

Nebraska Medicine

Summer 2014 | Volume 13, Number 2

Value-Based Health Care Delivery

How physicians
can do their part



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Advocating for Physicians and the Health of all Nebraskans

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Nebraska Medicine is published quarterly by the



Advocating for Physicians and the Health of all Nebraskans

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Lincoln, NE 68508
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www.nebmed.org

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Implementing Value-Based Health Care Delivery in Nebraska

by Scott Wallace, Visiting Professor and Elizabeth Teisberg, Professor, Department of Family and Community Medicine, Geisel School of Medicine at Dartmouth

Health care affects every person, and the stories people tell about their care speak volumes about our health care delivery system. Some stories highlight the best of what health care can be – they are heartwarming descriptions of health restored, concerned and loving caregivers, cures that appear miraculous. Unfortunately, other stories illuminate the gaps in our system. Too many of these stories are of failed health, complications made more complex by siloed, disjointed care, errors that should not have occurred, or missed opportunities to heal. Fixing health care – moving it to a place where more people enjoy better health – requires a focus on creating value and a commitment to a fundamental redefinition of care delivery.

Value in health care is the improvement in health for the costs incurred. Moving to a value orientation has been more difficult because too few organizations measure the health outcomes of their care, and too few can accurately measure the actual costs of the care they deliver to individual patients. The commitment of the Nebraska Medical Association and its leaders, together with a state-wide effort to improve

health and care, puts the state on the cusp of tremendous change.

Across the state, clinicians agree that the goal of health care must be better health. Making better health outcomes the singular goal of health care delivery transformation will address many of the problems that plague the system. People seek care when their health is threatened. Producing better health outcomes reduces the demand for health services. Examples abound demonstrating that better health is less expensive than poor health, and effective care reduces costs of complications and disability.

Historically, health sector competition was about dividing value. Competition focused on shifting costs – imposing higher co-pays on patients, excluding services from coverage, moving patients among care venues, and arm-wrestling over reimbursement rates. These efforts raise the overall costs of care by introducing unnecessary paperwork, bureaucracy, inefficiencies, transaction costs, delays, and complications. These activities frustrate physicians and other caregivers who prefer to put their time and energy into efforts that create value for patients and families.

Greater value means more health, success and efficiency, and it involves fewer problems, treatments, and hassles. Any size organization, from a single-physician practice to an integrated delivery network, can redesign care



Scott Wallace



Elizabeth Teisberg

delivery to achieve value improvement for patients.

The first step in redefining care delivery is to organize care delivery for excellence in what many patients need, and customize occasionally. Organizing around groups of patients with similar medical circumstances flips the current presumptions, freeing clinicians to focus time and resources on the needs of those who require the same types of tests or treatment, or those who need to make similar kinds of lifestyle changes. Bringing similar groups of patients together also creates natural networks of patients who can coach, support and assist each other as they work to achieve better health.

When there is similarity among the patients, it is easier to assemble and deploy a multi-disciplinary care team to treat them. For example, a primary care practice that groups most of its patients with Type 2 diabetes one day per week can more easily offer group medical appointments, partner with a pharmacist, retain diabetes educators, exercise

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“There’s a Hole in the Bucket...”

by Kevin Nohner, MD, MBA
President, Nebraska Medical Association

As we encounter the transformational years ahead of us, it is time for physicians to decide. Do we remain passive and hope that “this too will pass?” Or, will we be proactive and become engaged as leaders of change? Do we let insurers or politicians dictate the path health care will take? Or, will we use our knowledge, experience, and the years of patients’ compounded trust to forge a new and better way to improve service and make health care affordable for all?

Adaptation is very difficult and we currently are faced with a true C-change, a condition previously believed to occur “once in a century.” However, the world we live in is much different than it was only a few decades ago. Technologic advances and the rapid exchange of information have greatly increased the slope of the change curve. Today’s standards of treatment may be rapidly replaced as they become outmoded or exposed as being less effective (or causing unintentional harm). Best practices, cost efficiencies, redundancies and waste, and ineffective treatments will all undergo increasing scrutiny and we can expect that the number of parties monitoring health care will proliferate. For years, third party payers and CMS (Center for Medicare and Medicaid Services) have accumulated claims based data over a multitude of diagnostic codes that enabled them to assess a “value” of the services provided. As health care costs rose, this gave birth

to the failed HMO era of the 90s - an era where decisions in regard to medical care too often were based on cost rather than quality. The HMOs failed to account for the degree of patient dissatisfaction this would generate and they slipped out of favor. Nevertheless there was a lesson to be learned; for a few years the percentage of the rise in health care costs decreased and was held to single digits.

Today, we again face burdensome health care costs. Corporations, small businesses, and our patients and families find it increasingly difficult to afford the expense of providing insurance, increased co-pays, and deductible limits. In a current JAMA article, an analysis of data concluded that “1 in 5 U.S. households will struggle with medical bills this year, 1.7 million individuals live in a household that will file for bankruptcy related to medical costs, and more than 25 million adults between the ages of 19 and 64 will not take medicines as directed because of costs”¹.

The comic character Pogo said: “We have met the enemy, and he is us.” There are a multitude of factors involved and no one is solely responsible for our current status. Patients and their families want and demand medications or the latest technology, regardless of effectiveness. Entrepreneurs and alternative health providers market unproven treatments or tests based on anecdotal testimony and patient fears. Physicians, allied health professionals, hospitals are not immune. Overutilization driven by supply sensitive care has repeatedly been shown to consume more resources

yet yield poorer outcomes. It should not be a surprise to anyone that this path is unsustainable.

How, then, will this C-change occur? What will the new direction be?

I would propose that the process is not the sole responsibility of any single constituent. If we can keep in mind that our ultimate goal is to meet the patient’s needs first and foremost, we are likely to be successful. Going forward, strategies for active participation and collaboration by all will be essential:

- Patients will need to take more ownership in their health. Diet, exercise, and healthy lifestyles cannot be prescribed and, if not embraced by the patient, will be a set-up for failure. We need development of a mindset that promotes wellness and preventive care to replace our current model based on reacting to illness and health crises.
- Physicians and staff need to provide more education and engage the patient in the decision process. Patient and physician goals may not coincide and alignment is essential for progress to occur. The addition of Care Coordinators and implementation of the Patient Centered Medical Home Concept provide a new and unique resource to develop and integrate patient care.
- Raise awareness and promotion of programs such as the American Board of Internal Medicine’s *Choosing Wisely* or the AMA’s *Less is More* campaigns. Improvements can be accomplished by informing physicians and patients as to which treatments and tests are effective versus those that are likely to be

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Achieving the Triple Aim with a Physician-Lead Accountable Care Organization

by Bob Rauner, MD, MPH,
Gerry Luckey, MD, & Joleen Huneke
SERPA-ACO

Eighteen months ago, nine independent Nebraska clinics decided to band together on a project to improve care provided to their patients, decrease health care costs, and improve the health of their communities. After a series of meetings, an agreement was made and the South East Rural Physician Alliance Accountable Care Organization (SERPA-ACO) was formed. Our first successful contract was with Medicare to join the advanced payment option of the Medicare Shared Savings Program starting January 1, 2013. We have since added the majority of our Medicaid patients to our efforts and are working with several commercial plans.

SERPA has always had the mission of delivering high quality health care, but now the contracts with payers and SERPA-ACO are allowing us to prove it. "It is one thing to think you are delivering high quality low cost care; it is another to be able to have the data to verify it. The SERPA-ACO clinics have made big changes in the last 18 months and we are seeing the positive results of those changes," according to Joleen Huneke, executive director.

From the beginning, our philosophy was that we would be a patient-centered organization. The board decided if what we were doing was right for some of our patients, we would do it for all of our patients, not just a subset. Our first step was that all nine clinics would transform to become

Nebraska Medicaid Tier 1 certified Patient-Centered Medical Homes and each clinic would hire at least one full-time care coordinator. We started changing our clinic workflows and focusing on systematic quality improvement to improve clinical outcomes. This work has paid off and our ACO beat national averages on 21 out of 22 quality measures compared to other ACOs across the country (measures such as medication reconciliation, percentage of patients with their blood pressure under control, diabetes control, and depression screening).

The focus on quality improvement and better communication is also paying off in terms of clinical outcomes. SERPA-ACO's Medicare hospitalization rate, which was lower than national averages when we started, has dropped another 10%. That translates to over 300 fewer patient hospitalizations in 2013 compared to 2012. Our 30-day readmission rate at our last report was 10.6%, well below national averages. In addition, our costs per Medicare beneficiary are about \$300 less per beneficiary compared to our peer ACOs across the country.

We think we can make a solid case that our care coordination, quality improvement efforts, and patient centered focus is achieving the often touted Triple Aim – "improving the experience of care, improving the health of populations, and reducing per capita costs of health care."



Bob Rauner, MD



Gerry Luckey, MD



Joleen Huneke

One of the surprise benefits over the last year is the improved physician and staff morale we are seeing in our clinics. "Changes in the health care system are finally starting to incentivize quality care as well as cost savings. After 40 years of practice it is refreshing to participate in the transformation of our practices to a truly patient-centered, value-based model. The ACO prepares us for providing more value in the commercial market and reimburses us for the value we provide to our patients," says Gerry Luckey, MD, lead physician at Butler County Clinic in David City.

SERPA-ACO Medical Director Bob Rauner, MD, MPH, has seen similar results. "One of the best things I have seen during my regular site visits to our clinics is the excitement of the staff around what we are achieving. I think part of this comes from seeing solid results on quality improvement that everyone in the clinic gets to see. The clinics that really do it right know that everyone in the clinic plays a part in the effort, from the front desk to the back office. Another new area is the results we are seeing from our nurse care coordinators. One of the highlights of my job is when one of the care coordinators

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Value-Based Health Care and Your Practice

by Roger E. Howard, CPA,
Partner, Seim Johnson, LLP

The goal of this article is to briefly go full circle from exploring Value-Based Health Care (VBHC) concepts, to reviewing a few ideas from “thought leaders,” to providing some resources for your VBHC initiative, to proposing an overview of a work plan for your practice. VBHC isn’t “one-size-fits all,” so you will need to customize the concepts to your specialty, your practice setting, your resources, and your goals.

VBHC Definition

NMA has stated “Value is patient outcome/cost. The goal is better outcome at a lower cost. The focus is on the patient. Value-based health care delivery focuses on the patient experience to deliver value.”

INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS STATES -Value-based health care (VBHC) is a health care management strategy focusing on costs, quality and, most importantly, outcomes. Its goal is to create a culture of health within an organization by removing barriers and encouraging participants to pursue healthy lifestyles that ultimately lead to a healthy workforce. VBHC involves collaboration among plan sponsors, participants and providers to pursue high-quality and high-value care while reducing the need for high-cost medical services.



Thought Leaders Commentary

Observation #1 – High Deductible Health Plans are one key to VBHC, however the barrier is “measurement”:

FORBES MAGAZINE SAID IN 2012 (based on the Forbes Insights report “Getting from Volume to Value in Healthcare”): Successful transition to Value-Based Purchasing (VBP) will depend on winning hearts and minds: Fully engaging their doctors was seen by C-suite executives as the top barrier to VBP participation, selected by half of respondents. The study also issued a warning on consumer-driven health plans: About two-thirds of executives believed that consumer financial incentives are key to making VBP successful (64%). However, about the same percentage (67%) also thought that consumers won’t know when that success arrives, since they can’t judge the value of medical care accurately.

Observation #2 – Expanded coverage of preventative services could improve care and reduce the cost of chronic disease treatment:

PRESS RELEASE May 8, 2014 – Millions of Americans could benefit from expanded coverage of preventive services under health savings account (HSA)-qualified high-deductible health plans (HDHPs), according to a new white paper authored by researchers at the University of Michigan Center for Value-Based Insurance Design and Harvard University Medical School.

Funded by the Gary and Mary West Health Policy Center (Nebraska natives-Go Big Red!), the study developed and priced hypothetical HDHPs that incor-

porated “value-based insurance design” (V-BID) principles to better meet the needs of chronically ill patients and those at high risk for developing chronic conditions. Chronic diseases – such as heart disease, stroke, cancer, diabetes, and arthritis – are among the most common, costly, and preventable of all health problems in the U.S. and cost more than \$2 trillion a year, according to the Centers for Disease Control.

Many people with chronic diseases and enrolled in an HDHP must pay out-of-pocket for medically necessary treatments.

“Our goal was to find ways to enhance the ability of high-deductible health plans to improve clinical outcomes of the chronically ill while reducing costs,” said A. Mark Fendrick, MD, Director of the University of Michigan Center for Value-Based Insurance Design. “We were pleased to discover that expanding the definition of ‘prevention’ to include evidence-based services that slow chronic disease progression and prevent related complications could potentially benefit millions of Americans.”

Observation #3 – Collaboration of providers is the key to the transition from volume to value:

COLUMBIA, MD., May 8, 2014 -- xG Health Solutions and Geisinger Health System added 20 more hospitals to their bundled payment collaborative -- As a result of the recent expansion of the Bundled Payment for Care Improvement (BPCI) initiative by the Centers for Medicare and Medicaid

(continued on Page 6)

Services (CMS), Geisinger Health System (GHS) and xG Health Solutions™ have announced partnerships with 20 additional hospitals and will support those organizations as they continue to work towards value-based care.

All participants in the Geisinger-xG Health BPCI collaborative gain access to the team of experts from both entities' educational programs and are able to partner with xG Health on the services it provides for re-engineering care delivery and transitioning from volume to value.

“Adopting bundled payment methodology will encourage providers to examine their approach to care delivery,” said Ray Herschman, president and chief operating officer of xG Health Solutions™. “And this is where we are leveraging the vast experience of Geisinger and xG’s analytic capabilities to help those providers be better prepared for risk-based payment arrangements.”

NOTE: Network affiliations are available to smaller practices from groups such as Geisinger’s xG Health Solutions and Cleveland Clinic Affiliate Network.

Resources for your VBHC Initiative

MGMA – The Medical Group Management Association provides to members an online PQRS-Value Modifier Survival Guide to learn more about the program and how it interacts with PQRS, and to prepare your practice for the 2016 Value-Based Payment Modifier (VBPM).

AHA – The American Hospital Association has a free on-line guide to value-based contracting (July 2013), which may be instructive on future directions for physician contracts, and the hospitals’ perspective on the role of the physician in VBHC contracting.

http://www.hpoe.org/Reports-HPOE/Value-Based_Contracting_KaufHall_2013.pdf.

AHRQ – The Agency for Healthcare Research and Quality has multiple initiatives:

- Primary Care Practice-Based Research Networks (PBRNs)
<http://www.ahrq.gov/cpi/initiatives/pbrn/index.html>
- You can sign up for email updates
- ACTION II is a model of field-based research designed to promote innovation in health care delivery by accelerating the diffusion of research into practice. The ACTION II network includes 17 large partnerships and more than 350 collaborating organizations that provide health care to an estimated 50 percent of the U.S. population.
http://www.ahrq.gov/cpi/initiatives/ACTION_II/index.html

Your Value-Based Strategy

Value-Based reimbursement shifts the risk to the providers, and payors determine your payments based on empirically determined cost and quality of care.

In addition, with bundled payments you will be reliant on other providers managing their cost and quality in order to receive the best reimbursement for an episode of care. How will you

survive and succeed in this environment?

- Data/Systems – Physicians will need to collect, analyze, and manage cost and quality data on every patient.
- Collaboration – Communications will become even more critical between physicians and hospitals and other providers.
- Expectations – Collaboration across specialties will be required to improve care and manage costs. Doctors in different practices and specialties will have to agree on expectations related to patient care.
- Relationships – Creating relationships and sharing information and data with practices and payers will be a key to success in delivering and being paid for quality. You may find large national clinics and networks will provide cost effective resources for your practice.

DATA – In the near future, having data to support the quality and cost effectiveness of care will drive your reimbursement. To quote one of my clients, “presented with facts, physicians will change behaviors; unfortunately too many of our discussions about outcomes and protocols are based on anecdotal information.” You must measure, analyze, and report data on a regular basis.

Develop quality measures and cost measures that you plan to track and start the measurement immediately. Benchmark data is a challenge to obtain, however, you may obtain data from payors, specialty societies, or develop your own network (seek anti-trust advice before proceeding).

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Metrics that Matter

by Geoff McCullen, MD
 Orthopedic Spine Surgeon
 Lincoln Orthopaedic Center

Recently I started training as a student private pilot. After five lessons, I have learned that to fly successfully requires concurrent attention on several real-time instruments in the cockpit: altimeter, air speed and vertical speed indicators, heading indicator and the magnetic compass. In addition, you have your eyes and visual references and “the seat of your pants” to tell you where you are at any one time.

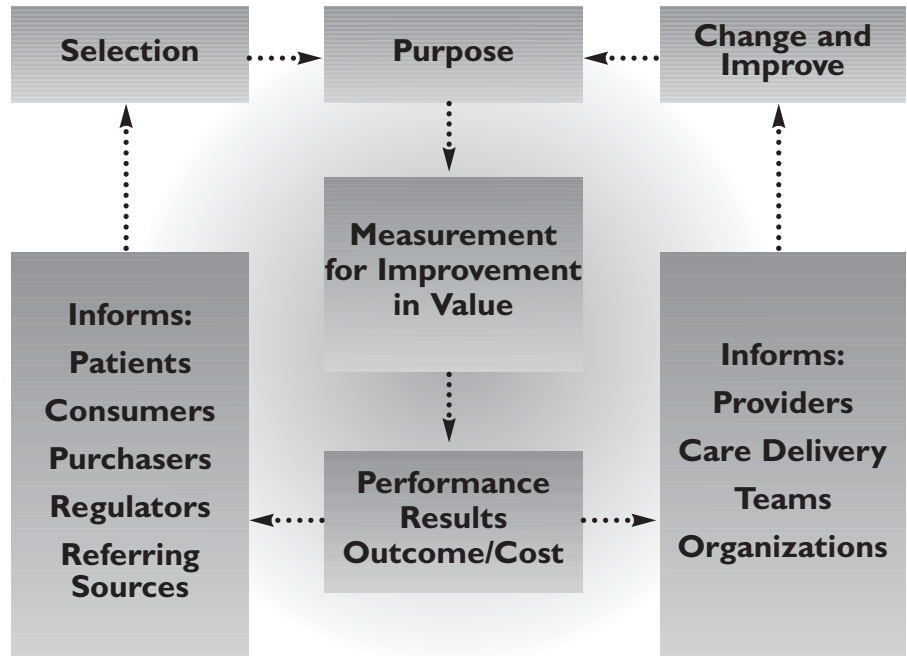


Everyone will agree that knowing where you are while flying is valuable. Indeed, it is essential.

What about knowing where you are while engaged in health care delivery?

We are seeing the term “value-based” permeate the health care discussion. We understand the essence of this term to mean the “clinical outcomes/results/quality delivered for a certain cost.” Value increases when better outcomes are obtained at a lower cost. Value can be degraded or lost with poor outcomes delivered at a high cost. To know if we are producing value we have to define it and measure it.

Practicing medicine these days has three different levels of defining and measuring value: system level (regulatory, payer); local community level (physicians and hospitals); and individual patient level (taking care of one unique patient, with specific preferences, at a time).



System Level

The government and many insurers have been collecting claims data for years. Data, good or bad, can be extremely powerful. Some entities are beginning to leverage that data to attempt behavioral change in providers. We are all influenced by incentives, either “the carrot or the stick.”

Such data may be useful, especially in assessing variations (outliers) in medical practices/procedures, utilization and costs across regions. However, claims data is aggregate (from 10,000 feet altitude) and fails to differentiate individual doctor-patient preferences and shared decision making. As it is also a “trailing indicator,” with summary data presented at a point distant from the delivery, claims data does not accurately reflect real-time practice.

Some of the “pay for performance” programs are really measuring adherence to processes, sometimes out of our individual sphere of influence. Some of

the processes encouraged by these programs are adding value. However, such programs may incentivize care in the wrong direction with negative consequences.

There is a potential trend that could lead to “death by metrics” at the system level, where there are thousands of measures that don’t accurately reflect practice and patient realities and to which we have limited contribution.

Local Level

At the local level, in our practices and in the hospitals, we have seen the implementation of cumbersome EHRs, potentially a source of useful clinical information, but grossly inadequate. We seek good technology that is efficient. For example, no Amazon customer has to pass through multiple screens of information to simply buy a book. EHRs need to make relevant information readily available, synthesize details to augment clinical

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Value-Based Health Care: An Opportunity for Physician Leadership

by *Kimberly A. Russel*
President and CEO, Bryan Health

The phrase “value-based health care” has joined the health care buzzword lexicon. As is so often the case with health care lingo, the term value-based health care has multiple definitions and derivatives. Value-based health care can be used to describe the aspirational goals of medicine – to provide high quality health care services in the most cost effective manner possible. Unfortunately, value-based health care can also be used as a rationale to cut federal and local funding for needed health care services.

This discussion will focus on the positive definition. The cost of care and quality outcomes of health care services are a great concern – to our patients, their families, the employers of our patients, and certainly to the nation as a whole. Although there are many things we can’t control in health care, there are countless opportunities to impact cost and quality in day to day patient care services, and this is our priority.

At Bryan Health, we believe physician leadership is essential to achieving the twin goals of improved quality with lower cost. In my own experience of

over 30 years in health care, I have always found physicians to be concerned about the costs directly experienced by patients and to be interested in genuine quality enhancement.

Due to their medical education and total immersion in both the scientific and operational aspects of medical care, physicians have the opportunity to lead change that will impact cost and quality in ways that really matter. When physician leadership is absent, the chase for quality and cost reduction can be sidelined or made ineffective.

A focus at Bryan Health has been to concentrate on quality and cost reduction that will have a real impact on our patients and their hospital bills. Physician leadership has been essential to lowering the cost of implantable devices for our patients. Local obstetricians led the establishment of the “no inductions before 39 weeks” policy at Lincoln hospitals – years before this policy became the nationwide standard of care. Other examples include the reduction of unneeded use of telemetry and reduction of readmissions.

We are now evolving from considering quality and cost enhancements from the perspective of a single specialty to interdisciplinary teams encompassing multiple specialties. This is complex

work – and it requires skilled physician leadership, along with mutual respect for the entire care team. This work is evolving as an essential ingredient of the newly formed Physician Hospital Organization (PHO), Bryan Health Connect. In the tertiary care setting, strong leadership from the hospital-based physicians is having a true impact on clinical quality and cost effectiveness.

On a national level, it’s the American Board of Internal Medicine Foundation that has led the “Choosing Wisely” campaign. This campaign has engaged multiple specialty societies and is making a real difference in the use of medical resources throughout the United States.

My challenge to the state’s physicians is to continue to seize opportunities to take a leadership role in quality advancement and cost reduction in your local communities. My challenge to the state’s health care leaders is to step up efforts to work in collaboration with local physicians to transform ideas into action. Physician leadership along with collaboration among all health care partners is the true formula for value-based health care. □



Blue Cross Blue Shield Supports Value-Based Contracts

by Joann Schaefer, MD
Vice President and Chief Medical Officer,
Medical Care and Medical Management
Blue Cross and Blue Shield of Nebraska

It almost certainly comes as no surprise to anyone in the health care industry that it is in serious trouble.

The current system is failing—in many areas failing badly—to contain costs, increase efficiency, or improve patient outcomes. Most experts agree that unless fundamental changes are made, the U.S. health care

system faces a bleak future.

Value-based reimbursement may well be the catalyst for this much needed change. It represents a fundamental shift in how medical care is provided and paid for and how success is defined, measured, and rewarded.

Under the value-based reimbursement model, medical practitioners are paid not for the number or quantity of services they provide, but how effectively and efficiently the overall care of the patient was delivered—what the Institute for Healthcare Improvement calls the “triple aim”: improved health, improved patient experience, and lower costs. While total cost of care is very important, quality measures and higher patient satisfaction are linked to that lower cost.

At its core, value-based reimbursement is built on the belief—supported by data—that the stronger a patient’s ties to his or her primary care physician are, the better the quality of care received, and the more efficiently that

care is delivered. Primary care physicians are in the best position to manage a patient’s overall care; the value-based reimbursement model reinforces and strengthens this all-important relationship.

At Blue Cross and Blue Shield of Nebraska (BCBSNE), we have been progressing toward value-based reimbursement through programs such as our Patient Centered Medical Home, Potentially Preventable Readmissions Shared Savings, and National Surgical Quality Improvement. These initiatives laid the groundwork for the next necessary step: systemic change that will drive quality enhancements AND meaningful cost savings.

In the coming months, we will be launching new reimbursement methodologies that invest in primary care, focus on value, and align directly with the triple aim. For our members, it’s about getting the right care at the right time for the best value.

The move toward value-based reimbursement comes at a time when consumers are being asked to pay for a greater share of their medical care out of their own pockets in the form of higher deductibles, coinsurance, and copay amounts. Because they have more “skin in the game,” consumers are actively participating in their health care more than ever, asking questions and demanding cost and quality information like never before. This also means they are also likely to be more receptive to cost and quality advice provided by an individual they trust: their physician.

These physicians must be armed

with the data they need to perform this new management role effectively. Providing practitioners with the tools they need to assess and measure quality, efficiency, and patient satisfaction are an important part of the equation.

Getting meaningful data into physicians’ hands is essential, so that practice transformation can continue to happen. Team-based care, clinical care management and coordination of patients—especially those with multiple chronic conditions—are the keys to success in these new models, but more importantly, they result in better care.

Blue Cross and Blue Shield of Nebraska recognizes and supports the critical importance of the primary care practice model and the holistic and results-driven perspective it fosters. The doctor-patient relationship plays a key role in the value-based reimbursement model. In a recent article appearing in *practicefusion.com*’s Physician Perspectives blog, Paul Godin, MD, wrote: “The doctor-patient relationship is not just a quaint anachronism. It is the single most important relationship in medicine because it is the one that protects most patients.”

As a not-for-profit mutual insurance company, the security and well-being of our members is our top priority; allowing us to focus on delivering value to our members rather than profits to shareholders. We look forward to working with Nebraska physicians and facilities in collaborative efforts to meet and exceed the triple aim of improved health, lower costs, and improved patient experience for all Nebraskans. □



Accountable Care: More Than Just ACOs

by *Tony Sun, MD*
 Market Medical Director,
 UnitedHealthcare – Heartland States
Michael Horn, MD
 Plan Medical Director, UnitedHealthcare
 Community Plans of Nebraska and Iowa;
 Past President, NMA

Our nation's health care system is at a pivotal point as we continue to see significant gaps in care quality, patient experience, and affordability. Nebraska faces challenges in improving access to quality care and managing costs, requiring thoughtful, practical solutions to expand access and strengthen care, and lower costs as well.

Central to addressing these gaps is the concept of “accountable care,” which is a departure from the traditional health care model of rewarding volume of care to rewarding quality of care and positive health outcomes. By achieving the Institute for Healthcare Improvement’s “triple aim” – increased patient satisfaction, improved population health, and reduced health care costs – the goal is to move the delivery system toward increased collaboration within the health care community, with a greater emphasis on shared risk and accountability for improved health outcomes.

UnitedHealthcare has been pioneering payment reform models for three decades. Our successes, as well as challenges, have led us to create a stepped approach to accountable care programs that feature a range of shared accountability and financial risk between our health plan and our network of care providers.

Accountable Care for All

Today, more than \$30 billion of UnitedHealthcare’s reimbursements to hospitals, physicians, and ancillary care are tied to its accountable care initiatives. By the end of 2018, we expect to reach \$65 billion.

What we’ve learned as we have embarked on this care payment transformation is that it cannot be “one-size-fits-all.” UnitedHealthcare’s accountable care approach is unique because we offer a variety of value-based programs so we can customize payment models with care providers and meet them where they are in terms of readiness to move from fee-for-service to value-based contracts. By creating a flexible and localized approach, UnitedHealthcare is able to align its programs with all types of care providers across all benefit plans, including commercial, Medicare, and Medicaid.

Accountable Care Organizations (ACOs) tend to steal the limelight in this space, but we need to acknowledge and embrace a broader definition of accountable care – one that encompasses the spectrum of collaborative models,



Tony Sun, MD



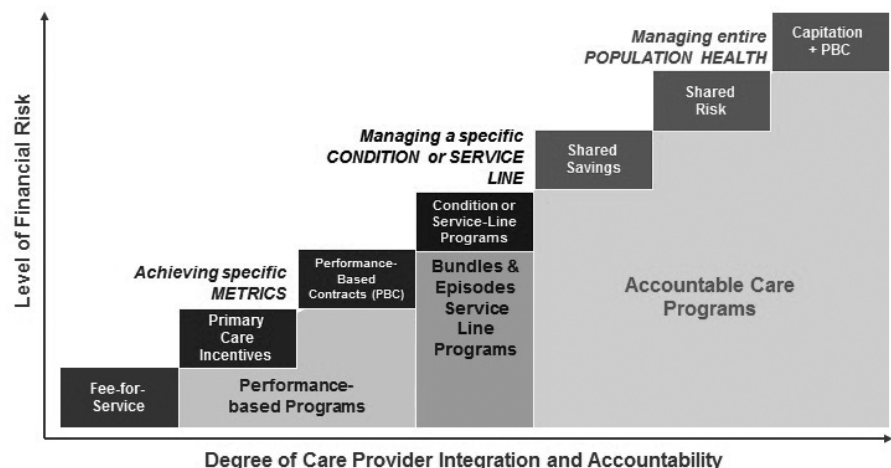
Michael Horn, MD

and illustrates flexibility and customization for our care provider partners.

In Nebraska, UnitedHealthcare has various provider incentive and payment models across our various lines of businesses. More than \$200 million of our reimbursements to care providers are tied to value-based contracts, which equates to more than 20 percent of our medical spend in the market. Examples include:

- *Primary Care Physician Incentives* that provide additional compensation based on quality measures met. We have implemented this with more than 20 clinics/sites statewide.
- *A Shared Savings Program* where savings are shared with physicians based on medical targets and quality measures met. *(continued on Page 15)*

Accountable Care Platform | Accountability Continuum



Duncan Aviation's Wellness Program's Success Leads to Growth, New Additions

by Marika Brack
Wellness Coordinator, Duncan Aviation

At Duncan Aviation, we have a vision of a healthy and productive workforce. Simply put, a successful company takes great care of their most valuable asset.



Our best asset is our workforce, our people, our family. Our results-based employee wellness program is committed to developing a culture of wellness that encourages

healthy lifestyle choices, which benefit our team members, their families and, in turn, the community.

Why Invest in Wellness?

As a self-insured organization, we view wellness as directly aligned with our company's vision of success. By taking care of our employees who take care of our customers, we're investing in the bottom line while benefitting our family.

In 1999, our senior team decided to start the Duncan Aviation wellness program, which was formalized in 2002.

As of 2013, nearly all of our team members participate in the wellness program in one way or another. Whether employees take advantage of the on-site gym, lunchroom fruit program or health club reimbursement, they're living healthier lives.

How Our Wellness Program Works

Each year, in order to be eligible for health insurance, it is mandatory that

our team members complete an annual biometric screening and online Health Risk Assessment.

Employees earn scores from 1-100 total points based on tobacco use, BMI, blood pressure, cholesterol, and blood glucose. We reward individuals who take advantage of our wellness program and maintain a healthy lifestyle outside of work.

Team members with a score of 85 or more receive a 20 percent discount on insurance premiums. If they received 75 to 84 points, they receive a 10 percent discount. Team members report that this incentive has given them the extra push to start a new wellness routine.

Wellness Benefits

In addition to the previously mentioned benefits, employees receive the following wellness benefits, free of charge:

- Tobacco Free Workplace
- Tobacco Cessation Reimbursement or On-site Cessation Classes
- 24-hour access to onsite fitness facility fully equipped with cardio, weights, and fitness classes
- Health Club Reimbursement
- Healthy vending options
- Quarterly wellness education presentations presented by Wellness Coordinator
- Annual Wellness Fair
- Health and Wellness coaching
- Continuum wellness, counseling, legal, financial, work and life services
- Free flu shots

Wellness Changes

The program continues to evolve

and in August of last year we opened Duncan Aviation Family Health. The onsite center is staffed with a Physician Assistant and Medical Assistant and is free to employees. The center's mission is to inspire patients to lead healthier lives through preventative and health coaching services. In addition, the center can treat simple acute cases. The program includes a patient health portal which gives patient access to their health histories (including biometric results) and the option to schedule appointments online.

The clinic advises patients to have a primary care doctor as it is not intended to take the place of that relationship. While we encourage the employees to utilize the health center and all the wonderful benefits, we also remind them that this is an additional resource meant to be used alongside their family physician. As the current medical environment shifts from pure fee-for-services to an emphasis on outcomes, Duncan Aviation Family Health's focus on preventive services complements primary care physicians' concentration on health results.

For acute care, Duncan Aviation Family Health is just a short walk for most team members instead of a drive across town. Team members say they are more likely to go to the center when they first start experiencing symptoms instead of waiting it out. This allows for early treatment before the illness progresses saving Duncan Aviation and the employee time, as well as money. In addition, appointments at the center are scheduled in 30 minute blocks

(continued on Page 14)

Implementing Value-Based Health Care Delivery in Nebraska *(continued)*

coaches or nutritionists. For multi-location practices, this kind of patient and caregiver grouping is even easier. As teams work together to deliver care, they become more effective and more efficient in delivering care.

Teams organized around the needs of medically similar patients can more easily deliver comprehensive solutions for those patients' needs. Particularly in the context of lifestyle-driven chronic conditions, convenient solutions are essential to enable patients to succeed with their health. Many clinicians have found that the presence of a consistent, closely-coordinated team of caregivers allows them more time to focus on their area of expertise and to gain a deeper understanding of the circumstances and challenges that those patients confront.

When care is structured around groups of similar patients over their continuum of needs, it is dramatically easier to measure the health outcomes of care. Teams can more easily see the outcomes that matter most to enabling patients to achieve better health. Teams that consistently work together also find it easier to measure the outcomes of their care and to learn from those measures. Outcome measurement is a potent tool for improvement, and conversely, the failure to measure outcomes impedes caregivers' ability to improve.

Having outcome measures also makes it far easier to demonstrate superior value creation. When teams can show that their patients recover more fully, their diseases progress more slowly, they miss less work or suffer less

disability, it is far easier to structure payments that align with that value creation. New kinds of partnerships, with employers, health plans, and the government, are far easier to envision and to create when providers measure the results of the care they deliver.

Change is always challenging and changing the structure of care delivery amidst ongoing care for patients is particularly daunting. The Nebraska Medical Association's commitment to value is impressive and inspiring. Its desire to bring organizations together and to support caregivers through meaningful transformation is promising, and experiments across the state are beginning to demonstrate better care, improving health and lowering costs.

“There's a Hole in the Bucket...” *(continued)*

unsuccessful or, even worse, actually add risk to the patients' health.

Physician leadership is critical for this to succeed.

- Physicians need to utilize more cost-effective and fewer low-value options such as those outlined in the American College of Physicians' High Value Care Initiative.
- Education of providers regarding the cost of services we provide – beginning at the student level and continuing throughout their careers. Patients, corporations, insurers, and the government will demand cost-efficiencies and we will need to know how to manage these with the best

interest of the patients in mind.

- Physicians and payers will need to collaborate for this to be successful. Sharing data should be a two way street, results of quality metrics and claims based data if analyzed correctly will have more impact together than separately.
- Development of Accountable Care Organizations (ACO) can facilitate the process of incorporating data into the workflow to increase the value of the services—improving both outcomes and patient satisfaction while containing costs. Utilization of electronic records at the clinic level and inclusion of

patient satisfaction as a key measure in value are important differentiators from the prior HMO model.

Improving health care for our patients will be a team effort, but physician input is essential for the transformation to occur. Our role as stewards to protect and provide care to our patients is ingrained as to who we are and why we chose this profession. Our patients need us now more than ever. Let's stop the leak and preserve health care for future generations.

1) Kuehn, B. Guidelines, Online Training Aim to Teach Physicians to Weigh Costs of Care, Become Better Stewards of Medical Resources. JAMA. June 04, 2014. doi:10.1001/jama.2014.5756

Achieving the Triple Aim with a Physician-Lead Accountable Care Organization *(continued)*

tells me yet another story about how their care coordination efforts have helped prevent a hospitalization, an unnecessary ER visit, or they received a hug of thanks from a patient they helped through a disjointed health system.”

The core component of the theory behind value-based health care purchasing is that outcomes get better and cost goes down. So far, we have found that starting with a focus on quality improvement and care coordination leads to lower costs by preventing

complications. We think the core mistake of the managed care approach in the 1990s is that they started with cost first, and then thought about quality second. We are convinced the quality comes first and then the savings follow.

Value-Based Health Care and Your Practice *(continued)*

Start by benchmarking against yourself.

QUALITY – What is quality? What are appropriate outcomes? Where do I find effective clinical protocols or pathways? Good questions. As we have worked on a national level with developing merged organizations and clinically integrated networks in different specialties, we discovered the information is sparse. The ANSWER is you need to develop your own quality measures (3 to 5 per specialty). Yes, your specialty society has some measures, CMS has a few cursory measures, and there may be a few other resources, however, depending on your specialty, you will need to develop all or some of your own measures.

1. **QUALITY** – Begin developing 3 to 5 quality measures for each specialty or subspecialty in your practice. Set annual goals.

- a. Initially report and benchmark against the other physicians in your practice.
- b. Seek other benchmarks. Consider a network.
- c. Inquire of your major payors what quality measures they are tracking and your comparative performance
- d. Each year obtain your QRUR reports from CMS and use your results to improve performance and to improve your reporting mechanisms.

2. **COST** – There are internal costs (cost to produce the service) and external cost (what you cost the purchaser of care). Develop tools to measure internal costs and measure and benchmark external cost.

- a. Develop an internal cost accounting system so that you know your cost to provide each service for future contracting.
- b. Obtain comparative cost per episode of care or diagnosis from your payors and develop strategies to improve your cost effectiveness

3. **RELATIONSHIPS** – Develop your strategy for alignment and relationships that will help assure your continued success.

Metrics that Matter *(continued)*

decision making on an individual and aggregate population level.

Individual Level

At the personal level, I have performed an informal inspection of my practice. I believe I am successful. Referrals are solid. I work hard on behalf of my patients. Most of the patients feel better. They bring in baked goods, jams, and write letters. I really appreciate those kind expressions. Like most, however, I am not systematically or scientifically measuring results.

What We Need

In the new era of “value-based health care,” we should accurately define “quality” from a patient perspective.

We should understand and appreciate the costs of care through the entire cycle of care. We should access useful data to inform our practices and continually improve.

We need a few focused metrics that matter concentrating on the essence of value for the patient.

To be relevant in the next iteration of the medical market, physicians and health care providers, hospitals, and systems must define and then demonstrate value and make it transparent. Rather than flying by the “seat of the pants,” we will need a few real-time flight indicators to assess where we are, where we are going, and what control-input changes need to be made. We need to collaboratively build this

capacity and capability together.

Where to begin? Pick a few simple questions around clinical effectiveness (both objectively observed and patient’s subjective perspective) in your specialty area. Concentrate on a recurring clinical “hot spot” of controversy that has high cost and variable results. Define the primary question. Collect data during the normal clinic work-flows. Measure. Use the data to inform programmatic change. Consider cost through the care continuum. Ultimately, make the results known for the patient to use to inform their decisions.

It is time to learn to fly using data, metrics that matter. Then, we will really get closer to the arriving at true “value-based health care.”

Duncan Aviation’s Wellness Program’s Success Leads to Growth, New Additions *(continued)*

ensuring that the team member has adequate time to talk about any health issues or concerns.

Wellness Collaborations

We know that having the support from our employee’s family doctor or physicians who are managing diseases is essential. We hope medical professionals encourage our team members to take

advantage and utilize the wellness program they have right here at work.

With the employee or patient in mind, the wellness team at Duncan Aviation feels that it is important to offer many different alternatives and opportunities in order to reach the vast majority of our population.

Whether it is a one-on-one consultation with the Wellness Coordinator or

completing a Comprehensive Health Review with our PA, our team members are welcome to take advantage of whatever avenue they prefer and are comfortable with. We believe that offering many options gives employees more opportunities to learn to live a healthy lifestyle.

Accountable Care: More Than Just ACOs *(continued)*

- *Performance-based contracts* with fee schedule escalators that are tied to efficiency and quality metrics.
- *Full-risk contracts* where care providers have upside and downside risk.

In 2013, UnitedHealthcare signed an agreement that was facilitated by Senators Mike Gloor and John Wightman and is intended to help reform the delivery of health care services in order to improve Nebraskans' overall health, promote an improved consumer experience, and control costs through evidence-based, comprehensive care.

UnitedHealthcare is also working on identifying ways to work with physicians to improve adherence to nationally recognized and evidence-based care guidelines, and reduce utilization of services that are considered to be of questionable value or may adversely

affect patient safety and cost of care.

Health plans can play an important role in helping patients make more informed decisions around both the quality and cost of health care services. For example, our UnitedHealth Premium® designation program, available in 41 states including Nebraska, recognizes physicians who meet or exceed quality of care and cost-efficiency standards. The program uses national industry, evidence-based and medical specialty society standards to evaluate physicians across 25 specialties to advance safe, timely, effective, efficient, equitable, and patient-centered care.

Transforming Care – today and in the future

The shift toward increased collaboration, outcome-based payment and new benefit design is transforming how we pay for health care and how health care

is delivered. This type of collaboration begins with health insurers and care providers, but results in better health outcomes for patients and lower costs. The system works by offering care providers tools to help identify best practices for overall patient wellness and disease management, and measure their own performance in these areas over time. In return, insurers provide financial incentives based on meaningful improvements in specific categories such as readmission rates, disease management and prevention, patient safety, and appropriate care utilization.

UnitedHealthcare has worked with physicians and health care providers for more than 30 years to manage the diverse needs of consumers. We look forward to enhancing and strengthening our relationships with care providers in Nebraska and working together to achieve the “triple aim.” □



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The Importance of Non-Tax Considerations in Estate Planning

by Ross Polking

Provided by the Foster Group

Too often, estate planning has been dominated by tax issues. With the recently increased exemption amounts, fewer families will have to write a check to Uncle Sam upon the passing of a loved one. However, challenges still exist that are not focused on mitigating taxes.

Avoiding Probate.

Probate is the court-supervised process of transferring property from a decedent's estate to the named heirs. Much has been made of the "need" to avoid probate under the theory that the process is expensive, time-consuming, and public, meaning otherwise private information becomes part of the public record. Those with real estate in multiple states may find it very advantageous to avoid multiple probate proceedings.

To avoid probate, a collection of will substitutes are available including trusts, joint ownership, Transfer on Death registration, and beneficiary designations. Make sure all assets are registered somehow in one of these forms. Also, make sure to coordinate these will substitutes and map out which assets are intended to go where. It is all too common to have people diligently list their wishes in a trust or will, yet have assets end up elsewhere by virtue of joint ownership or outdated beneficiary designations.

Durable Powers of Attorney, Healthcare Power of Attorney and Living Will.

Most estate planning practitioners will prepare ancillary documents for their clients. A durable power of attorney grants another person the authority to make financial decisions on your behalf. A health care power of attorney similarly gives another person authority on medical decisions. The living will or health care advance directive allows an individual to provide a written set of instructions specifying which, if any, medical treatments or care they want should they later be unable to make such decisions because of illness or incapacity.

Special Needs Trusts.

In certain circumstances, special needs trusts are needed to assist beneficiaries who face disabilities. Some of these trusts are designed to assist with personal planning needs such as helping with investment or spending decisions, and some are created to improve the quality of a person's life without disqualifying the beneficiary from receiving governmental benefits.

Diminished Capacity.

Executing a will or trust and most any financial transaction require a person be legally competent. Dementia is estimated to affect 1.5% of Americans age 65-69, and nearly half of the seniors in their nineties.¹ Varying legal standards of competency exist for

different acts (e.g., marriage, executing a contract, or implementing a will). It is often difficult to define when a person clearly moves from competent to incompetent. Sometimes, as mental capacity diminishes, people become more susceptible to influence. Proactive planning can help ensure a person's wishes are carried out throughout this struggle.

Asset Protection.

Protecting assets with well-designed trusts is especially important for medical professionals. The liability within this vocation is high, and advanced strategic planning is critical to ensure assets are not unjustly taken.

Bottom line, do not delay. Surround yourself with a team of professionals that can ask you good questions, help you determine what's most important, and then assist with the implementation of a solid plan. Stay diversified.

1) Robert B. Fleming, "Dealing with the Aging Client", presentation at Heckerling Institute January 2014.

The information and material provided in this article is for informational purposes and is intended to be educational in nature. We recommend that individuals consult with a professional advisor familiar with their particular situation for advice concerning specific investment, accounting, tax, and legal matters before taking any action. □

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