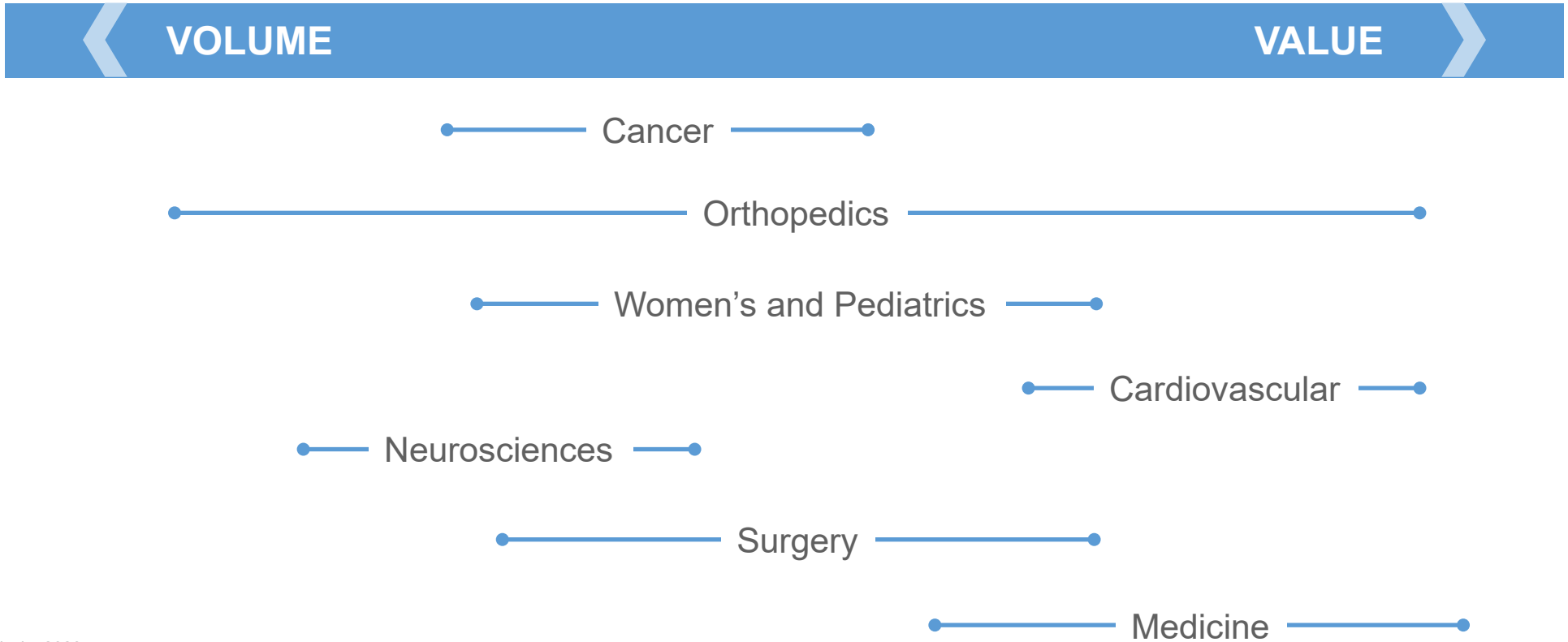
"If leadership is right, the rest is mechanical."

—Vice President of Planning, West

"Service lines have some runway ahead of them. The key will be how we align along the continuum."

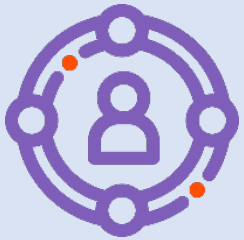
—Vice President, Operations, South

# Today's Service Lines Span Volume and Value



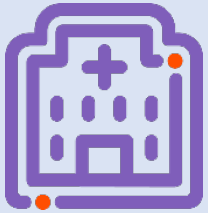

**Source:** Sg2 Analysis, 2023.

# Service Line Structure Survey



## Personas surveyed

- Service line executives
- Service Line Strategic Network participants
- Chief strategy officers
- Chief financial officers
- Chief operating officers
- Sg2 members



## Organizations surveyed

- AMCs
- Academic health systems
- Non-academic integrated health systems
- Community-based hospitals
- Specialty hospitals (cancer, heart)

Survey dates: April 10-24, 2023
N=139 respondents

# Understand How Your Service Lines Support Organizational Goals

Program Reach (Size & Draw)

Entire Health System
**53%**

Portion of Health System
**12%**

Hospital–Focused vs IP, OP and Ambulatory
**8 vs 27%**

Comprehensive Programmatic Offerings

**94%** have service lines

**Leadership structure**

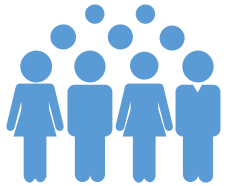
| 6% | 63% | 15% |
|---|---|---|
| Physician-led | **Dyad** model | Admin-led with clinical support |

Cohesive, Recognizable Brand

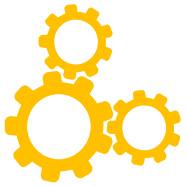
High-Quality Care and Outcomes

Patient Experience and Access

# Understand How Your Service Lines Support Organizational Goals



Program Reach
(Size & Draw)



Comprehensive
Programmatic Offerings

Cohesive, Recognizable
Brand

High-Quality Care
and Outcomes

Patient Experience
and Access

Main Goal: **Clinical**
**40%**

Main Goal: **Access**
**36%**

Main Goal: **Operational**
**25%**

# Understand How Your Service Lines Support Organizational Goals

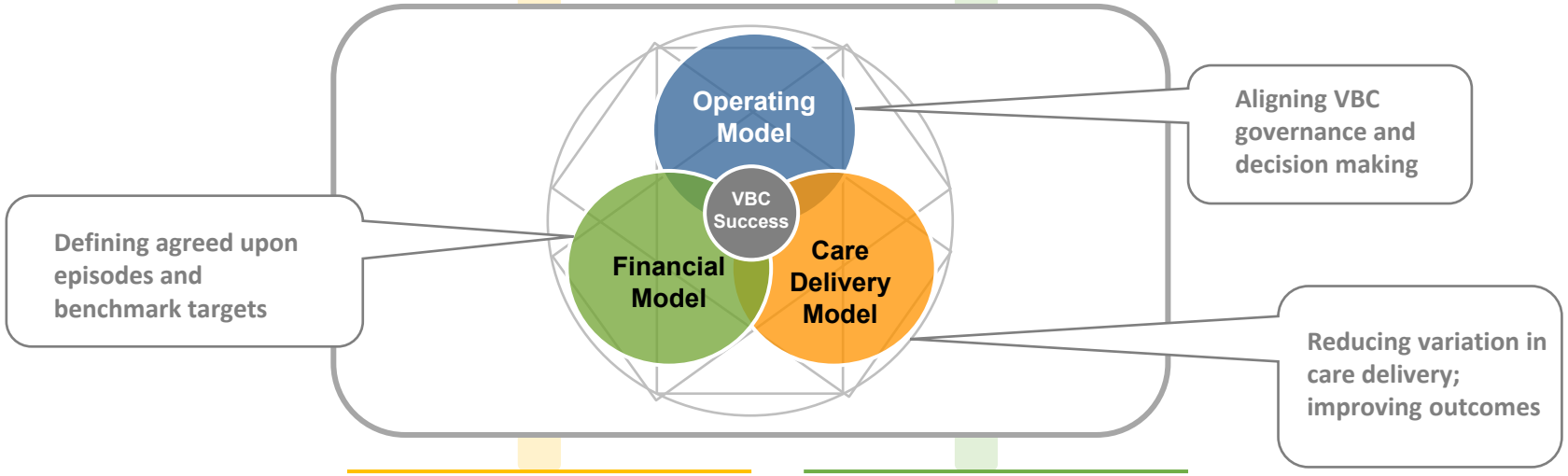
Program Reach (Size & Draw)

Comprehensive Programmatic Offerings

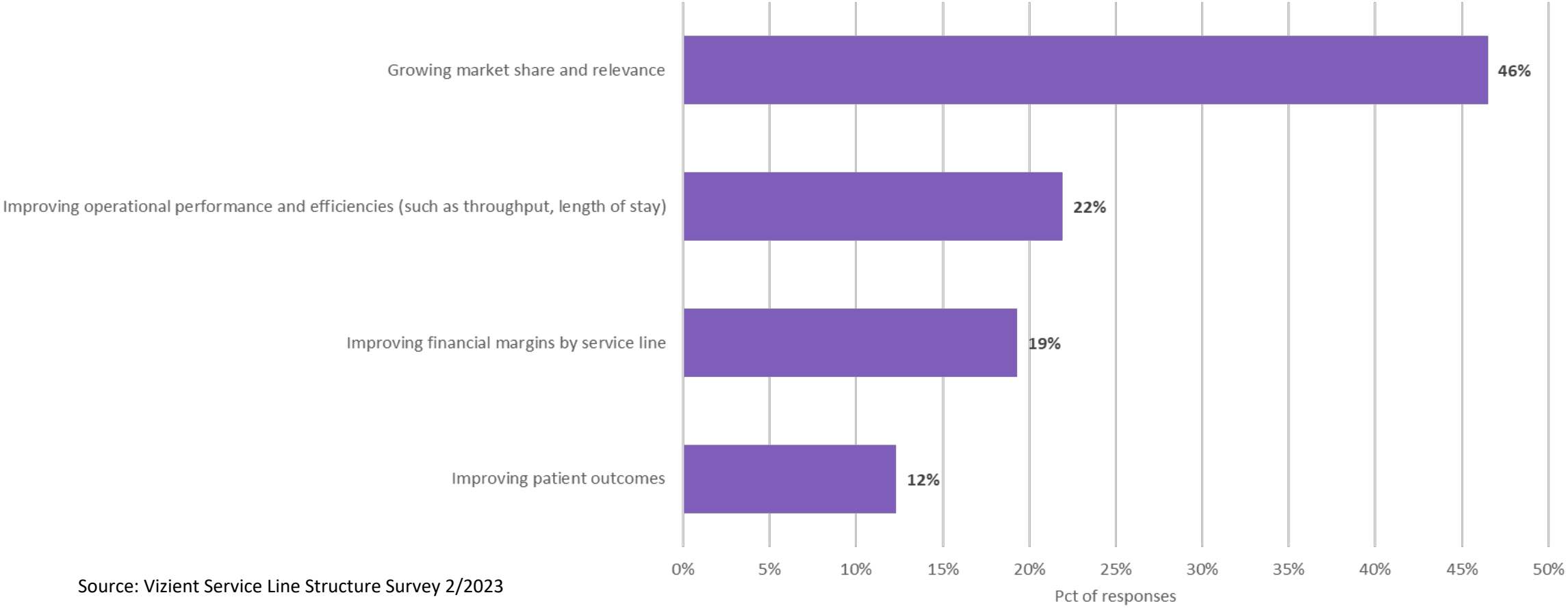
Cohesive, Recognizable Brand

High-Quality Care and Outcomes

Patient Experience and Access



# What is your primary indicator of success for the service line?

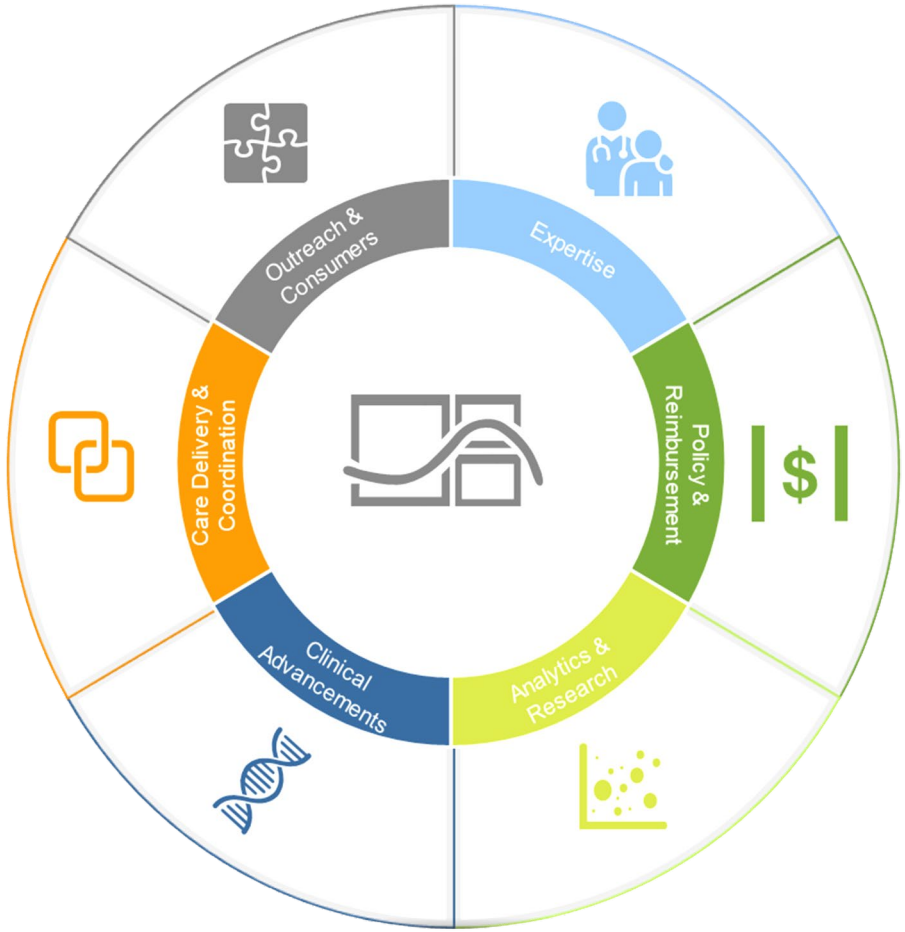



Source: Vizient Service Line Structure Survey 2/2023

# Elements of a High-Performing Service Line

**QUALITY**
- Care Pathways
- Outcome Measures/Data
- Seamless Integration

**OPERATION**
- Workforce Strategy
- Coordination/Navigation
- Leadership and KPIs




**GROWTH**
- Physician Alignment
- Consumerism Strategy
- Service Offerings

**INNOVATION/RESEARCH**
- Clinical Trials Portfolio
- Emerging Technologies
- Outcomes Research

# Lessons Learned

**Prioritized Service Line Criteria**

1. Commitment to collaboration between physicians, caregivers and system leaders
2. A continuum of services…something to integrate
3. Potential for improvement of quality, efficiency and experience
4. Critical mass to merit attention and investment
5. Market growth and differentiation opportunity
6. A base of capability and reputation on which to build
7. Presence of the “right” leadership and culture

# Key Takeaways

- Leadership
- Quality
- Collaboration
- Clarity
- Alignment
- Performance

## Keys to Optimizes a Service Line Systems of CARE


CARE = Clinical Alignment and Resource Effectiveness.

# Questions?

## Contact:

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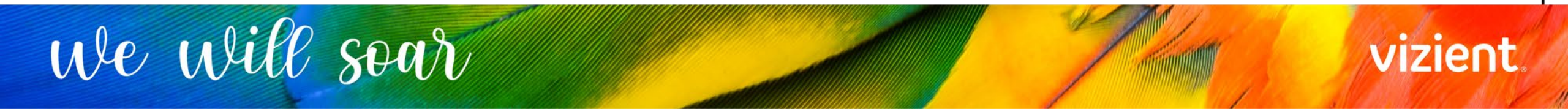


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# Building an Integrated Profit and Loss Model for Service Lines

***Michael Espinoza, ASQ-CMQ/OE,*** *Director, Strategic Planning, UC Davis Health, Sacramento, Calif.*

***Jesika Krasts, MBA, CSSGB, CPHQ, PROSCI,*** *Senior Strategic Planning Specialist, UC Davis Health, Sacramento, Calif.*

***Kristin Mensonides, MHA, MLS, FACHE,*** *Executive Director, Integrated Service Lines, UC Davis Health, Sacramento, Calif.*

# What is an Integrated Service Line (ISL)?

- An Integrated Service Line (ISL) is the organization of **multidisciplinary clinical programs** into an integrated **care continuum around a population or disease state**.
- Service lines reach beyond the traditional departmental structure in that the **accountability and responsibility for optimizing clinical services**, non-clinical operations, and capital and operational budgets reside with service line leadership (may be matrixed with clinical departments and operations).

# Why Build a Patient Centered Service Line?

A service line structure is intended to provide a more **integrated and focused patient experience** while contributing to clinical efficiencies, clinical research, performance improvement, and expansion and integration of clinical areas with high market demand.

# What is a Virtual Profit and Loss Statement (P&L)?

- Provides an **integrated view of the revenues and costs** across the health system and the faculty practices that contribute to the service line.
- Virtual means it is **used for planning purposes** not for day-to-day financial management and reporting.

# High Level Virtual P&L Workplan

1. Create patient attribution methodology
   a. Complete journey mapping to clearly define population of focus (care continuum start/stop and key components)
   b. Evaluate and compare disease group definition(s) and determine a source of truth
   c. Identify methodology to capture non-diagnosis driven care
2. Standardize data definitions (cases, encounters, revenues, assessments, direct/indirect costs, etc.)
3. Validate and obtain physician buy-in
   a. Review patient attribution methodology and data definitions with physicians for feedback
   b. Pull initial dataset using ICD-10 diagnosis codes and other defined criteria
   c. Review initial datasets with physicians to confirm appropriate exclusion/inclusion criteria and eliminate double counting
4. Develop education, roll-out, and change management plan
5. Produce the first official draft virtual P&L and review in practice/refine
6. Socialize with committees
7. Obtain leadership approval to publish
8. Develop service line growth goals and projected financial benefit

PATIENT JOURNEY:

# Stage II Lung Cancer Patient

*Fictious patient and stock photo

**PATIENT PERSONA:**

**Keith Harper**

61 Years old

**MOTIVATION & NEEDS**

A clear care plan and feeling that he is on the same page as his care team.

Care coordination to ensure his treatment isn't slowed down by trying to navigate all the appointments and scheduling on his own.

Financial stability as he nears retirement.

*"I get confused with too much medical information that I don't understand. I just want someone to make it easy to understand so I can get the care I need and move on."*

## Journey

- Doctor recommends low dose CT for lung cancer screening, based on patient's medical history
- Low Dose CT appointment
- Doctor calls to review LDCT results. Orders additional imaging scans and refers patient to Cancer Center
- Imaging appointments (Chest CT, PET, MRI)
- Call from New Patient Referrals to schedule appointment with Cancer Center Specialist
  - Ecosystem: **New Patient Referrals**
- Meets Cancer Center specialist
- Told about Multidisciplinary Tumor Board and treatment options ★
  - *"When he presented the feedback and recommendations from the tumor board – it provided me confidence in my decision."*
- Discuss clinical trials
- Given education materials & told about palliative care services ⚡
  - *"Mental health support and just talking about these services has to be done more often. You drink from a fire hose when you are talking with your doctor and you don't remember anything about these services. It would have helped me to not feel so alone in my journey."*
- Biopsy scheduled
  - Surgical Biopsy *(often thoracic surgery done during same procedure when cancer is confirmed)*
  - Radiology Biopsy
  - Interventional Pulmonology Biopsy

## People & Touchpoints

**TOUCHPOINTS**

- [redacted] (scheduling, test results, and communication)
- Phone (scheduling and communication)
- [redacted] (educational videos)
- Supportive Care Screening (palliative services)

**SCREENING (PEOPLE)**

- Primary Care Provider
- CT Technician
- Radiology MOSC
- Radiology RN
- IR Radiologist
- Patient Services Representative

**SPECIALIST CONSULTATION (PEOPLE)**

- New Patient Referrals
- Scheduler
- Thoracic Surgeon
- Interventional Pulmonologist
- Nurse Coordinator
- Clinical Research Coordinator
- Medical Assistant
- APP or Trainee

**BIOPSY (PEOPLE)**

- Thoracic Surgeon
- Surgery RN
- Interventional Pulmonologist
- Radiology MOSC
- Radiology RN
- IR Radiologist

## Opportunities

**MYCHART**

Patients often receive test results in [redacted] before physician can review them.

Not all members of the care team are available in [redacted] to contact, causing confusion/frustration.

**COMMUNICATION OF INFORMATION**

Information and **education materials** shared during specialist consult are overwhelming for patients to process.

Patients interviewed liked the idea of a **designated resource assigned to them** to help them navigate treatment.

**CONFIDENCE IN TREATMENT**

★ Patients who were told about the **multidisciplinary tumor board** felt confident in their treatment plan, lik they "had a whole team of doctors looking out for the

**LEGEND**

Good experience · Neutral experience · Negative experience · ★ Moment of Truth · ⚡ Pain Point (high impact for patie

# Determining a Source of Truth

| Source | Included Disease Groups | ICD-10 Codes Included | Notes |
|---|---|---|---|
| Sg2 | ▪ Transient Ischemic Attack<br>▪ Ischemic Stroke<br>  ▪ Neurovascular Diseases (some of the codes in this CARE Family appear to be ischemic stroke related)<br>▪ Hemorrhagic Stroke<br>  ▪ Late Effects of Neuro Trauma, Neurovascular Disease (one code in this CARE* Family appears to be hemorrhagic stroke related) | Highest volume | *Sg2 and Vizient methodology will be combined in the future* |
| Vizient | ▪ Primary Stroke<br>▪ Ischemic Stroke<br>▪ Hemorrhagic Stroke<br>  ▪ Aneurysm Repair<br>  ▪ Intracerebral Hemorrhage (ICH)<br>  ▪ Subarachnoid Hemorrhage (SAH) | | |
| Joint Commission | ▪ Ischemic Stroke<br>▪ Hemorrhagic Stroke | Lowest volume | |
| UCDH | Based largely off JC Definition with a few minor differences | | |

# Benefits to Using a Verified Source of Truth

- Different hospitals utilize different codes based on technology that is available to them and coding practices. If we only use UCDH's stroke definition, we may be underestimating another hospital's stroke volumes because we are excluding codes that other hospitals utilize for the same patient population. Companies with existing mapping tables may be able to show a more complete view of the market.

- Coding practices change year-to-year as new codes are added. If we only look at the codes that UCDH used in one year, we may be seeing artificial increases/decreases as we look at longitudinal data. Companies with mapping tables closely track which codes are being added and usually have a crosswalk for ICD-9 to ICD-10 diagnosis codes.

# Lung Cancer – An Outpatient Case Study

# Components of Lung Cancer ISL Virtual P&L

| Community-based and Sub-specialty Care (pre-diagnosis and diagnosis) | Interventions and Treatment | Post-Acute Follow-up Care |
|---|---|---|
| REPORT #1<br>▪ Screening:<br>  ▪ Counseling visit to discuss need for LDCT Screening<br>  ▪ LDCT Screening<br>▪ IR/Interventional Pulmonary:<br>  ▪ Lung Biopsy<br>  ▪ Bronchoscopy<br>▪ Diagnostic Testing:<br>  ▪ Diagnostic Chest Radiography<br>  ▪ Diagnostic Chest CT<br>  ▪ Diagnostic PET or PET-CT<br>  ▪ Brain MRI<br>  ▪ Pathology/Lab Work<br>  ▪ Genetic Counseling/Testing<br>▪ Specialist Referral:<br>  ▪ Thoracic Surgeon/Pulmonologist/Radiation Oncologist/Medical Oncologist Consult | REPORT #2<br>▪ Inpatient Surgery<br>▪ Radiation Therapy<br>▪ Chemotherapy<br>▪ Immunotherapy | REPORT #4<br>▪ Palliative Care<br>▪ Post-acute follow up for 5 years after diagnosis of lung cancer |

# Community-Based and Subspecialty Care (Report #1)

- Encounters were identified based on procedure codes and relevant ICD-10 diagnosis codes (pre diagnostic or lung cancer diagnosis)
- Non-surgery episodes, outpatient only

| Encounter | Defined By |
|---|---|
| **Screening** | |
| Counseling visit to discuss need for LDCT Screening | Procedure code G0296 and all ICD-10 diagnosis codes |
| **IR/Interventional Pulmonary** | |
| Lung Biopsy | Procedure Codes 32097, 32408, 10005-10012, 32608 AND one of the following diagnosis codes in the primary position Z12, Z13.83, R91.8, R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| **Diagnostic Testing** | |
| Diagnostic Chest Radiography | Procedure codes 71045-71048, 71100, 71101, 71110, 71111 AND one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| **Specialist Referral** | |
| Thoracic Surgeon/Pulmonologist/Radiation Oncologist/Medical Oncologist Consult | Procedure Codes 99241-99245, 99202-99205 AND one of the following diagnosis codes in the primary position Z12, Z13.83, R07.1-R07.9, R91.8, R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |

**Complete requirements can be found in appendix*

# Interventions and Treatment (Report #2)

- Encounters were identified based on procedure codes and a Sg2 lung cancer diagnosis code in the primary position
- Cost center and location center based
- Report #2 codes are the hierarchy if duplicate codes from report #1 are present on the encounter

| Encounter | Defined By |
|---|---|
| Inpatient Surgery | Procedures codes and one of the Sg2 Lung Cancer ICD-10 diagnosis codes in the primary position – Diagnosed with Lung Cancer in specified cost center |
| Radiation Therapy | Procedure codes 77261- 77799 and one of the Sg2 Lung Cancer ICD-10 diagnosis codes in the primary position – Diagnosed with Lung Cancer in specified cost center and location |
| Chemotherapy | Procedure codes 96401- 96549 and one of the Sg2 Lung Cancer ICD-10 diagnosis codes in the primary position – Diagnosed with Lung Cancer in specified cost center and location |
| Immunotherapy | One of the Sg2 Lung Cancer ICD-10 diagnosis codes in the primary position – Diagnosed with Lung Cancer in specified cost center and location |

# Post-Acute Follow-Up Care (Report #4)

- MRN/patient will be flagged to follow through post care once intervention or treatment is provided (will follow for 5 years)
- Palliative care will be specifically identified using supportive oncology cost center encounters

# Stroke – An Inpatient Case Study

# Components of Stroke ISL

| Community-Based Care | Acute Care | Post-Acute Care |
|---|---|---|
| | ▪ Inpatient Stroke Cases REPORT #1<br><br>▪ Preventative Procedures REPORT #2<br>• Aneurysm<br>• Carotid Artery Disease – TCAR, CEA, CAS<br>• AVM – Resection<br>• Cavernoma – Resection<br>• Moyamoya Disease – Revascularization<br><br>▪ Telestroke Consults REPORT #3 | ▪ Post-acute care attributed to inpatient stroke cases within a specified timeframe REPORT #4<br><br>• Inpatient Rehab<br>• Outpatient encounters (including ED visits) |

# Inpatient Stroke Cases (Reports #1 & 2)

- Inpatient stroke cases were identified using Sg2 stroke ICD-10 diagnosis codes
- Preventative procedures were identified using surgical codes independent of Sg2 stroke ICD-10 diagnosis codes

| Encounter | Defined By |
|---|---|
| Report #1 – Inpatient Cases | Primary stroke ICD-10 diagnosis codes (exclude primary surgical codes in report #2) |
| Report #2 – Inpatient Preventative Procedures<br>▪ Aneurysm<br>▪ Carotid Artery Disease – TCAR, CEA, CAS<br>▪ AVM – Resection<br>▪ Cavernoma – Resection<br>▪ Moyamoya Disease – Revascularization | Defined procedure codes for identified procedures independent of primary stroke ICD-10 diagnosis codes |

# Post-acute Care (Report #4)

- Inpatient rehab cases were identified using Sg2 stroke ICD-10 diagnosis codes
- Outpatient stroke cases were identified using Sg2 stroke ICD-10 diagnosis codes, product line summary, specified timeframe, and procedure codes

| Criteria | |
|---|---|
| Product line summary: neurosciences, within a year of inpatient discharge | Product line summary: radiology services AND within a year of inpatient discharge AND a primary diagnosis on the Sg2 stroke ICD-10 diagnosis codes list AND:<br>- CT head 70450-70470 OR<br>- MRI brain 70551-70553 OR<br>- Transcranial doppler 93886 (complete) 93888 (limited) 93892 (emboli) 93893 (bubble) |

**Complete requirements can be found in appendix*

# Validating and Obtaining Physician Buy-In

- Review patient attribution methodology and data definitions with physicians for feedback
- Pull initial dataset using ICD-10 diagnosis (dx) codes and other defined criteria
- Review initial datasets with physicians to confirm appropriate exclusion/inclusion criteria and eliminate double counting

# Evaluating and Addressing Readiness for Change

| ADKAR element: | Definition: |
|---|---|
| Awareness | Of the need for change |
| Desire | To participate and support the change |
| Knowledge | On how to change |
| Ability | To implement required skills and behaviors |
| Reinforcement | To sustain the change |

*Image sourced from Prosci*

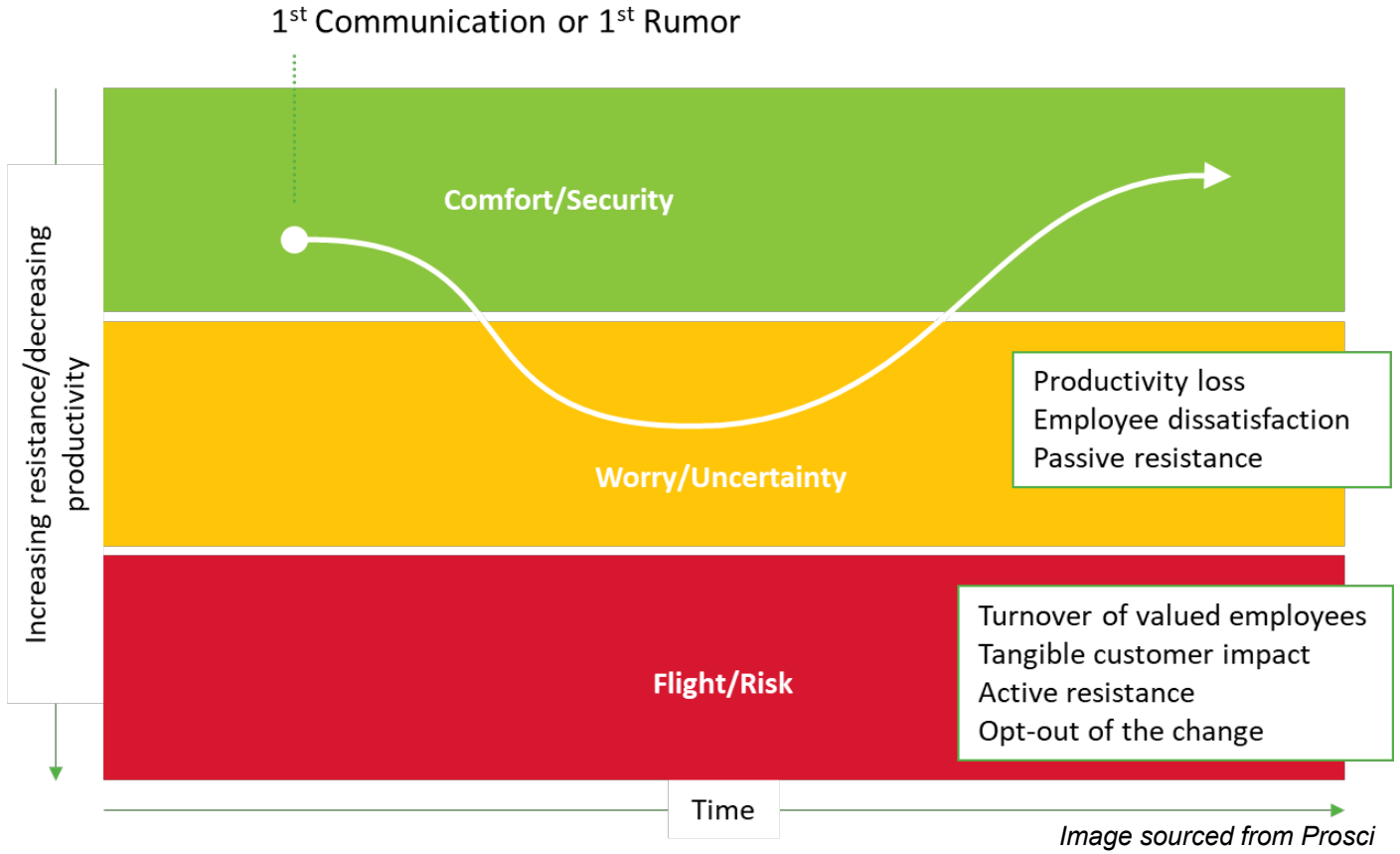


*Image sourced from Prosci*

# Developing Service Line Growth Goals and Projecting Financial Benefits

| Visit Type | Volume Projection | CPT Code | Revenue / Case | Revenue |
|---|---|---|---|---|
| Lung LEAD Clinic – New ISL Patient – Shared Decision-Making APP Visit | 837 | 99203 | | |
| Lung LEAD Clinic – Established ISL Patient APP Visit – Low Dose CT Results Follow-up | 837 | 9212 | | |
| Low Dose CT Scan (New & Incremental Scans) | 837 | | | |
| Cancer Center – Lung ISL New Patient Visits – Expedited Access Visit – APP Triage | 245 | 99203 | | |
| Estimated New Cancer Diagnosis | 8 | | | |
| Incremental MRIs | TBD | | | |
| Incremental PET Scans | TBD | | | |

# Lessons Learned

- Establish ongoing process to evaluate readiness for change (readiness assessment)
  - Incorporate into change management plans and approach
- Education, messaging, and roll-out of a Virtual P&L is very important
  - Understand where stakeholders are in terms of financial knowledge
  - Equip stakeholders with appropriate tools to understand and apply a virtual P&L in their respective roles

# Key Takeaways

How to get started:

- ❑ Create patient attribution methodology
  - ✓ Complete journey mapping to clearly define population of focus (care continuum start/stop and key components)
  - ✓ Evaluate and compare disease group definition(s) and determine a source of truth
  - ✓ Identify methodology to capture non-diagnosis driven care

- ❑ Standardize data definitions (cases, encounters, revenues, assessments, direct/indirect costs, etc.)

- ❑ Validate and obtain physician buy-in
  - ✓ Review patient attribution methodology and data definitions with physicians for feedback
  - ✓ Pull initial dataset using ICD-10 diagnosis (dx) codes and other defined criteria
  - ✓ Review initial datasets with physicians to confirm appropriate exclusion/inclusion criteria and eliminate double counting

- ❑ Develop education, roll-out, and change management plan

# Questions?

UC DAVIS HEALTH

## Contact:

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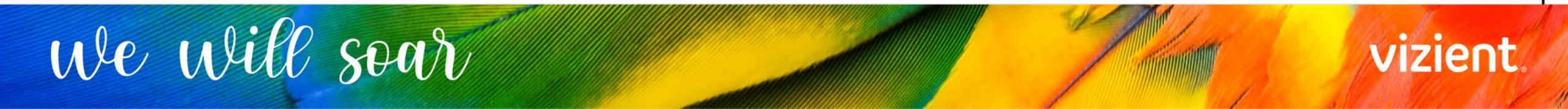
# What have you heard here you will take back to your organization?

# What steps has your organization already taken towards an integrated Service Line Profit and Loss model?

# Appendix



# Making the Case for Integrated Service Lines – Our Approach as an Academic Medical Center

Academic Medical Centers have long grappled with the challenge of delivering patient-centric and coordinated care across physician specialties and hospital departments.

- Service lines can be a highly effective tool in tackling these organizational challenges while keeping the focus on high-quality care and outcomes.
- Provides a mechanism for aligning disparate departmental incentives and hospital cost centers.
- Leverages an AMC's tertiary and quaternary expertise.

# Profitability Reporting Data Dictionary

1. **Cases:** Number of patients included in the report based on unique billing records (patient account ID number or “HAR” in EPIC).
2. **% of Total Cases:** The calculated percent of total based on the patient type (IP vs OP) classification. Inpatient will total 100% and outpatient will total 100%.
3. **Days:** The number of inpatient days, based on room charge records, associated with patients discharged in the time frame covered by the report. Newborn well patients are excluded. Outpatient days such as observation, recovery, short stays and OPSTDs are also excluded.
4. **ALOS:** The inpatient average length of stay (ALOS) based on billing records. Calculated as the number of days (column 4) divided by the number of non-newborn well cases. Note: Column 1 Cases on these reports include newborn well patients and can’t be used to manually calculate the ALOS.
5. **Inlier Expected LOS Index:** The expected LOS, as defined by the severity adjusted APR DRG national standards, divided by the actual LOS. An index of 1.0 means we are right at the national standard. Over 1.0 means we have an opportunity for improvement. Outliers are excluded from the calculation and are defined as an actual LOS +/- 5 times the expected LOS.
6. **Expected Days:** The expected LOS, as defined by the severity adjusted APR DRG national standards. APR DRG Source: Quantim. Expected LOS Source: California Department of Health Care Services website. Expected length of stay was calculated from the Nationwide Inpatient Sample by 3M Health Information Systems for APR-DRG.
7. **CMI:** The inpatient case mix index based on MS DRG weights. Calculation: Total MS DRG weight divided by total inpatient cases. Includes both Medicare and non-Medicare patients and includes Rehab, which is often excluded in external reporting. MS DRG Source: Quantim. MS DRG Weights Source: CMS Website
8. **Total Charges:** Total technical gross charges for all patients discharged during the time frame covered by the report. Excludes SOM professional charges. The report title will indicate if PCN is included or excluded.
9. **Net Revenue:** Actual or anticipated proceeds for all patients in the report including lump sum distributions such as DSRIP, legal settlements and cost report settlements. Actual cash received (plus lump sum distributions) is used for all patients that are considered fully paid. Estimates based on the prior 12 months of history are used for any patient that is not fully paid. A patient is “fully paid” if their account balance is less than 10% OR they have Medi-Cal and at least one payment has been received OR they are fully capitated OR the account age is greater than 1 year.
10. **Variable Cost:** All hospital expenses that change with an incremental change in volume. Examples of variable expenses include nursing salaries, patient chargeable supplies and pharmacy drugs.
11. **Variable Contr. Margin:** Contribution margin is a calculated metric defined as Net Revenue (# 9) less Variable Expenses (# 10).
12. **Margin %:** Contribution margin % is Contr. Margin (column 11) divided by Net Revenue (column 9).
13. **Fixed Cost:** All expenses that don’t vary with an incremental change in patient volumes. Examples include depreciation, management and executive salaries and office supplies.
14. **Net Gain:** Contribution Margin minus Fixed Cost

# Lung Cancer Community-based and Subspecialty Care Requirements (Report #1)

| Encounter | Defined By |
|---|---|
| **Screening** | |
| Counseling visit to discuss need for LDCT Screening | Procedure code G0296 and all ICD-10 diagnosis codes |
| LDCT Screening | Procedure code 71271 and all ICD-10 diagnosis codes |
| **IR/Interventional Pulmonary** | |
| Lung Biopsy | Procedure Codes 32097, 32408, 10005-10012, 32608 AND one of the following diagnosis codes in the primary R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Bronchoscopy | Procedure Codes 31622, 31624, 31625, 31626, 31628, 31629, 31630, 31631, 31634, 31635, 31636, 31641, 31643, 31653, 76377, 77001, 77012 AND one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| **Diagnostic Testing** | |
| Diagnostic Chest Radiography | Procedure codes 71045-71048, 71100, 71101, 71110, 71111 AND one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Diagnostic Chest CT | Procedure codes 71250, 71260, 71270 AND one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Diagnostic PET or PET-CT | Procedure Codes 78608, 78811-78816 AND one of the following diagnosis codes in the primary R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Brain MRI | Procedure Codes 70551-70553 AND one of the following diagnosis codes in the primary position R91.1 or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Pathology | Procedure Codes 88342, 88341, 88344 AND one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Lab Work | Procedure Codes 85027, 80053, 85610 AND one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| Genetic Counseling/Testing | Procedure Codes 96040, S0265 **AND** one of the following diagnosis codes in the primary position R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |
| **Specialist Referral** | |
| Thoracic Surgeon/Pulmonologist/Radiation Oncologist/Medical Oncologist Consult | Procedure Codes 99241-99245, 99202-99205, 99211–99215, 99241-99245 AND one of the following diagnosis codes in the primary, R91.1, or one of the Sg2 Lung Cancer ICD-10 diagnosis codes |

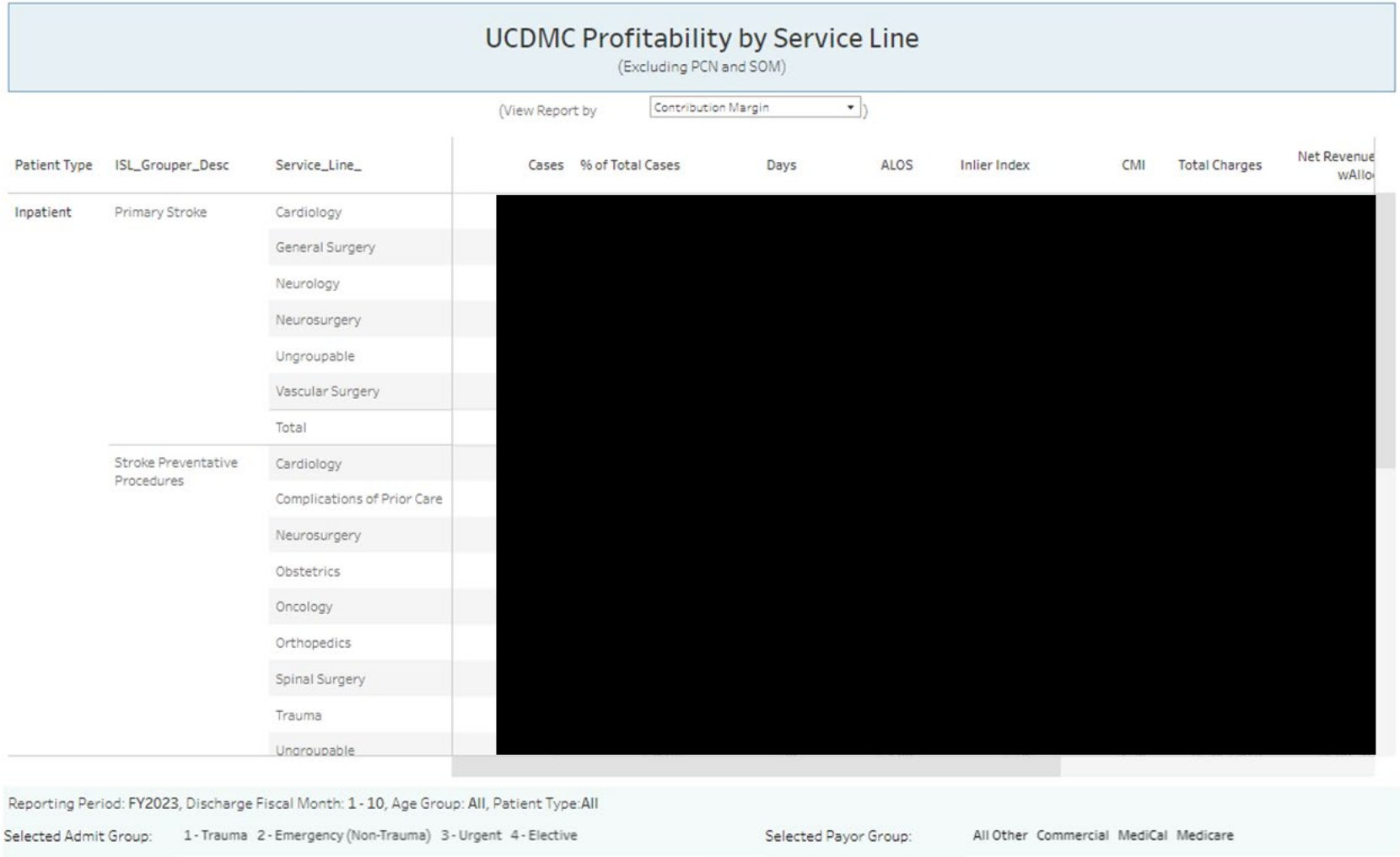
Source: UC Davis Health

# Stroke Post-Acute Care Requirements (Report #4)

| Criteria | |
|---|---|
| Product line summary: neurosciences, within a year of inpatient discharge | Product line summary: Speech therapy product lines, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list |
| Product line summary: emergency room, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list | Produce Line summary: Occupational therapy product lines, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list |
| Product line summary: home health/hospice, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list | Product line summary: family practice clinic, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list |
| Product line summary: PMR clinic, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list | Product line summary: Internal Medicine Clinics, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list |
| Product line summary: PMR services, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list | Product line summary: laboratory services, within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list |
| Product line summary: radiology services AND within a year of inpatient discharge AND a primary diagnosis on the primary stroke ICD-10 diagnosis codes list AND:<br>- CT head 70450-70470 OR<br>- MRI brain 70551-70553 OR<br>- Transcranial doppler 93886 (complete) 93888 (limited) 93892 (emboli) 93893 (bubble) | Product line summary: cardiology OR Cardiovascular OR Vascular Clinic AND within a year of inpatient discharge AND:<br>- PFO closure (outpatient) 93580 OR<br>- Carotid Doppler Ultrasound 93880 (complete) 93882 (limited) OR<br>- Transthoracic echocardiogram with bubble 93306 (complete w/ spectral); 93307 (complete w/o spectral); 93308 (limited) OR<br>- Esophageal echocardiogram 93312; 93318 (if for monitoring) OR<br>- 14-day cardiac monitoring 93245 – 93248 OR<br>- Implantable loop recorder 33285 (insertion) OR<br>- Carotid stent 37215, 37216 OR<br>- TCAR 37215 OR<br>- Carotid endarterectomy 35301 OR |

Source: UC Davis Health

# Dashboard View

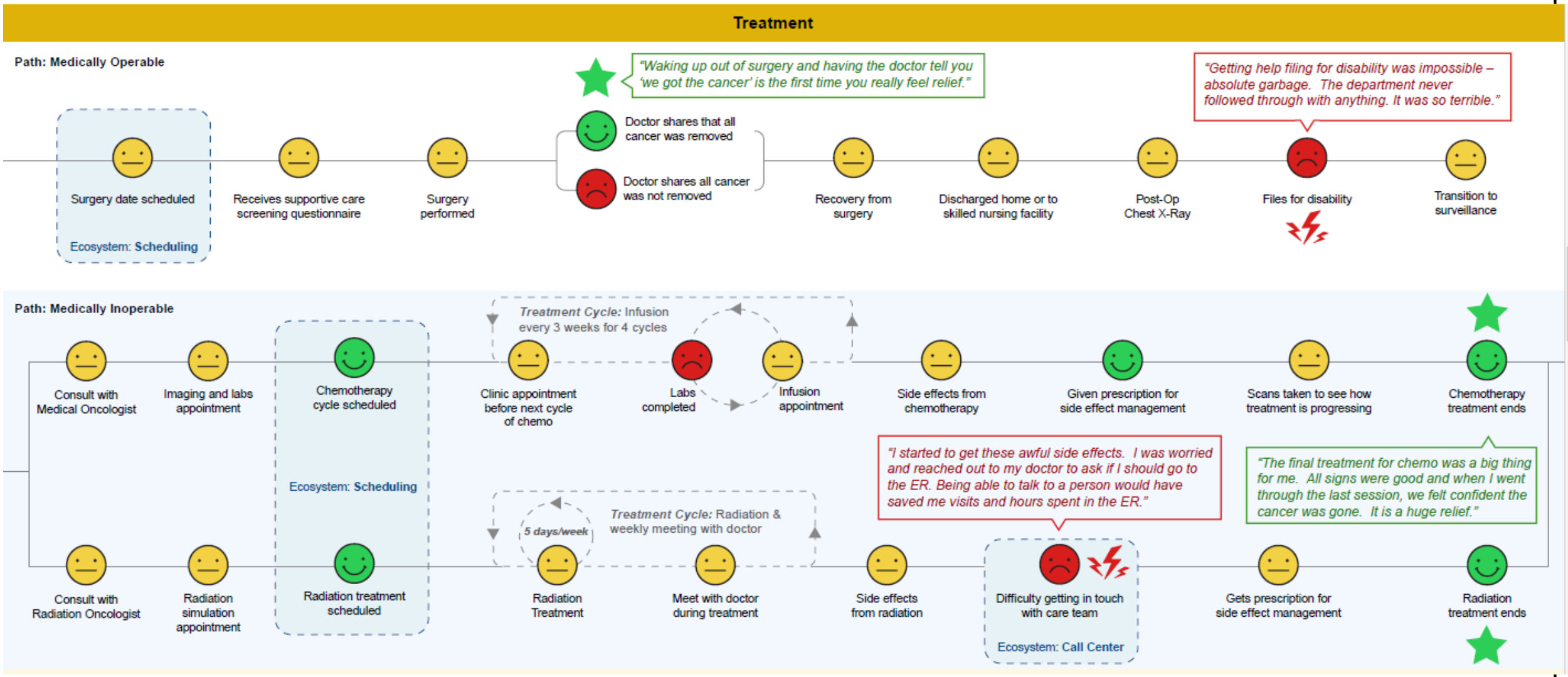


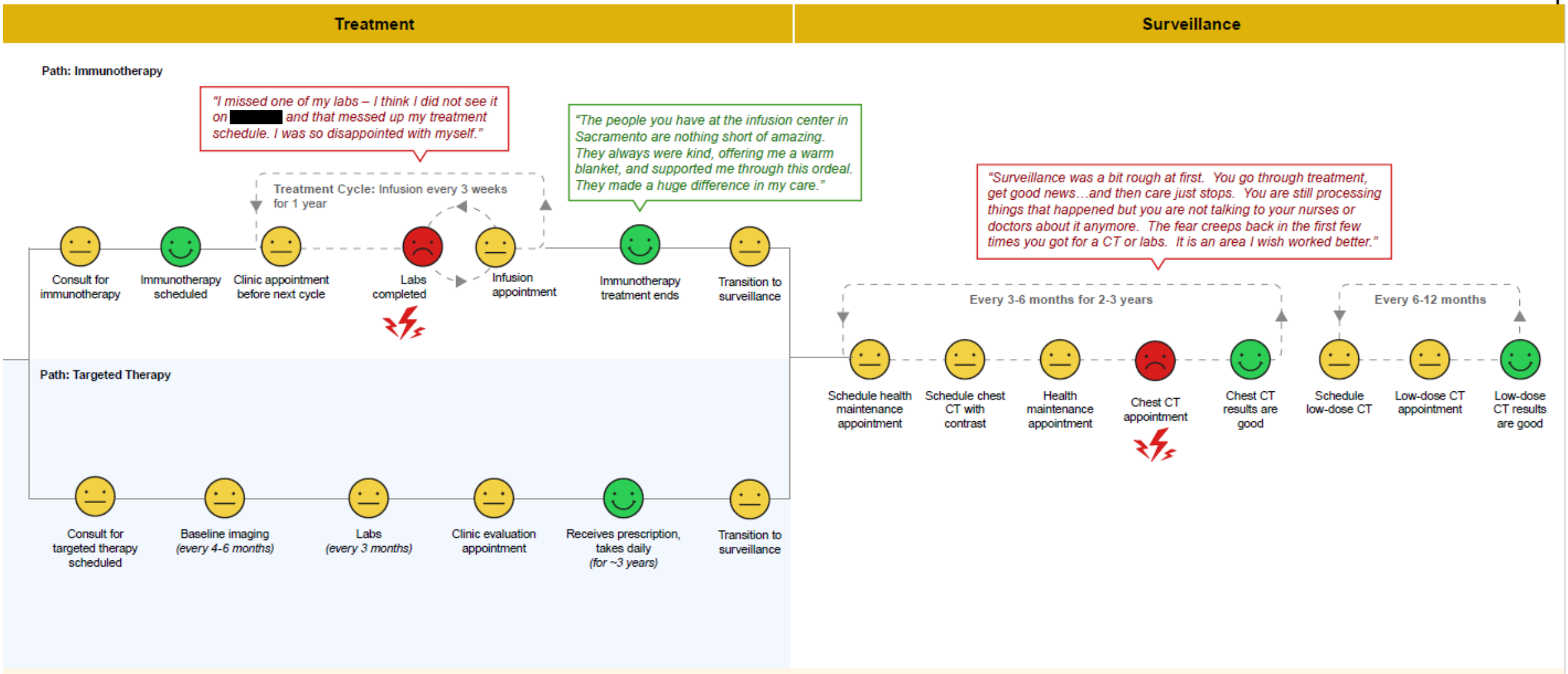
# Readiness Assessment Template

| Critical Readiness Factors Being Addressed | |
|---|---|
| **1. Readiness Factor** | Detail |
| **2. Readiness Factor** | Detail |

| Critical Readiness Factors Requiring Attention in Parallel to Integrated Service Line Implementation | | | | |
|---|---|---|---|---|
| **1.** | **2.** | **3.** | **4.** | **5.** |

*Sourced from Manatt*


Treatment
Path: Medically Operable
"Waking up out of surgery and having the doctor tell you 'we got the cancer' is the first time you really feel relief."
"Getting help filing for disability was impossible – absolute garbage. The department never followed through with anything. It was so terrible."
Surgery date scheduled
Ecosystem: Scheduling
Receives supportive care screening questionnaire
Surgery performed
Doctor shares that all cancer was removed
Doctor shares all cancer was not removed
Recovery from surgery
Discharged home or to skilled nursing facility
Post-Op Chest X-Ray
Files for disability
Transition to surveillance
Path: Medically Inoperable
Treatment Cycle: Infusion every 3 weeks for 4 cycles
Consult with Medical Oncologist
Imaging and labs appointment
Chemotherapy cycle scheduled
Ecosystem: Scheduling
Clinic appointment before next cycle of chemo
Labs completed
Infusion appointment
Side effects from chemotherapy
Given prescription for side effect management
Scans taken to see how treatment is progressing
Chemotherapy treatment ends
"I started to get these awful side effects. I was worried and reached out to my doctor to ask if I should go to the ER. Being able to talk to a person would have saved me visits and hours spent in the ER."
"The final treatment for chemo was a big thing for me. All signs were good and when I went through the last session, we felt confident the cancer was gone. It is a huge relief."
5 days/week
Treatment Cycle: Radiation & weekly meeting with doctor
Consult with Radiation Oncologist
Radiation simulation appointment
Radiation treatment scheduled
Radiation Treatment
Meet with doctor during treatment
Side effects from radiation
Difficulty getting in touch with care team
Ecosystem: Call Center
Gets prescription for side effect management
Radiation treatment ends


Treatment
Surveillance
Path: Immunotherapy
"I missed one of my labs – I think I did not see it on [redacted] and that messed up my treatment schedule. I was so disappointed with myself."
"The people you have at the infusion center in Sacramento are nothing short of amazing. They always were kind, offering me a warm blanket, and supported me through this ordeal. They made a huge difference in my care."
"Surveillance was a bit rough at first. You go through treatment, get good news…and then care just stops. You are still processing things that happened but you are not talking to your nurses or doctors about it anymore. The fear creeps back in the first few times you got for a CT or labs. It is an area I wish worked better."
Treatment Cycle: Infusion every 3 weeks for 1 year
Consult for immunotherapy
Immunotherapy scheduled
Clinic appointment before next cycle
Labs completed
Infusion appointment
Immunotherapy treatment ends
Transition to surveillance
Every 3-6 months for 2-3 years
Every 6-12 months
Schedule health maintenance appointment
Schedule chest CT with contrast
Health maintenance appointment
Chest CT appointment
Chest CT results are good
Schedule low-dose CT
Low-dose CT appointment
Low-dose CT results are good
Path: Targeted Therapy
Consult for targeted therapy scheduled
Baseline imaging (every 4-6 months)
Labs (every 3 months)
Clinic evaluation appointment
Receives prescription, takes daily (for ~3 years)
Transition to surveillance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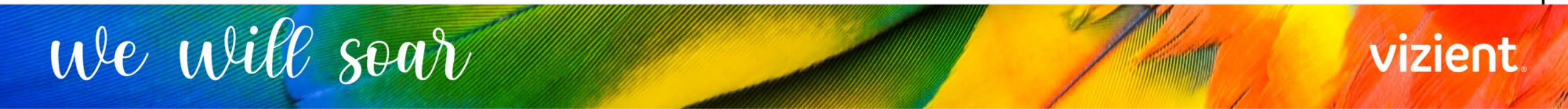
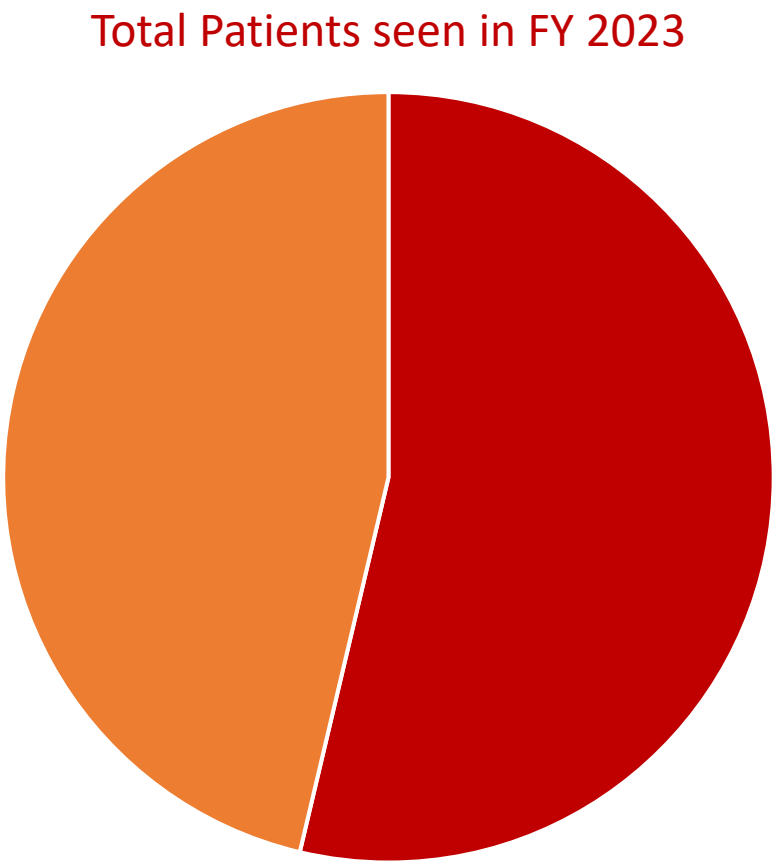
# An Innovative, Inexpensive Method to Help Providers Feel Valued

***Jennifer Bickel, MD, FAAN,*** *Chief Wellness Officer, H. Lee Moffitt Cancer Center and Research Institute*



# Burnout

# Burnout impacts care delivery




% of patients treated by a burned out provider

Not feeling valued is a key driver of burnout and associated with intent to leave

# What do physicians and APPs need to feel valued?

## Five Languages of Appreciation in the Workplace

- Words of Affirmation
- Quality Time
- Acts of Service
- Tangible Gifts
- Physical Touch

White & Chapman 2019 Moody Publishers

## Peer-reviewed literature

"Opportunities to improve perceived appreciation include structured communication of patient gratitude, community building programs, top of licensure initiatives and accountability for physician wellness, and inclusivity efforts from organizational leaders."

Nadkarni et al. Understanding perceived appreciation to create a culture of wellness. Academic Psychiatry. Dec 2020

# Moffitt Provider Appreciation Assessment

**Not a gap assessment!**

| | Minimal Impact | Moderate Impact | High Impact |
|---|---|---|---|
| Patient and family making positive comments about my clinical care | ○ | ○ | ○ |
| Academic promotion | ○ | ○ | ○ |
| Moffitt leaders rounding in my work area to learn more about the impact we make | ○ | ○ | ○ |
| Public announcement of my accomplishments | ○ | ○ | ○ |
| Opportunities for career development | ○ | ○ | ○ |
| Social fun with my team | ○ | ○ | ○ |
| Increased professional responsibility | ○ | ○ | ○ |
| Increased professional autonomy | ○ | ○ | ○ |
| Notes of gratitude, such as Moments that Matter | ○ | ○ | ○ |
| Transparent efforts to reduce the frustrations in my day | ○ | ○ | ○ |
| Quality time with my direct leader | ○ | ○ | ○ |
| Signs of trust in my medical skills | ○ | ○ | ○ |
| Inclusion in making decisions that affect my work | ○ | ○ | ○ |
| Private words of affirmation from those that I respect | ○ | ○ | ○ |
| Encouragement to contribute to our mission with my unique skill set | ○ | ○ | ○ |
| The ability to disagree respectfully without fear of retribution | ○ | ○ | ○ |
| Time for self-care or wellness related activities | ○ | ○ | ○ |
| Positive feedback about my skills from my colleagues and/or collaborating partners | ○ | ○ | ○ |
| Colleagues getting to know me personally, beyond my role | ○ | ○ | ○ |
| Team celebration with catered food | ○ | ○ | ○ |
| Colleagues providing cross coverage when needed | ○ | ○ | ○ |
| Departmental and Hospital Wide Awards | ○ | ○ | ○ |
| Financial incentives for superior outcomes | ○ | ○ | ○ |
| Gifts such as Moffitt swag | ○ | ○ | ○ |
| Reassurance of job security | ○ | ○ | ○ |
| Retainment discussions with my leader | ○ | ○ | ○ |
| Professional leadership titles | ○ | ○ | ○ |
| Public words of affirmation, i.e. during tumor board or in group emails | ○ | ○ | ○ |

# Key Takeaways from the Assessment

- No single method was high impact or low impact
- Demographics (such as gender, age, role) was not closely associated with preferences
- Each one of the 28 items could be considered impactful

# Lowest Ranked Methods with less than 25% High Impact

- Public words of affirmation i.e during tumor board or in group emails
- Colleagues getting to know me personally beyond my role
- Public announcement of my accomplishments
- Social fun with my team
- Moffitt leaders rounding in my work area to learn more about the impact we make
- Departmental and hospital wide awards
- Team celebration with catered food
- Gifts such as Moffitt swag

# Methods Ranked High Impact 59% to 26%

- Financial incentives for superior outcomes
- Ability to disagree respectfully without fear of retribution
- Increased professional autonomy
- Academic Promotion
- Encouragement to contribute to our mission with my unique skillset
- Opportunities for career development
- Colleagues providing cross coverage
- Reassurance of job security
- Retainment discussions with my leader
- Increased professional responsibility
- Professional leadership titles
- Quality time with my direct leader
- Notes of gratitude

# Highest Ranked Methods, High Impact over 60%

- Inclusion in making decisions that affect my work
- Private words of affirmation from someone I respect
- Positive feedback about my skills from my colleagues/collaborating partners
- Transparent efforts to reduce the frustrations of my day
- Time for self-care or wellness related activities
- Signs of trust in medical skills
- Patient/family positive comments about my clinical care

# Turning Results into Action

- Distribution of departmental results to leadership teams
- Distribution of medical group results to organizational stakeholders
- Full Day Wellness Retreat for medical group leaders and stakeholders
- Provided a guide and support for departmental appreciation initiatives
- Departmental appreciation initiatives were tied to faculty leaders' annual goals
- Sense of feeling valued and burnout rates are trending in positive directions

# Lessons Learned

- The impact of feeling valued is primarily driven by the method of appreciation not by demographics
- No single method is 100% high impact or 100% low impact

# Key Takeaways

- Not feeling valued is key driver of burnout amongst clinicians but there are actionable steps towards tailored appreciation which may reduce burnout and improve retention

# Questions?

## Contact:

Jennifer Bickel, jennifer.bickelyoung@moffitt.org

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# What have you heard here you will take back to your organization?

# What steps has your organization already taken related to workforce burnout?


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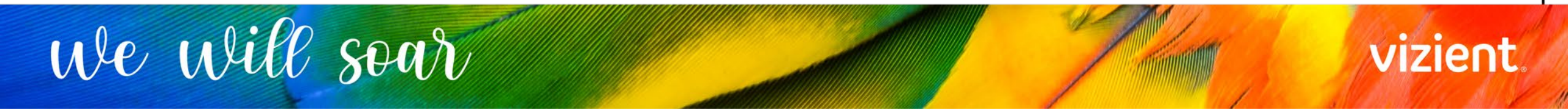
# Session wrap up and next steps



Take a moment to reflect on what actions you will take at your organization based on today's sessions.

# Key Takeaways

- Develop your service line's operating, care delivery, and financial models in alignment with and to support your organizational goals.
- An integrated virtual SL P&L requires patient attribution methodology, standardized data definitions, physician buy-in, and a change management plan.
- Not feeling valued is key driver of burnout amongst clinicians but there are actionable steps towards tailored appreciation which may reduce burnout and improve retention.

# Wait…there's more!

- 3:15 PM: Clinical Trial Equity: Achieving Representation and Improving Outcomes for All, **Chyke Doubeni, MD, MPH**, Chief Equity Officer, The Ohio State University Wexner Medical Center and **Jeff Hines, MD, AVP Chief Diversity Officer**, UConn Health

- 4:15 PM: Interdisciplinary Approaches to Service Line Integration and Optimization, **Matthew J. Wain, MAS**, Chief Executive Officer, **Chad W.M. Ritenour, MD**, Chief Medical Officer/Co-Chief Well-Being Officer, **Nancye R. Feistritzer, DNP, RN, NEA-BC**, Chief Nursing Officer/Vice President of Patient Care Services, Emory University Hospital/Emory Healthcare

# Questions?

## Contact:

Kate O'Shaughnessy, kate.oshaughnessy@vizientinc.com

Janet Schuerman, janet.schuerman@vizientinc.com

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