WHITEPAPER

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The High-Performing Physician Network 1.0

athenahealth

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A national faith-based health system with headquarters in Chicago; an orthopedic group in San Antonio; a cardiology practice in Mississippi. These organizations are different in almost every way but one: they all excel at operational and financial performance. In recent years, the healthcare industry has searched for organizations that can serve as national models for turning traditionally hard-to-lead physician groups into high-performing networks. Often, these efforts focus on the same group of well-known, highly-touted health systems—the established celebrities of the industry. But, as our research reveals, high performance comes in all shapes and sizes and appears in unexpected places.

How do we know? Over the last year, athenahealth has worked with research partner Dr. Leonard Schlesinger, Baker Foundation Professor at Harvard Business School, to develop a preliminary framework for how to improve clinical and financial performance by drawing from an unparalleled data set and established lessons from other service industries. The athenahealth data set is the digital by-product of providing electronic health records, billing, population health and other services to healthcare providers on a single, shared network. The database consists of more than 80,000 providers—57,000 of them physicians —practicing in a wide range of locations and specialties nationwide.

This national, standardized source of data enabled athenahealth and Schlesinger to use a "moneyball" approach. Much as the Oakland A's of the early 2000s used hard statistics to identify undiscovered stars on the rosters of Major League Baseball teams, athenahealth used quantitative screens rather than reputation to flag top-performing physician networks. We could therefore look beyond well-known industry players to find organizations that have outperformed—whether recognized or not—across a set of financial and operational metrics. In this way, we've identified hidden bright spots in American healthcare, and documented what makes them excel (see Sidebar: About the Research).

About the Research

To discover the essence of high-performing physician networks, we began with quantitative work. We focused on 39,000 physicians practicing in thousands of locations, rolling up to 363 parent organizations of all specialty mixes and sizes (six to several thousand physicians). We identified a set of core business metrics that serve as proxies for these organizations' financial health. These fell into five areas:

- **Productivity—**how many work RVUs providers manage for each full day of work.
- **Commercial collections per work RVU**, which implicitly measures both how effectively a practice collects what it is owed and how successfully it can negotiate higher rates from insurers. We excluded Medicare and Medicaid since those rates are essentially dictated to providers.
- **Days in accounts receivable (DAR),** a common measure of cash flow and revenue timeliness.
- **Patient pay yield,** or the proportion of what patients owe that a practice manages to collect. This is a significant—and for many specialties, a quickly growing—portion of practice revenue.
- **Growth.** We looked at same-store growth by department, an indicator of organic growth. Our metric gives credit for adding a doctor to a practice location, or improving revenue by adding ancillaries in the same location. However, we excluded growth that comes from acquiring practices wholesale.

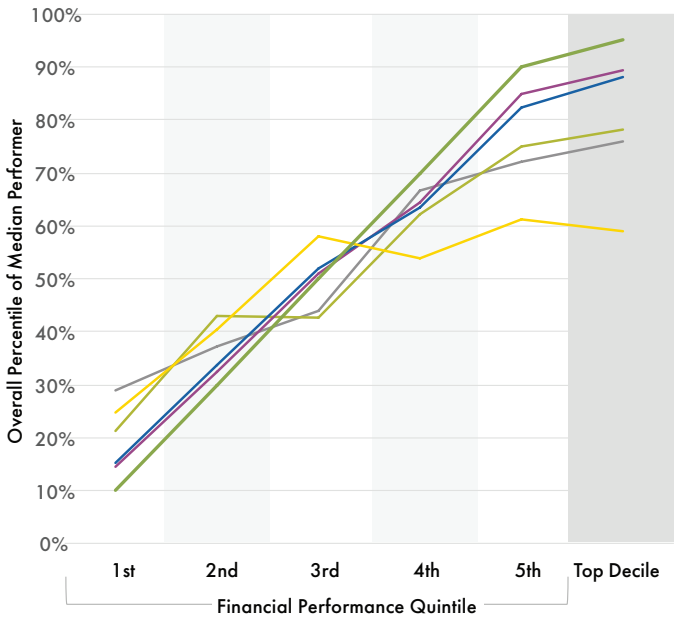
These metrics focus on fee-for-service performance. This is still the world most of our practices operate in, but we believe many of these metrics will translate to a value-based environment; productivity, better rates and shorter DAR are important under any reimbursement. What's more, we believe nearly all physician organizations aspire to perform better on this set of metrics. Our next round of research will be designed to incorporate additional metrics that better capture performance under risk-based financial contracts.

After we identified the top performers on athena's network, we then tested a wide range of variables, ultimately identifying seven that correlate most consistently with overall financial performance. Three were staff performance metrics: **Patient full registration**, **charge-entry lag** and **time-of-service collections**. One, **physician turnover rate**, suggests doctors' on-the-job satisfaction. The final three serve as proxies for patient engagement, satisfaction and access: **portal adoption**, **patient retention** and the **availability of open appointments**.

As we develop our framework, we'll be adding metrics for quality and patient experience. We'll also be refining and manipulating additional variables to tell a deeper story—about which combinations of factors are worth focusing on to drive improvements in business, clinical and service quality performance.

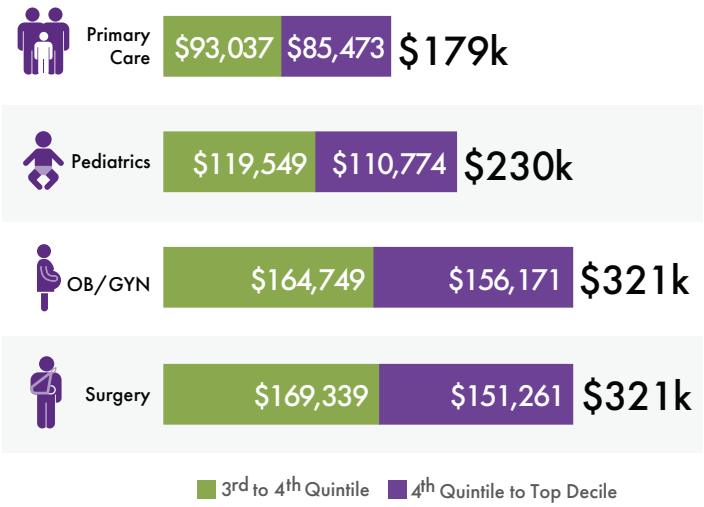
Over the course of the past year researchers then conducted extensive interviews with executives and physicians whose performance placed them in the top ten percent of all groups in the athenahealth data set. The interviews surfaced best practices across three categories: leadership, operational effectiveness and patient engagement. Schlesinger noticed that these best practices appeared to be consistent with a management theory he and colleagues first articulated 25 years ago after studying a broad sample of outstanding service organization across multiple industries: the Service-Profit Chain. In service organizations from traditional retail ventures to healthcare organizations, employee satisfaction, customer engagement and profit are linked in a virtuous reinforcing cycle that ultimate leads to higher profits and financial outcomes. Excellence breeds excellence. Working with athenahealth's research team, Schlesinger has begun to update and adapt the Service-Profit Chain for the healthcare industry—what is emerging is a unique managerial framework for improving performance.

Figure 1. Average Percentile Performance on Financial Metrics By Overall Financial Performance Score



What is the potential payoff of adopting the lessons of athenahealth's top performers? Ranking athena's clients according to their percentile rank in business outcomes suggest that improvements in performance will be rewarded by considerable financial gains (see Figure 1). For example, an organization that moves from the 3rd to the 4th quintile of performers can expect an extra $93,000 in annual revenue for each primary care doctor, $120,000 for each pediatric physician and $169,000 a year per general surgeon. Going from "average" to "great" by jumping from the 3rd to the top quintile drives significant benefits: around $180,000 a year for each primary care doctor.

Figure 2. Incremental Annual Revenue per Physician Associated with Quintile Improvement



Assuming athenaNet average payer mix and reimbursement rates (excluding self-pay). Revenue improvements from improved commercial rates, greater all-payer productivity and patient collections and reduced receivables.

Healthcare leaders should aim high. Athenahealth's top performers were often good (if not great) at all metrics, holding top spots across multiple business indicators. While seeking broad excellence across business dimensions may sound intuitive, in our experience most senior executives often think in terms of trade-offs—their primary duty of setting strategy, after all, requires choosing where to play and how to win. But athenahealth's top performers show that these kinds of trade-offs are not required when it comes to operations. Our high-performing organizations may all choose widely different strategies—they may target different markets or geographies, for example, or choose to focus their services on specific medical specialties—but when it comes to implementing those strategies they achieve excellence across multiple dimensions, such as patient service, clinical quality and efficiency.

Putting the Service-Profit Chain to Work in Healthcare

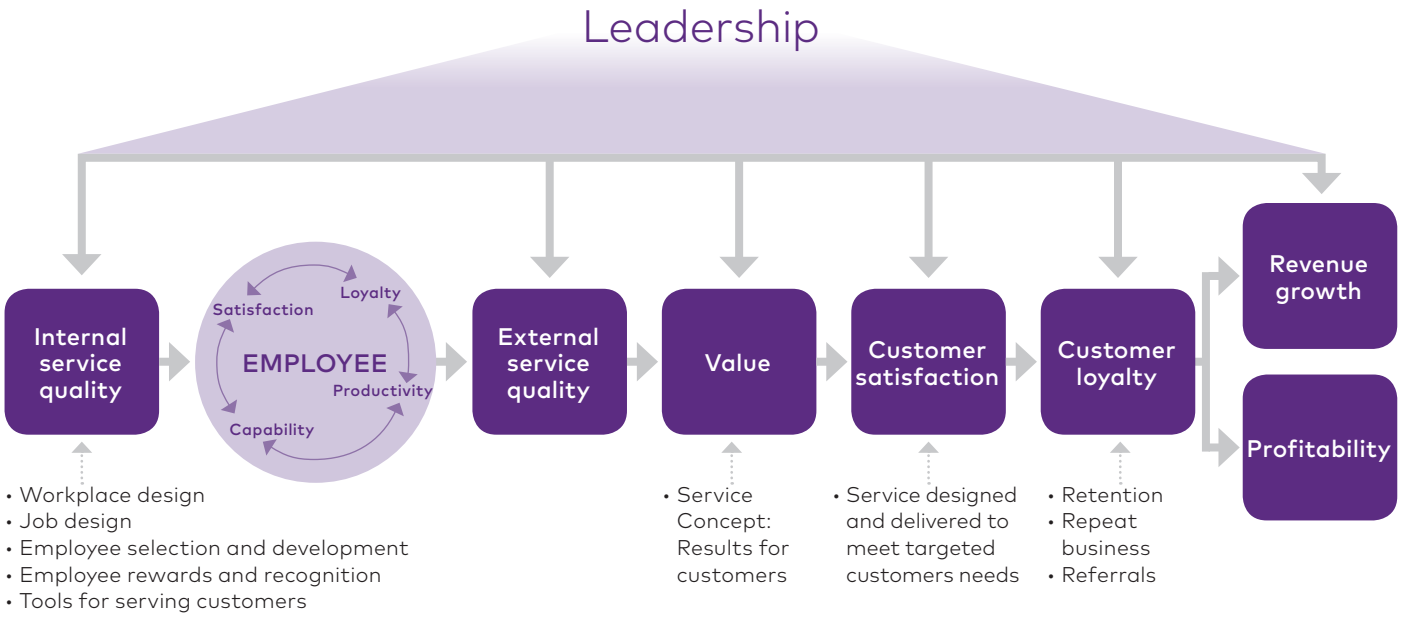
In 1951, Kurt Lewin, a psychologist at the University of Michigan and a pioneer in the study of organizations, wrote that "there is nothing as practical as a good theory." In the view of Lewin and subsequent management scholars, understanding what drives high performance is a prerequisite for achieving or sustaining it. Indeed, healthcare leaders in the U.S. have only recently discovered the importance of holistic approaches to organizational improvement such as Six Sigma, Kaizen and the Baldridge framework. Is there a similar framework that could help explain how to improve clinical and financial performance simultaneously?

As Schlesinger looked through the athenahealth data set, he realized that the service-profit chain management framework could explain the superior performance of athena's strongest clients, and thus provide a helpful roadmap for improvement. That framework, developed in the 1990s, is the most widely researched and cited empirical framework in service management. It has been tested in a broad array of industries, including in healthcare-related settings such as hospitals and home care.

The classic version of the service-profit chain works as follows: *profitability* (the ultimate goal of all companies) is driven primarily by *customer loyalty*. In many service industries, Schlesinger found that a 5% increase in customer loyalty could translate into a 25% increase in profits. For customers, loyalty is a by-product of satisfaction, which is created by providing *external service value*. Value cannot exist without *employee productivity*, which is the result of *employee loyalty and satisfaction*. Employees are satisfied when they are equipped with the skills and power to serve customers—what Schlesinger terms *internal service quality*.

To be fully applicable to healthcare, however, the classic service-profit chain framework needed to be adjusted in two key ways: First, it had to be updated to account for the essential role played by information technology (such as cloud computing) and the resulting "network effect" it enables among physicians, staff and patients.[1] Second, it needed to be adapted to account for unique aspects of today's healthcare landscape (for instance, distortions to market dynamics caused by the changing involvement of government as a regulator, payer and provider). Below is the healthcare-specific framework for the "High-Performing Physician Network" (abbreviated from here as HPPN) that has emerged from this work.

Figure 3. The Service-Profit Chain



1 A "network effect" refers to the fact that the value of participating in a network increases with the number of people on the network. The classic example is a social networking site. The more people who use the site, the more valuable the site is to each user.

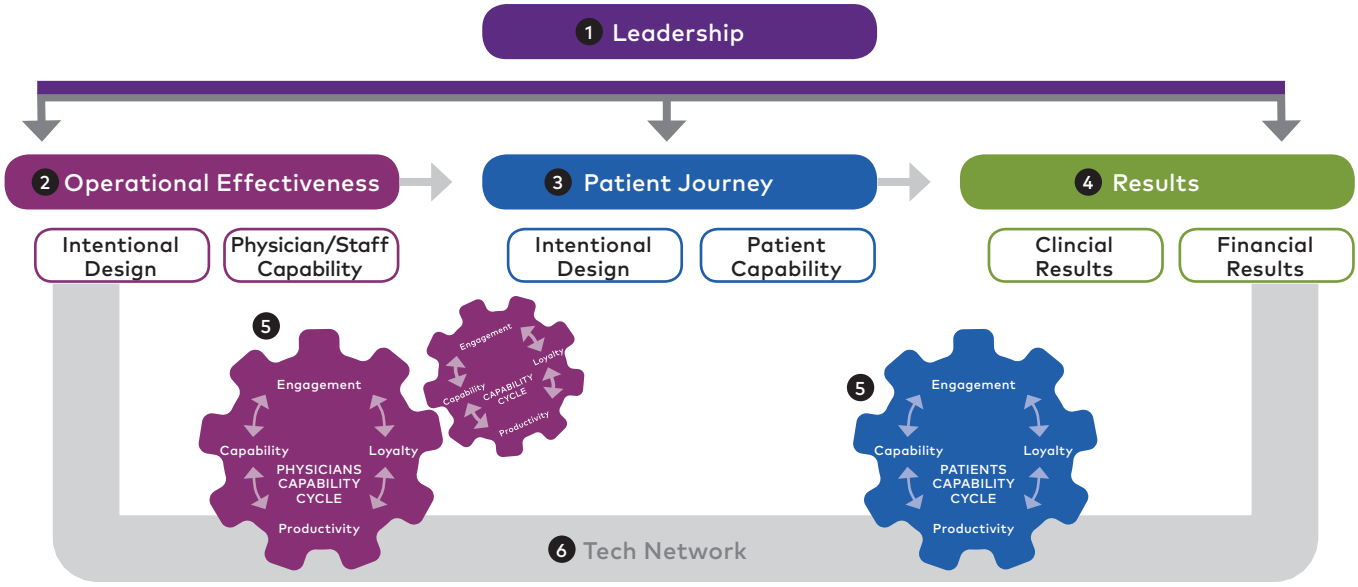
Let's look at the HPPN framework (Figure 2) in exactly the same way as the classic service-profit chain. Here's how it works: Physician and staff engagement, satisfaction and productivity all improve when **Operational Effectiveness (2)** improves in the healthcare delivery system. Thoughtful, intentional design of the operational activities empowers physicians and staff with skills and direction to serve patients at the top of their license or training. Engaging patients across their entire **Patient Journey (3)** to be part of their own care team—in the same way that organizations engage physicians and staff—fuels customer loyalty, adherence to protocol and productivity. Higher productivity across physicians, staff and patients drives **greater measurable value (4)**—both clinical and financial results—which can be invested back into the organization to start the cycle anew. The high-performing network is overseen and powerfully charged by **Leadership (1)**, and undergirded by a **Technology Network (6)** that allows for seamless coordination of care across the continuum while supporting physicians and staff to better meet the needs of their patients.

The framework reveals a fundamental truth: healthcare, like any service industry, is about engaging and inspiring people so that they can perform at their best, and so in turn engage and inspire each other. To foster this virtuous **cycle of capability (5)** for physicians, staff and patients, leaders must put in place the enabling conditions for successful job execution. This means designing the jobs of physicians and staff in such a way that they can answer the following question enthusiastically: "To what extent do you believe you are capable of serving the needs of your patients?"

For patients, developing capability is more complex, but it is based on the view that patients have their own job to do. Patients perform a great deal of "unpaid work" in service of their own care. They chase referrals, manage medications, do physical therapy, drive to the pharmacy to pick up their medication and are often the main point of information flow between their doctors. To build patient capability, healthcare leaders must intentionally design the job of the patient, just as they design the jobs of physicians and staff. This requires the careful and conscious construction of the patient experience to promote engagement (which, as we argue later, goes beyond traditional patient satisfaction measures). It also requires the underlying support of networked technology, which has the potential to remove work at every point in the patient journey.

The HPPN links all of healthcare's main actors together in a reinforcing chain of engagement. Patient engagement goes up when patients feel loyalty to their providers, understand the role they must play in their own care and are given the technology and other tools required to do it. Engaged physicians and staff provide a better patient experience. Satisfied patients inspire physicians and staff in a reinforcing cycle. The end result is better financial and clinical outcomes.

Figure 4. The High-Performing Physician Network Framework



2 The Epocrates survey measured engagement by asking participants to score their level of agreement with three statements:

1. My organization inspires me to go above and beyond what is required
2. I am very likely to be working for my current organization 3 years from now
3. I would recommend my organization to a friend or relative to receive care

To be considered engaged, respondents had to assign a 6 (on a 6-point scale) to at least 2, and no lower than a 5 to the third.

Leadership plays a critical role in driving performance.

The management scholar John Kotter was the first to identify the strong distinction between management and leadership: while management focuses on coping with complexity by bringing order and predictability to organizations, true leadership helps organizations cope with rapid change by setting direction and motivating staff to follow. In today's turbulent healthcare landscape, effective leadership is a critical driver of physician and staff engagement while serving as a bulwark against burnout. Indeed, in our model *leadership* sits above the HPPN framework where it calibrates and drives all the interconnected gears in the chain. Primarily, strong leadership ensures that jobs are designed in such a way that ensures physicians and staffs are engaged and motivated in their work.

How crucial is this motivation? In athenahealth's 2016 Physician Engagement and Leadership Index—a survey of more than 2,000 physicians on the Epocrates app—73% of the physicians who gave top scores for both physician and non-physician leadership reported being engaged at work, compared to 20% engagement overall.[2] Granted, the U.S. workforce on the whole has relatively low levels of engagement—some polls put it at just 30%. But even compared to disengaged counterparts in other industries, doctors appear to be particularly unhappy in their working lives.

Among athenahealth's high-performing physician networks, **effective leadership begins with a galvanizing vision**. We define this as a clear and compelling value proposition for patients and providers, supported by an inspiring purpose. This may sound easy in an industry with such a laser focus on improving the health of its customers, but most healthcare organizations fail at this foundational leadership challenge. In the survey, less than a quarter of physicians indicated that their organization's vision is clear and well communicated while only 14% find the vision to be personally inspiring.

No single vision is appropriate for every organization. Some have a mission of helping the poorest and sickest; some are focused on organizing integrated delivery systems to address the cost and quality of care for defined populations; some are focused on building the best places to work or allowing their providers to be entrepreneurial. Many faith-based health systems focus on helping indigent patients. New England Baptist motivates its physicians and staff around the goal of becoming the best in the region in orthopedics. Privia Medical Group describes itself as "population health technology company that partners with top doctors to keep people healthy." These visions from high performers on the athenahealth network are varied but their purpose is the same: to ensure that major strategic decisions align with the organization's deeper ambitions; to motivate staff and providers to do their best work; and to enhance and sustain the culture of these groups as they grow. Leaders at these diverse organizations also share an ability to effectively communicate their

Key attributes of High-Performance Physician Networks

Leadership

- Galvanizing vision
- Physician voice in leadership
- Principled growth orientation
- Hiring for fit
- Defined accountability structures

Operational Effectiveness

- Performance improvement resources
- Radical transparency
- Autonomy against clearly defined performance goals
- Strategic incentives
- Sustainable physician job design

Patient Journey

- Focus on total patient experience
- Rapid access standards
- Multi-channel patient connections
- Effective processes for closing care gaps

vision so that it infuses everything that their organizations do.

Who constitutes leadership within the organization is equally important. Top performers tend to have **physicians within their leadership**. This finding aligned with results from the Epocrates survey: physicians who describe themselves as working for non-physician-led organizations are 75% less likely to be engaged than peers who say they are in physician-led organizations. Among physician-owned groups, engagement is significantly higher than the average—32%, compared to 20%. For health system-owned medical groups only 17% of the medical staff reported feeling engaged at work.

Top performers identify and develop physician leaders who generally remain clinically active and are distributed throughout the organization. Those organizations that do not have physicians in their senior leadership can overcome this handicap by embedding physician leaders at all levels below the executive suite. Some top performers employ a dyad model, in which regions or practices are led jointly by a physician and a non-clinical administrator. This arrangement empowers physicians to advance the organization's mission, work closely with providers and set the group's long-term course. The administrator in each dyad has operational expertise to scope and execute on this vision. The dyad model recognizes that few individuals possess clinical knowledge, credibility with providers and implementation ability, but that pairs of leaders can check all of these boxes.

Another means of ensuring that physicians and staff feel empowered to serve their patients is by maintaining a **principled growth orientation**. Common wisdom supports the notion that healthcare networks can achieve economies of scale through increased procurement and pricing power and lower administrative costs. Athenahealth's analysis, however, suggests that chasing size for its own sake is generally not a path to excellence—clear operational diseconomies of scale can counterbalance the economic gains of consolidation and growth. For example, large enterprises in athenahealth's client base have a lower same-store growth rate—a strong indication that enterprise growth is often being fueled purely by acquisition without the creation of economic value at the operating unit level.

Recognizing the M&A can be a drain on productivity, top performers do not grow for growth's sake—they do so only when new physicians and practices fit into a broader strategy and do not compromise culture or threaten to burden the organization with complexity. For example, Summit Medical Group, a 550+ physician group in New Jersey, has been growing at a steady clip of around 75 physicians a year. Yet Summit's leaders take a highly disciplined approach to acquisitions—they commit to walking away from any practice that does not fit culturally, no matter how attractive the synergies or revenue growth appear on paper. These lessons did not come easily. "We grew very quickly and hurt ourselves," Summit's Chief of Operations Karen Graham recounts. "We weren't getting the quality of staff we wanted at the rate we were growing, so we changed the recruitment process." The group now has a "template for growth"—a defined due-diligence process for evaluating potential acquisitions and an onboarding team that helps get these groups up to speed after they join Summit.

Summit has become expert at post-merger integration: onboarding teams will spend 2-3 weeks on site after a new practice joins Summit, then generally takes 6-12 months helping practices ramp up to speed.

"The biggest challenge is maintaining a small-group feel, and so we make it a priority to maintain a connection between leadership and the distributed practices and among the physicians themselves, even as they grow," says Graham.

In much the same way, top performers focus on **hiring for fit**. They recognize that new providers and staff can change group culture in unwanted ways, and the best approach to promoting the right culture is to hire the right people from the start. That often means passing up on renowned specialists or researchers in favor of grooming and teaching newly hired providers. Research from Harvard Business School that tracked top performers across a range of industries found that high fliers were often blazing successes for a while but quickly faded out—often with great damage to their new organization. In medicine, a field that values reputation and credentials particularly highly, it can take courage to pass on superstars for the sake of cultural cohesion.

The hiring practices at The San Antonio Orthopaedic Group, one of athenahealth's top performers, are particularly exemplary. The group, like many high-performing orthopedic groups, has a strong focus on productivity, financial performance and other "hard" metrics for evaluating staff. Potential physician recruits are given targets for expected productivity and revenue numbers. Yet even in this results-based recruiting model, the group places its primary emphasis on cultural fit. Candidates meet with many providers and staff during a day-long interview process—and all the providers and most of the staff have veto power over even the most financially promising candidate. The result is that only around one of eight candidates interviewed ends up being offered a job. But the group is happy to remain picky. "We're always thinking about fit," Chris Kean, the group's COO explains. "If the candidate starts asking about how we're going to bring them their patients, it's usually a sign that they won't do well. They have to be self-starters. They have to be ones that can get out there and find their own referral sources. The group's going to give them the tools, but they need to build their own success."

Finally, among top performers, an individual is often assigned to "own" each important business and clinical goal for his or her organization. It is the leader's job to clearly articulate these **defined accountability structures**. Apple uses the term "direct responsible individual," or DRI, to describe this organizational approach; a more common moniker is project management officer. But the idea is the same—for each important goal, the buck stops with a dedicated senior leader.

One five-state health network appointed a DRI to address what had been an intractable problem: collecting financial obligations directly from patients, who are responsible for a greater proportion of total costs than in the past but are often unable or unwilling to pay their share. The health network's leaders focused their efforts on the time-of-service, when practice staff members can explain financial expectations and collect payments in person, and designated a DRI—the network's revenue cycle

director—for driving improvement. A year ago, when this initiative began, the organization collected 15% of patient obligations at the time of service. Their goal was to double those collections by the end of 2016.

The goal was ambitious. And for the revenue cycle director in charge, whose merit pay is based primarily on her execution against this goal, the personal stakes were significant. But the organization empowered the DRI to promote real improvements. She set aggressive but achievable goals for each market, identifing key opportunities for improvement by sharing data—down to the level of the individual front desk clerk—to encourage friendly competition and pinpoint areas for re-training. In the year since, the organization has improved time-of-service collections by nearly 60%.

Intentional design of jobs and culture drives operational effectiveness.

Leadership is crucial to engaging employees. But inspiration is not a panacea for physician or staff burnout. Operational effectiveness depends on employees that feel their jobs are meaningful, clear and achievable in scope, and that they are enabled with the tools and conditions they need to execute effectively. Continuous improvement is their goal. This understanding of employee engagement builds on seminal research by the management scholars J. Richard Hackman and Greg Oldham, who identified five core job features as motivational: skill variety, task identity (in the sense of understanding when a project has been completed and its outcome), task significance, autonomy and feedback.

Top performers seem to have internalized this insight. For example, they **provide ample performance-improvement resources to staff**. Top performers have very high expectations of their employees, but they understand that their job is not just to hold employees accountable but to enable their success—to provide the resources to help providers and staff understand and improve their performance.

For example, if time-of-service collections are lacking, scripting might be given to the front desk staff; a dedicated financial counselor might be hired to handle challenging patient accounts; or a digital check-in system may be provided to relieve the front-desk's workload. Larger networks undertake internal "bright spotting" to find effective practices and processes developed by a particular office or staff member—and then standardize and share these approaches across their networks. Large networks may also have dedicated internal consultants who can work with low-performing groups (or even high-performing groups, to help them do even better).

The management teams at top-performing organizations understand that none of the essential features of a motivating job can be achieved without **radical data transparency**. That means, first, reaching consensus over what to measure; second, agreeing on a process to gather and report these measurements; and third, building a culture of sharing and openness among physicians and staff. Most organizations generally only share group averages or blinded data. By contrast, top-performing groups share unblinded performance data, and encourage the exchange of best (and worst) practices.

For average or low performers, radical data transparency taps into the natural competitiveness of physicians. Sharing unblinded data also addresses a common refrain heard among doctors—that they or their patients are fundamentally different, and therefore their data is not comparable to others. If providers know who the top and bottom performers are, they have additional context for the numbers. They may recognize that the top performer is actually working more efficiently, or delegates more to mid-level clinicians; often the reason for variability has nothing to do with differing demographics of patient panels.

Full transparency is not without risk. Top groups are very clear about why they share data, how they select the indicators they will track, and how they are used—they work hard to avoid the perception that radical transparency is a "name and shame" exercise. Cardiology Associates of Northern Mississippi, a 20-doctor group, holds monthly physician meetings for the group's leadership to share full, unblinded data on physician productivity. The group does not explicitly tie physician compensation to productivity, but they achieve extremely high rates of productivity because of what they describe as a healthy element of competition—nobody wants to be the bottom performer. Physicians decide among themselves what the right target should be and how to help low-productivity physicians do better. Management is constantly attuned to their obligations for helping low performers thrive. For instance, if one physician has low productivity because he's traveling between offices every day, management will look at consolidating his schedule, or they'll look at having physicians do all of their procedures on one day and follow-up on another.

Indeed, the top performers identified by athenahealth are generally prescriptive in terms of setting expectations for staff—but they do not manage by dictate. Instead, they provide staff the **autonomy to execute against goals**. Physicians and most staff are encouraged to improvise and problem-solve. The management knows that patients are gained and lost at the front line of the business, not in executive suites. Schlesinger's research into the service-profit chain showed that satisfied customers lead to satisfied employees and vice versa—the best way to engage physicians and staff is to let them feel they are serving their patients well. Underperformers are the exception to the hands-off approach—they are provided with training, oversight and in extreme cases redeployed to new tasks or let go if they are unable to meet expectations.

None of this is to minimize the importance of compensation. But top performers favor **targeted incentives** that don't simply reward productivity but rather engage staff on a variety of goals. In general, these top performers set incentive models that support broader improvement efforts; are supported by physicians and staff; offer variable compensation with a meaningful percentage of pay tied to incentives; reward the teams and individuals that have the biggest

impact on improvements; and are reevaluated regularly and adjusted as priorities change or new challenges emerge.

All of the workplace-quality measures discussed above should reduce the risk of physician and staff burnout—an increasingly troubling phenomenon facing many healthcare organizations. For many physicians the workload can be unsustainable, the administrative work burdensome, and the impact on personal well-being damaging over the long term. According to athenahealth's 2016 Physician Engagement and Leadership Index, overall physician engagement stands at 20%—lower than engagement across other industries. Engagement for female physicians is even lower (the figure for men is 22%). Medical group leaders therefore have an important obligation to address well-being in their own clinicians first and foremost.

To that end, top performers focus on **designing providers' roles to prevent burnout**. They understand that doing so is a business imperative: our data shows that the least overwhelmed physicians are often the most productive. For instance, Adventist Health System, a large, faith-based system in Florida with more than 130 hospitals, employs a VP of Medical Mission who is in charge of physician wellness. He oversees a system that provides numerous opportunities for informal discussions among physicians about burnout—including regular lunches where the issue is raised. "I'm sure this program has saved careers, not to mention marriages and even lives," he says.

He adds: "We've learned through our own surveys that it's not the day-to-day clinical work that burns doctors out. Generally, they love to do what they were trained to do and are willing to get up in the middle of the night and go in on the weekends to do it. It's the two hours at the end of the day doing the documentation and the regulatory work and the bureaucratic overlay that just crushes the physicians' spirit."

Adventist regularly solicits feedback on physician workload—through surveys and an annual Conference on the Mission where physicians can talk about how well they're doing on their mission as caregivers and where there are impediments that need to be removed. Managers look for creative ways to redesign physician workflow to relieve the burden of administrative work and allow physicians to spend more time working at the top of their license.

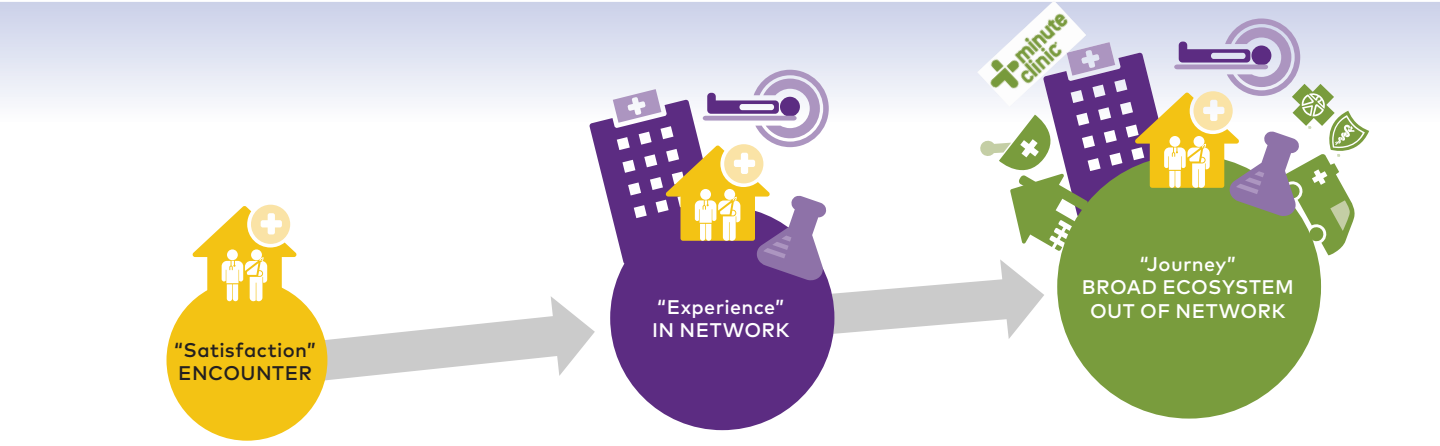
High performers are also designing the job of the patient.

An axiom in management is that managers should treat customers like employees—by, for instance, training them to become familiar with their brand and treating them as part of the brand "family." Nowhere is this more important than healthcare, where patients have direct influence over their own health. That is what makes the patient experience so important. A positive experience fosters engaged patients who enthusiastically team up with the clinical staff, which in turn makes the work of staff more rewarding and impactful. It is a virtuous, reinforcing cycle.

Athenahealth's top performers are starting to find out the impacts of intentionally designing the roles of patients. These top perfomers do two things differently. They commit to understanding and improving upon the patient experience, moving well beyond superficial patient-satisfaction surveys. And, over time, they begin to move beyond a transactional, episodic view of the patient's experience and beyond their own networks.

In other words, they are beginning to shift to focus on the total patient journey. Physician groups have historically measured "satisfaction" by looking at how positively patients feel about discrete encounters. While relevant, this falls woefully short of what needs to be measured. Current

Figure 5. From the Patient Encounter to the Patient Journey



Touch Points
"Moments of Truth" associated with individual encounter interactions between patients and their healthcare provider.

"The sum of interactions"—
institution-specific—shaped by the organizations culture that influence patient perceptions along the continuum in *one network*.

Expands concept of patients' experience to include all interactions
across the broader ecosystem of care, thus influencing patient perceptions and capability.

best practice looks at the "patient experience," which is the sum total of all of the institution-specific touch points, inside any given network. The "patient journey" expands the concept of patient experience to include all interactions across the broader ecosystem of care, thus influencing both patient perceptions and capability wherever they receive care.

While athenahealth's top performers, like most healthcare systems, are only beginning to understand and manage the patient experience and journey, they have identified several stand-alone dimensions of the patient experience that can enhance their patients' satisfaction and loyalty. An often underappreciated loyalty driver is **rapid access for patients**. Allowing patients to quickly see a provider is a key part of the patient experience and is important for clinical outcomes as well. Sick patients need to be able to see a provider before they get sicker and costlier. What's more, rapid access provides a competitive advantage—right now, many healthcare organizations fall short in this area, creating opportunity for new disruptive players such as retail and urgent-care clinics that give patients the ability to be seen quickly and at the patient's convenience. As one leading executive put it, "we are moving from an ethos of 'the doctor will see you now,' to 'the patient will see you now.' It's a huge shift."

Summit Medical Group, for example, built a centralized call center with patient navigators who help patients make an appointment when they need to, even if it's not the patient's primary care physician. This call center has visibility into appointment availability so Summit can adjust staffing by location as necessary. Since many physicians are reluctant to relinquish control of their calendars, Summit has provided financial incentives to expand access: physicians whose patients report an easy time finding appointments can earn up to 20% more in compensation if they do well on that and other patient experience metrics. The group's leadership reports on this patient experience data each month so underperforming providers can adjust course.

Athenahealth's high performers are taking other steps to improve access. While some have centralized scheduling so patients can schedule across multiple providers and locations, others are offering open-access hours, and some are even reimagining access through virtual encounters so patients don't need to come in at all. Still others are partnering with retail clinics or building their own convenient care centers. These groups believe that access to clinicians is important enough to justify considerable investments in process redesign, staffing, technology and even brick-and-mortar facilities.

Another measure that top performers use to improve the patient journey is **multi-channel patient connections**. These innovators recognize that the traditional way providers and patients interact—through scheduled visits and by phone—is outdated. Instead, top groups are looking to take a page out of retail by leveraging more channels to engage patients—via mobile health, SMS texting, virtual visits, secure messaging on a patient portal, remote monitoring and more.

HealthPartners, a 1,700-physician health system in Minnesota with an insurance arm (not an athenahealth client), is fundamentally rethinking how and where patients interact with providers. The organization has emphasized that patients can "call, click, or come in" for care. Standard office visits are still an option but so too are urgent-care centers affiliated with HealthPartners. And for tech-savvy or time-constrained patients, HealthPartners built an online clinic called Virtuwell, which is staffed by nurse practitioners who are available at all times to treat more than 60 non-acute conditions such as conjunctivitis and sinus infections (with options for prescriptions in many cases). These virtual visits cost $45 each, more than $100 less than the price of an equivalent office visit. Patients have voted with their wallets: Virtuwell has provided more than 200,000 patient consults since its inception in 2010.

HealthPartners is unusual not just for the breadth of options they provide patients, but for their focus on maintaining a coherent patient experience across these settings. HealthPartners nurses are available through the group's CareLine and Nurse Navigator programs to help patients navigate their options consult on home treatment options or answer questions about a patient's medications. Increasing the channels available to patients generally means imposing more work on patients—but a thoughtfully designed, carefully implemented system can provide a patient journey that is convenient and coherent.

Recognizing that the patient experience in healthcare too often feels fragmented, athena's top performers all have in place **effective processes for closing care gaps**. Many patients experience fragmented care; athena's top performers recognize this problem as potentially undermining both patient satisfaction and clinical quality. As a result, they take an expansive view of the care experience and create systems for both detecting and addressing gaps in care. These gaps could range from service breakdowns—such as factors that make it difficult to schedule a visit—to clinical issues, such as patients who are out of compliance with screening guidelines. Gaps are reported on regularly and systematic approaches are in put in place to ensure they are addressed.

Community Care of West Virginia (CCWC), a 14-location, federally-qualified health center in the rural Appalachians, regularly reviews its performance on clinical metrics. Medical director and physicians found that some clinic locations were underperforming on mammograms and diabetic retinopathy screenings. They looked first to the providers in these underperforming clinics to make sure patients indicated for these screenings were referred for them. But they found that this wasn't a provider problem—the providers were referring patients for these screenings, but patients didn't follow through on them.

Some groups might have given up at that point—it is difficult to influence the decision patients make when they leave the physician's office, and the physicians seemed to be doing the right thing. After some investigation, the group's medical director discovered that the

real impediment was logistics. He told athenahealth's researchers, "these are rural communities, and if you don't think you have breast cancer, driving to the city to get a mammogram is a tough sell." So CCWV got creative. They collaborated with the University of West Virginia to bring mobile screening units for diabetic retinopathy and mammograms to underperforming clinics, so that patients receive their screenings in their own communities. They move them around from office to office based on where they identify the most need. This approach is working. "People are much more likely to show up when the mobile unit is at the clinic," the medical director tells us, and the data bears that out: some of the underperforming clinics are now seeing screening rates 20 percentage points higher than before—and staff have been inspired and engaged by the results. It's an example of how top performers can find creative approaches to bring the right care to the right patients, which in turn enhances the patient experience, which in turn leads to more engaged and satisfied physicians and staff.

Support the patient through network-enabled technology.

While patients have a job to do, they must not be asked to shoulder the burden of their responsibilities unsupported. Technology is the key enabler of the patient's success, providing the information, visibility and feedback they need to do their jobs. What does this look like? As part of its research and development efforts around population health management, athenahealth has begun the work of mapping out a series of patient journeys tied to distinct patient types. The goal is to understand all the key points of engagement that are needed in order to support the patient before, during and between visits. Naturally, the patient journey looks very different for a healthy 28-year-old from the way it does to a 55-year-old smoker with diabetes and hypertension. But both have jobs to do that can only be done effectively with the support of surrounding technology.

For example, data aggregated from a multitude of sources—from electronic health records to insurance data—can be used to paint a complete picture of the patient. Smart scheduling systems and patient portals help patients access care on-demand. Reminders via text and other modes help the patient arrive on time and prepared. Open data exchange allows personal health information to travel from one provider or encounter to the next so the patient isn't playing courier. For high-risk patients, wearable devices and care management apps help them stay compliant and connected to care teams.

Technology can't do the patient's job for them. They still need to embrace behavior change and take accountability for their own care. But it can make their job easier to do, stack the odds in their favor and make the hard work of convalescence or health maintenance more satisfying and rewarding.

The best practices identified among athenahealth's top performers are consistent with the operating principles of the high-performing physician network (HPPN) model. They focus on the front line of care, and their effect is to drive satisfaction and engagement among physicians, staff and customers in a virtuous cycle. The San Antonio Orthopaedic Group's commitment to hire for attitude and fit and train for skills; Adventist's understanding that the best buffer against physician burnout is not reducing hours or workload but freeing physicians to spend more interrupted time caring for patients; Privia's rigorous commitment to unblinded performance metrics tied to continuous physician and staff improvement; Summit's focus on maintaining a principled growth orientation that doesn't fray its cultural fabric; HealthPartners provision of tools to help patients connect with their clinicians when and how they wish; athenahealth's emerging population health technologies: these all reinforce the cycle of satisfaction, engagement and loyalty that is fundamental to achieving a high-performing physician network.

We view this research as an ongoing process as we work with athenahealth clients and others to refine and expand on our initial findings. As payment models shift, we will focus our our evolving research on clinical outcomes and better understanding patient and physician capability cycles. For instance, we will be working with a number of clients to link patient satisfaction and patient engagement to overall business performance. What aspects of the patient capability cycle correlate most tightly to overall performance? Another question we will be exploring is how the level of physician and staff engagement affect overall operational and business performance.

As we address these and other questions, we will also be developing a methodology for identifying excellence at population health management. To do this, we will be pursuing the indicators that best reflect a medical group's ability to manage the health of its patient panel—for example, specialty costs, ED admissions for ambulatory sensitive indicators, readmissions rates and so on. We will use these indicators in the same way that we used financial metrics in this first phase of research—to find the objective bright spots in athenahealth's database, and share out their best practices and management secrets.

We see this research as part of an ongoing analytic partnership between athenahealth and its clients. The ultimate goal is an increasingly rigorous, nuanced model of physician performance—encompassing the experiences of physician, staff, and patient, and tied to both clinical and financial outcomes. This model and our ongoing learning will, in turn, inform our reporting capabilities and inform our reporting capabilities, product design and how we serve our clients. If we are successful in the long run, we will form a holistic view of healthcare delivery that surpasses any model available to practitioners and leaders today. Our journey of discovery is ongoing.

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