

Clinical Integration Self-Assessment Tool v.2.0

By

Alice G. Gosfield, JD

and

James L. Reinertsen, MD

Alice G. Gosfield, J.D.
Alice G. Gosfield and Associates, P.C.
2309 Delancey Place
Philadelphia PA 19103
(P) 215-735-2384
(F) 215-735-4778
agosfield@gosfield.com
www.gosfield.com

James L. Reinertsen, M.D.
The Reinertsen Group
375 East Aspen Meadow Lane
Alta, Wyoming 83414
(P) 307-353-2294
(F) 307-353-2293
jim@reinertsen.com
www.reinertsen.com

Clinical Integration Self-Assessment Tool

Context and Use

This document is a Clinical Integration Self-Assessment Tool which we hope helps disparate parties who are positioning themselves for the coming environment. Whether in a single medical group, among now hospital-employed physicians, or, alternatively, through the organized medical staff or a separately coalescing accountable care organization (ACO) of some stripe, the attributes of clinical integration have elements in common.

This self-assessment follows on many of the ideas we set forth both in *õInformed Consent to The Ties that Bindö* [<http://uft-a.com/PDF/InformedConsent.pdf>] and our white paper *õAchieving Clinical Integration with Highly Engaged Physiciansö* [<http://uft-a.com/PDF/ACI-fnl-11-29.pdf>]. Following the *õFour Fø Frameworkö*, which we expounded there, the self-assessment groups our 15 attributes of clinical integration around the Four Fø.

The **green** language follows issues relevant within a single medical group or hospital-employed physician model. The **purple** language is oriented around the organized medical staff and/or a newly developing ACO of any type. Please note we are not talking exclusively about the Medicare Shared Savings Program Accountable Care Organizations in the Health Reform legislation. Although we have expressed some skepticism about how that will unfold, we do believe that the move towards all healthcare providers becoming accountable, transparent, patient-centric, safe, and with clinical processes standardized to the evidence-base, are mandates starting immediately. In order to improve quality and deliver value with contained costs, clinical integration is essential.

The descriptions in the grid of what changing entities might experience with regard to each of the attributes are simply examples of ways in which we think physicians coming together to do this work might be more or less organized. We do not believe that the descriptions indicate phases that are a necessary evolution. These are simply descriptors of more or less evolved programs. To the far right are descriptions of more organized and integrated organizations.

As we have begun using this in the field, we have come to understand that while all of the attributes are in some way relevant to coalescing and integrating physician environments, they will, of necessity, have to be modified for certain settings. For example, we have found that academic medical centers have very different problems with respect to internal compensation models. Public hospitals and public health clinics are constrained by direct government budgetary contexts and defined resources. Nonetheless, even these types of programs have found the document useful.

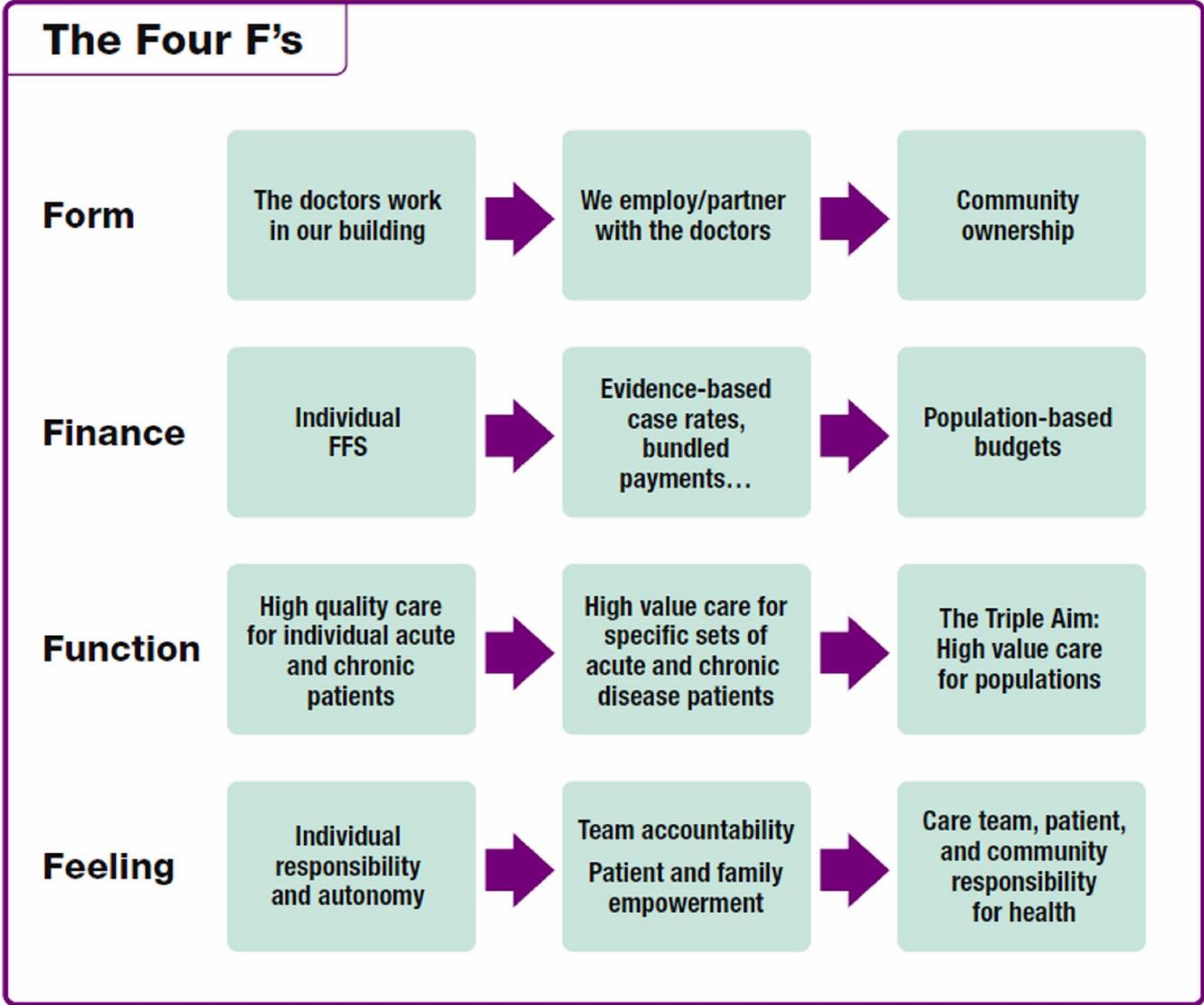
We think its greatest utility comes in sharing it among colleagues to both measure a starting point on the fifteen attributes discussed, as well as to stimulate conversation about what the idealized version of what a truly clinically integrated entity would encompass.

We hope to refine the tool over time and would welcome comments with respect to its application, potential additions or deletions, or comments on how it has worked in defined settings.

To reset the context for its use, we are including here, first, the *Four Føö* framework and then the Clinical Integration Self-Assessment Tool.

We look forward to your comments to us at info@uft-a.com.

Alice G. Gosfield, JD
James L. Reinertsen, MD
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Clinical Integration Assessment Tool

| | | Not Really in the Game | Making an Effort | Committed and Capable |
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| FUNCTION Structure and Purpose | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We're a group in name only. No apparent shared purpose other than limiting overhead. No interest in changing anything. "A medical arts building". Individual physician autonomy is paramount. | Many of us feel we're ready to be a real group practice, but there are plenty of dissenters who want to be left alone, and we don't seem to be able to deal with them | Stable organization with clearly stated, shared purpose. It's understood by everyone who joins that they're expected to practice as a group, not just as an individual. "A real group practice" |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | Medical staff in general has no idea what the hospital/ACO's vision for quality and value is, and what it requires of them. The doctors simply signed up for the ACO because everyone else did, and no investment was required. This is about "Me." | The doctors understand the need to work collaboratively to improve quality in the ACO, but are skeptical about reducing costs. And there is no history of working well across in/outpatient practices on anything. | The medical staff knows and embraces the vision of the hospital/ACO for quality and value, is engaged in making it happen, and has a track record of some successes working across diverse practices and settings. There is a strong sense that this is about "Us," not about "Me." |
| FUNCTION Governance and Leadership | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | It's not clear how decisions are made. In fact, they're made by a few powerful doctors who have their own personal interests in mind. Leadership is suspect, and not valued. | The board discusses a lot, but decides very little. If we do decide, we often revisit decisions. Implementation is patchy. Leadership is tolerated, but not valued. | Big decisions, including major strategic and cultural changes, are openly processed. Once made, decisions are implemented effectively. Leadership is trusted and valued. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | There have been "no confidence" in management votes in the medical staff, terminations of senior leadership in the organization and upheavals in management. | The medical staff is split between those who value independence and those who want hospital employment for security. The ACO/hospital management is trying to stay neutral and neither side trusts them. There is some question about the strategic direction of the organization. | There is a high degree of confidence in management and leadership. There is active communication among the medical staff, management and the board, and clear sense of direction. |

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| FUNCTION Leadership and Followership | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | The five doctors who founded the group control everything and keep the financial transactions of the group secret. The younger physicians really have no idea about what decisions are made and how. They think there are secret deals somewhere. | We have sent some of our physicians to some outside educational programs about the business of medicine. Someone mentioned succession planning once. We are beginning to share some of the details of the group's finances. | We expect all of our staff to be aware of the challenges to the practice and participate actively in learning about how to meet the challenges. We have a clear plan for leadership development. Everyone knows about all the financial transactions of the practice. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | Individual rights have historically been paramount in credentialing, privileging and all other decisions, and that appears to continue in the ACO. Eight physicians on the staff get called on to do everything. The rest of us just keep our heads down and ignore them. | The MEC functions well for the inpatient staff but there isn't much engagement among the broad membership of the medical staff. The MEC doesn't appear to have any way to govern what we do in our office practices. We no longer have more than one staff meeting a year. | Our medical staff leaders actively engage with the membership on issues important to traditional inpatient care, as well as new ACO issues such as readmissions and chronic disease coordination. Interest and participation in meetings to manage all of this has been rekindled, and attendance is high. |

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| FINANCE Business Model : Volume, Throughput, Efficiency, Value | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | 100% of our business is FFS. The group makes money by generating RVUs and reducing overhead. | 40-60% of our business is FFS. We are schizophrenic. Our CFO doesn't know whether to laugh or cry when we have a busy month in the OR, or imaging. We have one P4P program for doctors but it hasn't motivated people much. | More than 60% of our payments are "value" driven (bundled payment, case rates, episode of care, capitation, and other shared incentives for quality and cost). |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | Both the hospital and the doctors make money from generating volume, particularly in lucrative services. Each entity keeps its prices secret from the others. Our main joint purpose is to negotiate higher rates from payors. | We have a Center of Excellence with some quality incentives with our biggest payor. Otherwise, we have had a little pay for performance, but not much else. Essentially, we still make money on volume, but we're dabbling with some experiments on value-based payment. | We are primarily focused on value-based payments and have multiple programs where the ACO's/hospital's success and the physicians' success are bound together financially and clinically. |
| FINANCE Compensation: Salary, Productivity, Value | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | Pure FFS productivity. No relationship to practice costs or quality, special deals for some physicians. Each is his own cost center. All arrangements are secret. | FFS productivity, with <5% bonus for quality scores (e.g. a small stipend for a year) and other individual performance. The metrics for the bonus are known. | Market-based salary, with more than 10% bonus for living the values of the group, and achievement of group goals. Everyone knows what everyone gets paid. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | Physician comp is each practice's business; there is no connection to our larger joint organizational work. | We have had conversations at the "steering committee" for the hospital/physician organization about aligning compensation methods across all the independent practices, but there is a lot of tension about this. | Even though we are all independent practices and entities, we have reached agreement in principle that we will align compensation methods across all practices with the external payment model for our hospital/physician organization. |

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| FINANCE Financial Relationships with Others | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We own our own endoscopy suites, clinical lab and high end imaging. We openly compete with the hospital. We had a joint venture with them which was a disaster. We have hostile relationships with our managed care plans which never pay us enough. | We had a good recent experience in negotiating with the hospital and our biggest payor over a center for excellence model for one of our specialties which will require us to work more closely with them to produce better scores. We are beginning to think that the hospital might be able to help us measure our value so we can be more effective in our negotiations. | We are actively engaged in contracts which require us to clinically collaborate with the hospital in order to be able to get better payments from the plans. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | There is a strong residue of distrust from previous failed joint ventures between various doctors and the hospital. Our history of managed care contracting in the PHO was a nightmare. Now, it appears that our primary purpose in contracting together is to get higher rates for physician services, without any change in what physicians actually do. | We are working with cardiology, oncology and orthopedics to develop co-management arrangements that will facilitate more bonuses for better performance from our two largest payors. We have purchased the diagnostics of some of the practices in the community. | The physicians and the hospital are significant business-wise. We don't do anything without open consultation with each other, and we have a good track record of collaborating from a business perspective on joint ventures, co-management agreements, and other strategies. |

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| OPERATIONS Standardization: Guidelines and Protocols | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | Each doctor does his own thing. Any standing order sets etc. are for each individual doctor. | We formally adopted some practice-wide protocols but only a few enthusiasts actually use them. | We have standardized whatever is standardizable. We are all measured on and expected to follow the protocols that we've adopted. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We don't evaluate physicians for their economic performance, nor do we require standardization for privileging or participation. | A few clinics and practices have adopted guidelines and some standing order sets, but they are not an expectation of all physicians on the medical staff. | Standardization is an expectation of all physicians, is taken into account in credentialing and privileging and those who cannot conform or actively resist have their privileges and/or ACO contracts terminated. |
| OPERATIONS Standardization: Referrals and Care Coordination | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | Our doctors refer wherever they wish. We have no knowledge of how well this is working, from either a quality or cost standpoint. Why should we? This is the health plans' problem. | It's understood that most referrals go to certain specialists and agencies, but this is based on longstanding relationships, habits, and subjective impressions - not on any data on the performance of those referral providers. We have no formal agreements with anyone. | We actively manage a preferred list of doctors, SNFs, home health and other agencies to which we refer, based on measured performance on both quality and cost. We actively share performance data with these referral providers, and they have a stake in our bundled payments and other value-based performance contracts. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | The physicians in the ACO are free-range chickens and refer wherever they want. We can't really control that. | We have a list of preferred physicians to whom our ACO physicians are supposed to refer, but it's not mandatory. (The "preferred" doctors take call here and that's why they're "preferred." We have no actual data on their quality or cost.) | As an integrated organization we require that our employed physicians and those with services agreements with us (e.g., co-management) refer to our specified list of providers, which is developed based on specific performance criteria for quality and cost. |

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| OPERATIONS Standardization: Relationships with Referral Sources | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We accept referrals from people and agencies we don't know and send form reports to them with no further follow-up or communication | We are beginning to talk more with our referral sources, including primary care physicians, visiting nurses, and social service agencies, and are thinking it might be useful to know how they are scoring in the quality initiatives in town. | We are actively engaged with our referral sources, meeting with them, using common practice guidelines, clinically collaborating in the treatment of patients in the community, and sharing quality and performance data. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We take referrals from anyone. We don't actively engage with primary care physicians who don't come to the hospital anymore since they use the hospitalists to manage their patients when they are here. | We have begun to engage around clinical issues (e.g., readmissions) with physicians in the region, but this is primarily focused around the negative financial impact we'll suffer if we don't get this under control. | We are actively engaged with community physicians who participate in our care design/coordination committees. Some of these physicians have begun to participate in our ACO payment relationships as well. |
| OPERATIONS Standardization: EMR and Documentation | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We have 2 or 3 warring camps of doctors. Some want one EMR system, some want another, and a third group doesn't want anything. So we have nothing. | We have piloted a potentially practice-wide EMR in primary care and it seems to have gone well. We are in discussions about extending it to specialties but there is a lot of resistance, and capital is short. | It is a requirement of participation that all clinicians (including referral providers) use our e-health record and templates for documentation and measurement. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | Our first attempt at CPOE was a nightmare. As a result, the physicians are not very receptive to this and the EMR we have doesn't lend itself easily to physician documentation. | We have found a new EMR vendor and have a modified CPOE program which we are rolling out carefully over some time, but we think it will be at least a year before everyone is using it effectively. | We have had EMR and CPOE in place for a couple of years now and everyone is on board. We are now moving to expand the capacity of these programs to provide more meaningful data that will permit us to manage more effectively to produce better value. |

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| OPERATIONS Standardization: Medical Home Implementation | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | Our primary care physicians manage their chronic disease patients using their best efforts. We have no registries or staff specifically to support these PCPs in improving coordination of care. Why would we add this overhead? We're already losing over \$100,000 on each doctor. | We are looking more at how we can keep our chronic patients out of the hospital through chronic care guidelines and training of our office assistants e.g. we call the patients to follow up on weight control and drug regimens. We are trying to track the effectiveness of this but don't have any evidence that it helps. | We use patient registries and patient navigators. We focus intensely on keeping patients out of the ER and the hospital, using high-risk clinics and other evidence-based methods. We have achieved Level III NCQA certification as a Patient-centered Medical Home. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | Medical home (PCMH) is something primary care physicians do in their offices to get more reimbursement. We don't see what this has to do with specialty care, or with the hospital. | We are beginning to understand that if medical homes succeed, we will see far fewer admissions, but patients will be healthier. We think it is better if we get involved with our primary care physicians to help them with this. For example, we are training NPs and PAs in the Wagner chronic care model and will lease them to the primaries in the community. | We are actively supporting PCMH models throughout our network. We help our primary care physicians, even those whom we do not employ, to become accredited. We are beginning to deploy the PCMH principles to interactions among primary physicians and specialties which address complex chronic patients including hematology-oncology, endocrinology, rheumatology and infectious disease. |

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| OPERATIONS Standardization: Capacity Control (See also Feelings: Value as Value, p.15) | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | <p>Our physicians like to be on the cutting edge with new technologies. Wherever possible, we buy and use the latest imaging and other technologies, because they increase our group's revenues. We wonder if some of our doctors are over-utilizers, but we don't have any data on this.</p> | <p>Because of RAC audits on medical necessity, we document very carefully. We are beginning to track utilization patterns of our doctors, but take no action. We rarely say "no" to a new technology, especially if we or our physicians can bill for it.</p> | <p>We make our decisions on new technology based on "best value for patients" rather than "highest revenue opportunity for us." This includes our recruitment decisions as well; we don't bring in doctors who appear to be major drivers of overuse of technical procedures that are lucrative for them, but of little added value to our patients.</p> |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | <p>We acquire technologies to keep our physicians happy and increase our revenues. We will buy the expensive diagnostics the cardiologists can't bill for anymore, even though the higher co-pays are bankrupting our patients. We haven't found a titanium implant or other new technology we don't like. If we build it, they will come.</p> | <p>We've started to be concerned about the technology use of some of our medical staff, especially in their offices. Our concern is partly about our cost profile to purchasers, but it's also about internal competition. With what's in the hospital plus our physicians' offices, we have more MRI capacity than most small nations. We know that's a problem, but are struggling to do anything about it.</p> | <p>We've revised our recruitment and capital planning processes with the explicit aim of controlling the capacity of overused services in our community. For example have actually said "No" to the acquisition of a urology practice that wished to continue office radiation therapy. We have sent a clear signal that members of the ACO must clear it with the ACO board before acquiring expensive new technologies.</p> |

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| OPERATIONS Measurement and Transparency | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We measure individual doctors' productivity, but nothing else. We don't have a common medical record—paper or electronic. Each specialty keeps its own record, which no one else sees. So each specialty has a "private," unmeasured, unmonitored, practice. | We have started to measure quality, service, and efficiency for a few departments, as a pilot. If it goes well, we will expand it. There is a lot of concern about whether the data are accurate, and relevant. But we believe we'll need to do this at some point, so we'd better get started. | We have a common clinical record, shared across all providers who are part of any patient's care team, whether they're in our group or not. Performance data for the whole group (productivity, quality scores, customer satisfaction) is shared with patients and the public, and is a major driver of improvement. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We do traditional credentialing and privileging and take incident reports in the physician's file into account in reappointment, but we are really only focused on egregious quality outliers. | We have begun to engage in more systematic measurement of known problems to take into account in privileging and quality initiatives. The physicians have been a little skeptical but there hasn't been any outright mutiny and some think it is actually improving care. | We use explicit measures that are known and publicized and that all the physicians understand are a predicate for their continued participation with us. We not only measure quality in terms of patient satisfaction and conformity with the evidence-base and our programs, we also measure value, efficiency and overuse. |

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| FEELING Culture and Values: Teamwork | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We have no stated expectations for professional team behavior. There are a number of jerks in the practice but they're technically OK and productive, so we tolerate them, as long as there are no actual physical assaults. | Teamwork is a stated value, and clearly described as an expectation in employment agreements, but it really isn't translated into action or systems e.g. recruiting criteria, regular performance feedback, or compensation. | Teamwork is a stated value. We specifically recruit for teamwork and respectful professional behavior. Jerks are not tolerated, regardless of how technically proficient or productive they are. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We have a disruptive physician policy, but only physicians who actively throw things in the OR have ever been disciplined. We talk about teamwork, but the nurses aren't very happy about the physician-centric culture here. | Some departments have run team-building projects, and in those instances there was higher employee satisfaction and better quality results overall, but we don't require this on an enterprise-wide basis. | We have formally organized teams with shared accountability and organizational responsibility across the enterprise. We evaluate physicians for their continued participation with us based on how well they work in teams. |
| FEELING Culture and Values: Non-physicians | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | We don't use mid-level providers because the doctors don't want to "give up" the 15% more Medicare pays them for the same work and commercial payors don't recognize what the mid-levels anyway. | We are beginning to deploy mid-level personnel in an organized way, with common expectations regarding the tasks they can perform and that they will be used. They are a shared expense to the whole group. | Our mid-level practitioners are fully engaged as part of the "team" with sufficient standardization that all practitioners, including the physicians, are engaged at their highest and best use. We actively use the mid-level practitioners to enhance the value of the practice's services. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We don't recognize non-physician practitioners (NPPs), no matter how independent under state law, as staff participants. | We permit those physicians who want to, to utilize non-physician practitioners. We do lease some NPs to primary care physicians in the community to help them deliver better chronic care. | With the influx of insured patients and more Medicaid patients, we expect to utilize NPPs more and more; and our medical staff bylaws and agreements expect physicians to engage with them effectively as members of the clinical care team. |

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| FEELING Culture and Values: Patient-Centeredness | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | This is a medical group. It's designed for the convenience of the doctors, and to reinforce their professional authority. Doctor knows best. | Our group thinks patients can be helpful with design and improvement of care, mainly for marketing purposes. We've discussed the creation of a patient advisory council but we haven't done anything to formalize this idea. | We have an active patient council that has a lot of influence on the design of our care, particularly for coordination of chronic disease care. Patients and families sit on the search committees for leadership positions. Physicians are expected to share informed decision-making with patients and families. Our guiding question is "What would be the right thing to do for our patients?" |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We measure patient satisfaction because it looks good to do so, but we are mostly concerned about risk management and avoiding lawsuits. | We have patient focus groups to help us orient our services from a satisfaction perspective and have had some patients come to a board meeting once or twice to describe their experiences. | Patients are deeply involved in our organization. They sit on the MEC and other committees. They are among our board members. |
| FEELING Culture and Values: Value as a Value | <i>We are either a multi-specialty group practice, or we are hospital-employed physicians</i> | Our job is high quality care, as we define it. Period. Higher quality always costs more. Lowering health care costs is someone else's problem. | Operating costs (overhead) are influenced by how we practice, and we need to reduce overhead to maintain any margin, given ever-shrinking reimbursement. So that sort of "cost reduction" is a business necessity. | We actively manage overuse, both in our group and in our larger referral community. Our job is to deliver the same or higher quality at ever-decreasing overall cost, whether by decreasing overuse, or overhead. |
| | <i>We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO</i> | We are all about "No margin no mission." We are intensely focused on revenues. We like physicians who order our services a lot and the physicians who do the professional components of those services like them, too. | We understand that we are at risk for better value and readmissions and have implemented some new programs with physicians to focus on how to begin to change this, but this is not really a driving force for us. We've heard about "lean" organizations, but we don't really know what that means or how it could help. | We are intensely focused on how we can work with our physicians to create better value in terms of improved quality at the same or lowered costs. We provide actionable data to the physicians on a contemporaneous basis, and then support them in helping us effect meaningful change. This is our mission. |