Optimizing Your Onsite/Near-Site Clinic with a Data-Driven Approach to Better Patient Management

Presenters/Discussion Panelists:
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Executive Summary

Employers, providers, brokers, consultants and other stakeholders attended the BHCG's third Delivering Value Series symposium of 2022 (in-person and via webinar) to learn about the new BHCG/Centivo solution developed for employers and vendors operating onsite or near-site clinics. The new solution helps member employers realize improved returns on their investment in these clinics by enabling them to operate as advanced practice primary care centers.

Through the BHCG-Centivo high-performance health plan solution, employers with onsite or near-site clinics can refer patients for additional services to high value specialists throughout the state of Wisconsin. These high value specialists have been identified using the results of the BHCG-commissioned Physician Value Study conducted by GNS Healthcare.

Attendees got an overview of the new solution and heard about the substantial savings opportunities available when patients are referred to high value specialist. They also heard employer, health system and clinic administrator perspectives on the advantages of optimizing the onsite/near-site model to support better health outcomes.

Introduction – Jeff Kluever, BHCG

- **Centivo and GNS Healthcare Physician Value Study opportunities**

- Allows BHCG to move forward on its mission to be a good corporate citizen and improve health care value for the business community and all stakeholders within the state of Wisconsin:
  - BHCG member employers and non-member employers
  - Health system and provider group partners
  - Other community stakeholders

Dave Osterndorf, BHCG/Centivo

- **Continuous improvement needed in health care world**
  - BHCG-Centivo high-performance model holds great deal of promise to evolve health care (in WI and other markets)
  - Emerging data has shown a strong relationship with a primary care physician (PCP)/team results in the best care – need to start there
    - Employers can encourage PCP relationships through plan design and encourage high-value care
  - Want providers to do their best work, but be held accountable for patient management
    - Pay for outcomes, not volume
- **Potential for savings**
  - WHIO data shows significant variability between the performance of the top performing half of PCPs and specialists resulting in savings potential of:
    - 40% for PCPs
    - 8.5% for specialists
    - 25.7% savings potential overall for both PCP and specialist procedures combined ($1.5 billion)
  - This is a resource utilization issue and not a negotiation issue
  - Real opportunity to get people back to better health as quickly as possible with the least amount of resources
- **Supercharging onsite/near-site clinics**
  - WI is a leader in the number of onsite/near-site clinics used by employers
    - Convenient and close by
    - Provide urgent care
  - Want to transform them into advanced practice primary care medical home
    - From episodic to primary care and patient management
    - Make investments around data and tech to have ability to refer to higher value specialists
  - Opportunity to have a much broader conversation
    - Looked at medical homelessness (between 20-40% of people don't have PCP relationship)
      - Onsite/near-site clinics can help with proactive outreach
    - Optimize a significant resource to provide better health care

Jihye Tahk, Centivo

- **Clinic optimization within the model**
  - Provides services employees need but with cost savings/high quality outcomes to supercharge clinics for a better return on investment
    - Employers don't need to do the legwork
  - Making it feel like part of the plan
  - Helping PCPs/staff at clinics understand who they are responsible for
  - Drive engagement through incentives
  - Direct members to appropriate care at the right time in the right setting to the right specialist
    - Opportunity to bring tremendous value to employers
  - Have the data (adjudicate claims, pre-auth, etc.) and tech to share with employers' data that is rightfully theirs to drive greater value
- **Best practices learned**
  - Align financial incentives with the clinic and benefit strategy
    - Make sure employees have PCP relationships with no financial barrier
    - Encourage use of all services available
    - Incentive to go to PCP for referral when downstream care is required
  - Tailor communication to members around the strategy so it resonates (e.g., what is the value?)
    - Use all assets to communicate (e.g., open enrollment, health plan information, ongoing reminders, etc.)
    - Comprehensive communication strategy
    - PCP engagement and accountability: (PCPs know who they are responsible for; members activate with PCPs)
      - Outreach to encourage activation (reminders and/or assign PCPs after 90 days)
      - Drive more touchpoints
  - Use data to drive care to appropriate settings/individuals for specialty care
    - Referral portal – build a medical neighborhood
    - Configure so it's clear who high performers are

Panel Discussion – Health Systems & Employer Perspective

Ashok Rai, Prevea Health; Donna Owens, Wisconsin Employer Solutions, Ascension Wisconsin; Janet Lucas-Taylor, Northwestern Mutual; Jihye Tahk, Centivo

Q. Are we headed in the right direction with the onsite/near-site clinic program?

A. (Dr. Rai) At Prevea, we have 45 onsite/near-site clinics and 75 employers that partner with us. What you presented here is a good start and we believe in it. We want to make sure the level of care (at the clinics) and technology is the same as any one of our primary care practices (e.g., EMR, vaccine stock, lab, etc.). We talk about the cost plus model to reduce costs and drive

engagement and it works, but does plateau. You get utilization to go up and all components are great, but you need to drive engagement at every level. To do that, you need to expand well beyond the walls to get that higher level of care (e.g., clinic hours available, urgent care wraparound, etc.). We are looking at some of the tools right now. These clinics were born out of convenience and the cost plus savings model and we can do that outside of the company environment, we just have to have engaged employers to help us do that.

Q. What do you see as the biggest challenges to make the new program work?

A. (Owens) The foundation for onsite clinics is access or expansion of access and cost reduction. But for employers' goals, the cost savings are usually at the top of the list. ROI calculations are really looking at transactions and comparing costs by setting. Results are good, but when we talk about supercharging the clinics – taking transactional cost and making it into outcome savings and to be shared back with employers – this is the next level. We should also be talking about data sharing. Ascension has had a very positive launch with Centivo. We get wellness data and we do outreach on that, but we are not really getting the big picture data – increasing the partners who are sitting at the table is a really intriguing thing. Number one challenge is dealing with people making changes (e.g., changing a PCP relationship). We also have to deal with lack of confidence in the onsite center and also their concern if they make an employment change. The biggest challenge is getting people into a new strategy and getting them to truly adopt it. But the data is richer and the opportunity to react is greater.

Q. Can you speak to employer responsibility and commitment to onsite/near-site clinics?

A. (Dr. Rai) I cannot think of one employer that discontinued their clinic. We do one-year contracts because we feel we need to earn the business every year. After they've started the clinic, it is one of the hardest things to take away.

Q. What should be included in the ROI?

A. (Owens) For employers, there is a lot of comfort in the transactional visit, direct ROI calculations. When we take the next step to talk about productivity, downstream savings and better management, we are looking forward to better data and partners that can help us with that. Looking at every opportunity to prove the next level.

Q. (from audience) How can you measure engagement?

A. (Dr. Rai) The most costly patient is the one who is not engaged. There is a difference between seeing and engaging a patient. We have to find a way to define and measure engagement – we need to figure it out and make changes driven by it.

Q. (from virtual attendee) What do you see as the opportunity for utilization of the data from the Physician Value Study (WHIO scorecard) for the referral to the high value specialist?

A. (Owens) We now have confirmation as to which of our providers are higher ranked and what is that next level to get to get them on the high value list. When we talk about high value, we are talking about the combination of quality and cost (not one or the other). Who gets patients to a better status with less cost attached to it.? For specialists, it's who is on our list? How do we stay diligent about keeping them on that list?

A. (Dr. Rai) The biggest cost missing in the scorecards is site of service. If we are going to truly make a difference, we need significant site of service data and site of service transformation in Wisconsin – too many procedures are done in the hospital. The scorecard is a start, but when you really look at costs, the one thing you can't argue is site of service – we need that data to drive real value.

Q. Northwestern Mutual just went through the transition to the BHCG-Centivo high-performance plan on January 1 – how did it go and what would you tell other people?

A. (Lucas-Taylor) Northwestern Mutual operates three Mutual Health Centers. Our services include primary care for all members, behavioral health, labs and physical therapy. We have been operating the clinics for a number of years. When we implemented the high-performance plan, we saw the patient attribution and utilization go up. We worked with Centivo to increase patient activation with PCPs. We've had very little noise related to that. We've had tremendous response to how convenient it is. We work with the staff to drive behaviors that we want and make referrals out in the community. Also, we worked with Centivo to allow staff to look at referrals that are expiring, look at the clinical record, determine if they need to see the patient and whether they need to message the patient or extend the referral (make it seamless to the patient).

Q. How difficult was it to get clinic staff to move to a data-driven referral process?

A. (Lucas-Taylor) Really, very easy – the technology is very simple. Have not had any issues using the Centivo portal, the staff has been very open to it. We understood that staff had some relationships in the community (some may be high performing), but we told them we are giving them an extra piece of information and that has been appreciated and eye-opening in some cases. In the past, some had been making referrals based on operational procedures and convenience, but now they can look at quality metrics as well.

Q. (from audience) Is there any extension of your clinic services for those who are truly remote or hybrid employees?

A. (Lucas-Taylor) We are working on that and have implemented virtual primary care with the clinics – focusing on extending virtual care options in the future.

Q. To what extent have you been able to use your onsite/near-site clinics to augment telemedicine/virtual health capabilities?

A. (Owens) We have been able to implement virtual options with all our clinics and about 10-15% of all our visits are done virtually or as hosted visits with support staff in the clinic. We are all-in on virtual visits.

A. (Dr. Rai) We have extended all our services to accommodate virtual visits. For occupational medical injury, we have 24-hour occ med access for triage as a component of the clinic. We continue to expand what we are doing virtually.

Q. (from virtual attendee) Are the physicians employed by the employer or are they contracted? How do physicians learn of the opportunity?

A. (Lucas-Taylor) The physicians are not employed by Northwestern Mutual – they are employees of Premise Health. I would advise employers to check clinic contracts to make sure physicians are able to stay if you do change vendor partners.

A. (Dr. Rai) Prevea contracts with the employers. Our physicians are owners in Prevea (own 50% of the common stock), and we recruit to that opportunity.

A. (Owens) Our providers are employees of Ascension and part of our medical group. If there is an opportunity at one of our onsite clinics, they are presented with that opportunity by recruiting. We partner with our employers through the interviewing process to make sure it is a good fit.

Q. (from virtual attendee) It is clear you believe in the onsite model. It could be difficult for employers to make the leap to an onsite clinic – do you provide any contractual guarantees for savings and/or engagement?

A. (Dr. Rai) We do.

A. (Owens) As health systems, we have had a pretty good opportunity to be a low-cost onsite provider, so the management fee is usually pretty small. We are always willing to talk about guarantees. What intrigues me is moving into a model like Centivo and the tools/richness of data. Performance guarantees are also aligned with performance bonuses – so being paid on value and outperforming expectations is also an opportunity.

Q. (from virtual attendee) Do you share in the risk to help employers see you are dedicated to the partnership?

A. (Owens) Yes, we are totally dedicated to that partnership and communicating. We always want to talk about goals, responsibilities and rewards.

A. (Dr. Rai) We do assume some risk, but a lot of the weight is on us – all the marketing, communication and design work, we handle that. But the employers are our partner and are

fully engaged in the planning which can take up to six months to figure out marketing, plan design, etc. – there are a lot of complexities.

A. (Lucas-Taylor) We currently have performance guarantees in place. We believe quality aspects and engagement drive the savings. We focus on that and the care and making sure clinical metrics are above standard.

Q. To what extent should we be paying our onsite clinics on a value compensation model?

A. (Dr. Rai) We own our own health plan so that is the world we live in for a big chunk of our commercial market. That is the infrastructure we created and designed around value-based payment systems.

A. (Owens) We would love to learn more. In our current system of onsite clinics, there is a cost to have staff there and because it is very transactional, that is how we get paid. Getting paid on value but understanding there is a panel of individuals who have chosen those onsite providers as PCPs, opens up an entirely different discussion.

Q. Can you comment on the new world of onsite/near-site clinics as being an integral part of health care and not just something on the side?

A. (Tahk) It's important to think about what the real drivers are for employers to offer onsite/near-site clinics as a part of the health plan. Large carriers have put together custom networks of providers that are not really part of the network – and they are not really thinking about how to plug in those partners. The benefits of integrating the clinics into the health plan are that there are opportunities to add value to the health plan and benefit the members. This is just the beginning to get paid on value, transparency, etc. (hard to do when you are not integrated). It makes sense for an employer to integrate the clinics into the health plan.

A. (Lucas-Taylor) Northwestern Mutual had been asking the health plans for years to put the clinic physicians in their networks to increase chances of engagement and have employees think of the clinic as part of their health care network – and they were resistant. Very helpful to have them in the network and it helps physicians feel like they are connected to the community and have a different level of information.

Q. What are the pros and cons for both health system clinics and independent clinics?

A. (Dr. Rai) We are a multi-specialty group, so we believe in coordination of care. The best way to do that is make sure PCPs and specialists are in the same group and partnering and sharing the same EMR, etc. and making sure you are hiring and monitoring quality for everyone so they are delivering value. It isn't just about driving volume to us because an employer will kick us out in a year. Unless your costs are going down and you see value – we are out. We have to provide value to keep those contracts.

A. (Owens) I have worn both hats. Some of the differentiation between health system and independent onsite clinics have started to get blurry. Years ago, when health systems got into it, PCPs said onsite clinics compete with us. It started to look like a funnel to specialty care. But that is not the case – now we are one system, this isn't a competing service. Integration of the medical record has evolved the model. It gives us an absolutely dedicated onsite primary care provider. We can make the referrals; they are already part of the system.

A. (Lucas-Taylor) We don't have a true integration issue because of EPIC. The challenge is in creating the relationships – now they can use the data and it's much more effective. I have noted a vast desire for health systems to partner with us for specialty care, etc.

Q. (from the audience) Do you partner with any other third parties or point solutions to augment your capabilities?

A. (Dr. Rai) Yes, we are looking to augment our internal disease management with a platform that would help our disease managers to double or triple their panel size. We have internal mental health and AODA and occupational med. We are always looking for new opportunities to augment our chronic disease management.

A. (Lucas-Taylor) It's important to integrate with point solutions – it's how you get engagement.

Q. (from virtual attendee) Do your clinic models allow for treatment of workers' compensation claims?

A. (Dr. Rai) Yes, we do see some work comp in the onsite clinics. It structured a little different contractually. It's not mandatory but we can treat for work comp injuries.

A. (Owens) The same answer, but there is a sensitivity that we are billing it to work comp.

Q. (from virtual attendee) Can you provide some additional insight on the Centivo product for near-site/onsite clinics?

A. (Osterndorf) There are three different kinds of employers. Employers ready to move down the path to implement the high-performance model – and using the data for referral is an obvious part of that integration. Secondly, there are those thinking about moving down the path and are asking, "can you get my onsite clinic moving ahead of where I am as an employer by using the data and referral portal (as an initial step to move to the high-performance model)?" The third group are those not likely to go down the path but still want to use the data. The data in the Physician Value Study is available to the onsite operators to create their own medical neighborhood.

Q. (from the audience) Can you comment on what makes you successful in offering an onsite clinic? What are the challenges and what makes you best in class?

A. (Dr. Rai) The most successful are the clinics where the c-suite leaders and leadership on down are really engaged in the success and the communication of the success of the clinic. Those who structure it as a benefit and part of their health strategy and consider other services they can bring in. Those are the ones that are getting more than just the transactional ROI.

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