2017 ANA/AUPN Chair Course Summary and Evaluations

CHALLENGES IN FACULTY COMPENSATION

Faculty:
Robert G. Holloway, MD, MPH,
Professor and Chair of Neurology, University of Rochester Medical Center
Sara Uschold, Chief of Finance and Research, Dept. of Neurology, University of Rochester

José Biller, MD, FACP, FAAN, FANA, FAHA
Professor and Chair of Neurology, Loyola University
Chicago Stritch School of Medicine
Michael Budzynski, Loyola University Chicago Stritch School of Medicine

Course Description:

Salary disparities are increasing between procedural and cognitive subspecialties and between research or education-oriented faculty and predominantly clinical faculty, while traditional salary differences between junior and senior faculty are shrinking. At the same time, funding for faculty salaries is challenged by declining reimbursement for clinical activity, the NIH cap on research salary support, which prevents adequate reimbursement for research effort, the need to compete with salaries offered by the private sector, and the lack of support for educational activity. In this environment, how can chairs effectively cross-subsidize the salaries of research or education-focused faculty? Are salary disparities disruptive to morale, or simply the new normal? How can chairs argue effectively for institutional subsidies and support when other departments face the same challenges? Are there novel revenue sources (philanthropy, concierge medicine, legal consulting, device and pharma industry relationships) that can fill the gaps?

Learning Objectives

1. Understand the various funding resources available to a faculty member within a university setting and identify the internal/external pressures associated with each resource

2. Examine alternative funding for clinical compensation that may not be directly related to RVU (Relative Value Unit) production, but is necessary for the university neurologist to remain competitive with private practices (directorships, committees, call pay, etc.)

3. Develop systems to understand what each neurology patient is worth to the institution in terms of direct patient care and downstream revenue. Understand the total financial picture of a patient presenting to the institution with a neurological condition and track the total financial contribution

4. Related to morale/burn-out, offer non-monetary means for compensation to the university neurologist – protected research/educational days, funding for educational activities/conferences, provide an environment conducive to fostering research activities (bench and clinical trials), etc.

Lecture Summary**:**

Dr. Holloway and Sara Uschold presented the compensation plan at the University of Rochester. UR is a large department with 88 full time faculty and a hospital based clinical program. Faculty spend 62% of effort in clinical activity, 25% in research, 8% teaching and 5 % administration. There was no incentive compensation plan prior to February 2015, when a plan was drafted and task forces were created to determine appropriate RVU targets for subspecialties and non-wRVU targets for incentive rewards for accomplishments in administration, education and research. They developed blended productivity benchmarks for each subspecialty and percent clinical effort, with tiers for E&M intensive specialties and procedure-based specialties. Research incentives were formula-based for salary recovery from grants based on % effort, and also included goal based and award-based components. Teaching incentives rewarded teaching awards, new courses/curricula, and educational service on local/regional/national committees, as well as educational grants. Compensation was based on national AAMC benchmarks, and productivity measured against homegrown blended benchmarks based on several surveys (Faculty Practice Solutions Center, MGMA, AAN). Two tiers of practice style, office based (E&M) and procedural based, with blended benchmarks for different amounts of clinical effort. Faculty were eligible for incentive if clinical productivity was > 10% of targeted salary placement AAMC percentile (within a range of -15% to +10% of target), with RVU incentives capped at the 75%ile. The value of incentives gradually increased from 2% in FY16 to 7-10% in FY19, taking the place of base salary raises during those years. The incentive pool was 50% RVU based and 50% based on research, teaching or other accomplishments. Transparency of the process was an important goal, and letters were sent to each faculty member outlining their targets and incentive compensation when targets were met. The major "lessons learned" were 1) Developing a compensation plan takes time and shareholder input, 2) Be prepared to negotiate, 3) Avoid the Heisenberg Uncertainty Principle (i.e. don't keep adjusting against a moving target, since benchmarks will never be exact, 4) Find creative approaches to funding the incentive pool, and 5) "Transparentize".

Dr. Biller and Michael Budzynski reported on the compensation system at Loyola University Medical Center, located in a Chicago suburb with a 547 bed hospital and 25 faculty neurologists, 24 residents and 3 fellows. They noted pressures on traditional compensation schemes due to declining physician reimbursement and research funding, reduced academic base salaries for teaching medical students, and narrowing of networks which reduces access to patients. The disparity between private practice and academic practice is growing, with the 50th Percentile MGMA private practice salary at $286,000 while 50th Percentile AAMC academic practice lags behind, even at the full professor level (Assistant -$215,000; Associate -$240,000; Professor $279,000). A variety of compensation models are possible including Fixed Salary (Academic Salary + Clinical Salary + Administrative/Hospital Support Salary), Productivity Model (Pay based on clinical production –$/RVU) and Academic Productivity Models (Small Academic Base Salary + Clinical Base Salary + RVU/Productivity Incentive). Compensation has moved from collections-based (less Dean's tax) to RVU-based, with teaching funded by clinical revenues, to RVU targets with bonus compensation derived from alternative sources including on-call compensation, Teleneurology, affiliate hospital coverage agreements and revenues from clinical trials. New financial models can determine the net worth of a patient to the hospital, which can be used to bolster arguments that hospitals should provide financial support to Neurology departments. Meeting quality goals for subspecialties can provide additional evidence. Small departments have unique challenges, including "n=1" subspecialties in which a single provider may be in high demand, other neurologists may

need to cover a less familiar specialty, and support and time for research may be limited. Mr Budzynski noted that financial incentives for performance can be a two-edged sword; if the amount of incentive is too high, there can be too much focus on the incentive, causing stress that reduces the level of performance. The Loyola compensation plan uses a guaranteed base plus incentive tied to quality. Activities and accomplishments are tied to base compensation, and behavioral and professionalism expectations are required to earn incentive. Benchmarks (productivity and compensation) to set base compensation. Up to 5% of base compensation is at risk for activities in five (5) categories: research/scholarly activity, educational activity, community service, professional medical/societal service, uncompensated committee/leadership or departmental leadership positions. Base clinical compensation is reduced by 1% per point not earned. Earning more than 5 points will not increase compensation increasing over 100% of the benchmark. It is possible to earn up to 3 points in one category to offset a category with zero points, and it is expected that faculty earn points in at least 3 of the 5 categories for compensation at the benchmark. Faculty are also expected to close charts, complete resident and student evaluations, and dictate operative/procedure notes in a timely manner, as well as 2 other department-specific expectations, in order to be eligible for quality incentives, which are based on scorecard metrics and payable annually. Additional chair compensation incentives are also available. Academic productivity is based on an Academic RVU model.

Evaluations:

Responses to the talks were consistently positive, with ratings from 4.33 to 4.60, with individual speaker scores in the same range.

1. Comments included:

> "The most useful session of the entire meeting from my perspective. Need more of these programs to share information on pressing topics to chairs"
>
> "This is such a challenging session to come away from due to the increasingly depressing work environment neurologists face."
>
> "GREAT! Incredibly important and something we don't get alot of decent insights into."
>
> "very useful we should create a white paper"
>
> "A good session but in the end did not provide a lot of clear directions. It was interesting to hear about a comprehensive compensation plan but then disappointing to know that we are still uncertain how it is working."
>
> "Cogent discussion of models for faculty salary determination."
>
> "active participation"
>
> "great speakers, good energy"

2. 68.9% learned anything at the session that you plan to take back and apply to your practice:

> "call pay; infusion margins; teleneurology contracts"

"It was particularly helpful to see and hear about an approach taken by another department - sharing 'practices' is SO valuable and this was so well done by the Rochester group. The other group also provided useful information."

"understand faculty compensation and can support my department in its efforts"

"Great to hear how other departments are handling this."

"administrative compensation"

"Will use information in adjusting faculty salaries appropriately, based on clinical activity."

"develop comp plan"

"interesting ideas on incentives for academic work"

"Various methods of compensation (besides clinical compensation) that may be available for faculty"

"Better capacity to advice junior faculty"

"Will begin work of improving faculty compensation plan"

"several specific strategies for leadership in the area"

"It was a lovely conference with valuable pearls from colleagues from a large department of Neurology. Attendants participation and input was very valuable as well."

"complications of RVU system and issues for non-RVU activities"

"Consider a compensation plan that is equitable and rewards academic as well as clinical activities."

"Different models for faculty compensation"

"Different systems of faculty reimbursements at different schools"

"Components of the plan"

"diversity in comp plans across depts, use of incentives in comp plans"

"different RVU models"

"different business model approaches to medicine (unfortunately)"

3. How the information you obtained during the presentation will directly impact patient care/outcomes:

IDK

will not

I will be able to afford more faculty and thereby serve more patients.

This is indirect as it will help me support the faculty, who take care o f patients

I am already stretched too thin and cannot meet the wRVU expectations at my institution. Adding more to my plate can only result in worse outcomes for my patients.

help retain MDs to see patients

Physicians will have more time to spend with patients.

helps to address clinical workload and burnout

type of comp plans

Allow me to hire and retain outstanding faculty

Improving access

very much

better understanding the generation of RVUs will aid in my efficiency

Very Good information

balance between volume of patients and quality of care

Improved faculty morale will lead to better and more consistent patient care.

no effect on patient care and outcomes

I have a better understanding of how alternative funding could allow me to provide better patient care and yet ensure compensation is still adequate

better able to align incentives

4. What barriers may prevent you from applying knowledge and/or techniques to practice?

bureaucracy

Getting adequate funding

Need to be able to negotiate within my own institution

Strategies do not apply to my specific institution

balancing clinical and academic incentives is challenging

unknown

$$$$

Faculty participation/buy in

Financial

Institutional requirements

Did not hear anything i had not already learned. But i have been doing this awhile.

different systems at different institutions

financial pressure to see lots of patients

This session was about motivating my faculty, not benefitting patients in practice. I suppose indirectly, my faculty's well-being could affect their effectiveness in caring for patients.

resources

hospital administration

chair

POLITICS FOR NEUROLOGY CHAIRS

Faculty: Richard Kronick, PhD,
University of California, San Diego

Dr. Richard Kronick is a Professor in the Department of Family Medicine and Public Health at the University of California, San Diego, where he has been a faculty member since 1991. Dr. Kronick's research focuses on understanding the causes and consequences of lack of insurance, on the development and implementation of risk-adjusted payment systems designed to encourage insurers to develop systems of care that are responsive to the needs of the most vulnerable, and on design and evaluation of health care financing interventions. His career has included work both in academia and government, reflecting a commitment to using health services research as a means of improving health care delivery. From 2010 to 2016 Professor Kronick served in the Obama Administration, on leave from UCSD. From 2010 to 2013, he was Deputy Assistant Secretary for Health Policy in the Office of the Assistant Secretary for Planning and Evaluation (ASPE), where he primarily worked on implementation of the Affordable Care Act, and the design and evaluation of Medicare and Medicaid payment policy. From 2013 to 2016, Professor Kronick was the Director of the Agency for Healthcare Research and Quality (AHRQ). Professor Kronick was a Senior Health Policy Adviser in the Clinton Administration in 1993-94, and was the Director of Policy and Reimbursement in the Massachusetts Medicaid program from 1985-87. Professor Kronick received a Ph.D. in Political Science from the University of Rochester, and was elected to the National Academy of Medicine in 2014.

Course Description:

With the seismic shift in political alignment brought about by the 2016 federal election, the fates of the Affordable Care Act, Medicare and other major systems supporting healthcare are in question. When is it appropriate (and when inappropriate) for Chairs to be politically active and lobby for what academic neurology needs to meet its missions and goals? How do the goals for academic neurology differ from those for private practice neurologists? What are the most effective means to inform our legislators, executive branch, and the public of our perspective and needs? How do we prioritize those needs (more GME slots, better reimbursement for cognitive specialties, more funding for research)? What can/should we as Chairs do to promote a new plan for healthcare that accounts for the challenges faced by academic medical centers in general and neurology in particular?

Learning Objectives

1. To understand the major health policy issues confronted by Congress

2. To understand the major factors that influence Congressional decisions on these issues

3. To understand how neurology chairs could develop priorities for advocacy

Lecture Summary:

Professor Kronick's talk focused on the successes and challenges of the Affordable Care Act. Implementation of the ACA resulted in a dramatic reduction in the percentage of uninsured Americans from 18.2% in 2010 to 10.5% in 2015. Health spending growth has slowed, and was close to being on pace with economic growth from 2010-2015 (about 2.5%, down from more than 4% in the 2000's). The annual change in expenditures per insured person for private insurance, Medicare, and Medicaid have also declined, particularly for Medicaid. This has occurred without any reduction in quality of care, as the rate of adverse events has also declined, resulting in 124,000 lives saved, 3.1 million patient harms avoided and $28.2 billion in savings. However, there continue to be systemic problems. Heallth care continues to be a fragmented system with tens of millions of people uninsured and many inequities. Mortality continues to be inversely proportional to income. High deductibles and out of pocket costs create access barriers for low-income people. Cost structure pathologies include the fact that primary care is still undervalued, reimbursement is still primarily Fee-for-Service which rewards volume, high administrative costs and high prices. The percentage of US office-based physician visits covered under capitation arrangements has steadily declined since the 1990s. The costs of healthcare administration in 1999 were $1059 per person in the United States and only $307 in Canada, a country with nationalized healthcare. Quality Pathologies include underinvestment in public health, the imperative to 'pay for value' when we have very limited ability to measure it (and underinvestment in developing measures), lack of care coordination, particularly for patients with chronic care needs, insufficient attention to patient preferences, and insufficient involvement of patients in decision making, and insufficient rewards for safety and process improvement. Electronic Health Records are not yet interoperable, hence valuable information is often not available to clinicians and patients. Even an HHS fully committed to making the Federal Marketplaces work had many troubles, but under the Trump administration, HHS appears to be committed to undermining the market for individual insurance. They have announced discontinuation of Cost Sharing Reduction (CSR) payments, shortened open enrollment (OE) from 12 weeks to 6, shut down the web site during open enrollment for maintenance at strategic times, slashed an already inadequate marketing budget from $100 M to $10 M, and cut support for navigators by 60%. HHS may direct the IRS to not enforce the 'individual mandate' and continually tells people that the ACA is on the verge of collapse, discouraging enrollment. HHS is also attempting to encourage 'association' plans, further undermining the individual market. An HHS hiring freeze is diminishing the capacity to get anything done. The expected consequences include higher premiums for non-group insurance, fewer people purchasing non-group coverage, healthy people being more likely to drop coverage than the sick, further increasing premiums, and an increase in federal government expenditure due to discontinuation of CSR payments. States that operate their own marketplaces will largely be able to insulate themselves from the assault on the ACA. We should expect health insurers to push back hard, but not clear that Congress will be willing to act, or that the Administration will care. When premiums go up in 2018, and again in 2019, will people blame Trump, or believe his claim that the ACA was imploding?

Medicaid is a federal-state partnership, in which the federal government pays a share (averaging around 60%) of what each state spends, as long as state spending conforms to federal rules. In the 'repeal and replace' bill that passed the House, financing was converted to a 'per capita cap', in which federal payments to each state would be capped at the status quo level of per capita spending, and would grow at the rate of the Medical Care CPI. The Senate came close to passing a similar bill. Republicans in Congress have not given up on transforming Medicaid from a defined benefit to a defined contribution

system. Speaker Paul Ryan has long wanted to transform Medicare from a defined benefit to a defined contribution system, but has not been able to generate much traction for this proposal yet. It seems likely that Medicare spending will increase more quickly under Republican control than under Democratic control, but there are many uncertainties. Secretary Price slowed, and partially reversed, CMS efforts to move towards bundled payments; it is unclear what the next Secretary might do. MACRA and MIPS are in for turbulent times.

In summary, the ACA resulted in 20 million fewer people uninsured and a reduction in cost growth closer to GDP growth than any time over the past 50 years. Medicare spending per beneficiary is growing especially slowly. There is some momentum towards increasing the value of primary care, and attention to population health. Problems include 28 million still uninsured and many others underinsured, high prices for many goods and services, with volume still rewarded financially, and insufficient rewards for quality and safety. The future is uncertain, with clear expectation of moving backwards on access, and high likelihood of moving backwards on cost. It is less clear what effect there will be on quality/delivery system reform.

Evaluations:

Overall comments for the session were positive, with scores ranging from 3.80 to 4.27. The average score for the speaker was 4.0.

1. Comments included:

> "politics (local level, not national) E.G., experience chairs can share 'case studies' of their own successes and/or failures"
>
> "Interesting", "Good Session", "Excellent" "Very informative."
>
> "This session was a waste of time. It dwelt on things beyond our control."
>
> "Focused on Medicare-relevant issues"
>
> "This session was a bit of a monologue on one person's perspectives."
>
> "Most of the content is known from daily news"

2. 40% of respondants learned anything at the session that you plan to take back and apply to your practice

> "Need for neurologists to be involved."
>
> "Role of advocacy in gaining resources to treat patients."
>
> Understanding of political climate for insurers
>
> "better understanding of ACA"
>
> "understanding of the political situation regarding health care financing in US"
>
> "Be able to explain benefits and negative aspects of ACA"
>
> "ANA needs to be more involved in Washington"

3. How the information you obtained during the presentation will directly impact patient care/outcomes:

"Better information for patient advocacy"

"will support ANA effort in Washington"

"Not particularly relevant to the issues that face my PEDIATRIC practice."

WINTER IS COMING, BUT MACRA IS HERE: REIMBURSEMENT FOR QUALITY AND THE SHIFT TO POPULATION-BASED CARE

Faculty: Marc Nuwer, MD, PhD,
Professor of Neurology and Chief of Clinical Neurophysiology
University of California, Los Angeles

Lyell Jones, MD,
Associate Professor of Neurology and Residency Program DIrector
Mayo Clinic School of Medicine, Rochester, MN

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate formula, which threatened massive reductions in Medicare payments, and replaced it with a program that bases reimbursements on quality and innovation. How will this change affect academic Neurology departments? What are the implications of MACRA for academic neurology? How can we address the new MACRA requirements using either Advanced Alternative Payment Models (APMs) or the Merit-based Incentive Payment System (MIPS)? More broadly, how will population health measures including disease prediction, prevention, and early intervention, be incorporated into academic neurology practice? Can such practices improve outcomes and reduce costs, and will they be adequately reimbursed?

Learning Objectives

1. Explain MACRA's two major pathways: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (AAPMs)

2. Implement a plan to report under MIPS or participate in AAPMs

3. Develop strategies to manage the impact of value based care on academic neurology practices

Lecture Summary:

The goals of the talk were to provide an overview of the factors driving the value-based care movement, discuss the essential elements of MACRA, and develop a plan for participation in MACRA and related value-based payment models. The motivation for MACRA was to slow the growth in healthcare costs, which consume an increasing percentage of GDP (projected to increase from 17.8% in 2017 to 19.3% in 2023). This will be accomplished by reducing fee for service payments and increased payments for value and bundled services. This transfers risk from the insurer to the provider, and includes both performance risk and actuarial risk. There are 4 payment categories: Category 1 is straight fee for service, Category 2 is fee for service with a link to quality and value, Category 3 is Alternative Payment Models, initially with upside gainsharing and eventually with downside risk, and Category 4 is population-based payment. The goal is to shift away from Category 1 and increasing Categories 2 -4. MACRA is the Medicare Access and CHIP Reauthorization Act of 2015, which passed with wide bipartisan and bicameral support (House vote: 392-37, Senate vote: 92-8) and was signed into law in April 2015. The first final rule was released in October 2016 governing 2017 implementation, and the final rule for 2018 is coming soon. MACRA permanently repealed the sustainable Growth Rate (SGR) and implements a completely new payment structure, shifting from payment for volume to payment for value, defined

as (Quality + Safety + Service)/(Total Cost Over Time). MACRA has 2 options, Alternative Payment Models (APMS) and the Merit-Based Incentive Payment System (MIPS) which is the default pathway.

MIPS is essentially a heavily modified form of fee-for-service. Providers may be excluded from MIPS if it is their first year of Medicare Part B participation, if they are below the low volume threshold (<$30,000 of Medicare allowable charges or they see fewer than 100 Medicare patients), or they are a qualifying participant in an approved Advanced Alternative Payment Model (APM). MIPS Categories include Quality (initially 60%, reducing to 30% in 2019), Cost (initially 0%, increasing to 30% in 2019), Advancing Care Information (formerly known as Meaningful Use of Electronic Health Records, 25%) and Improvement Activities (15%). CMS estimates that of 17,378 eligible neurologists, a total of 24.9%will be exempt from the MIPS program in 2019 (based on 2017 performance): 18.5% due to low volume threshold, 1.6% due to being a qualified APM participant, and 4.8% due to being newly enrolled in Medicare. For MIPS, the Quality component will closely resemble PQRS. It requires reporting 6 quality measures selected from multiple domains: Clinical care, Safety, Care coordination, Patient and caregiver experience, Population health and prevention, andAffordable care. In 2017, reporting just 1 measure will help avoid penalty. The measures for Outcomes, Patient experience (such as patient reported outcomes or PROs), Care coordination and appropriate resource use have been given priority. Cost measures will be similar to the Value-based Payment Modifier (VBPM) program: no reporting is necessary, and resource use (cost) data are collected automatically by CMS from submitted claims. Most current methods of risk adjustment and patient attribution will be carried forward. Advancing Care Information (ACI, formerly Meaningful Use or MU) will align with existing MU requirements. Inconsistencies between current programs (e.g., PQRS and MU) will be eliminated. The final rule calls for reporting a combination of Base and Performance ACI measures, and approved measures (in the Quality category) will automatically satisfy the MU quality measure reporting requirements. Quality measures examples include ALS Patient Care Preferences, Evaluating Risk of Opioid Misuse, Headache Disorders Quality of Life Assessment, Parkinson's Treatment Options Review, Counseling for Childbearing Potential for Epilepsy, Cognitive Assessment for Dementia, and Tobacco Use Screening & Cessation Intervention. Improvement Activities is a new area similar to practice improvement activities. Axon Registry participation will positively impact score. The final rule for 2017 calls for participants to report 2 "high-weighted" activities, or 4 "medium-weighted" activities. 2017 is a "transition year," with several reporting options and outcomes. Full-year reporting begins on January 1, 2017, or partial year reporting for a reduced number of days. There is a "test" option under which physicians can report minimal amounts of data.

Advanced Alternative payment Models (APMs) pay to incentivize quality and value in health care. Elements of an Advanced APM include: a certified EHR, quality measures like MIPS, and risk for annual financial loss. Advanced APM Participants do not have MIPS bonuses or penalties and get an annual 5% bonus, higher fee schedule payments, and must meet a participation threshold percentage. Issues with APMs include too few qualified Advanced and other APMs, particularly for specialists, the timeline for developing new models is long, transition bonus payments expire after 2024, and risk requirements are unrealistic and complicated. One way to achieve APMs is through Bundled Payments (BP) for Episodes of Care. The goal is to cover 50% of Medicare costs. Examples already in use: cataract/lens surgery; mastectomy; aortic/mitral valve surgery; coronary artery bypass graft; repair of hip/ femur fracture, and others. BP in Neurology could include acute conditions or episodes such as stroke or traumatic brain/spine injury, or chronic conditions such as MS, ALS, or Epilepsy. Episode durations might be 3

months or longer. As an example Headache Bundles could include: Category 1: Initial Diagnosis and Treatment for undiagnosed, difficult to diagnose or poorly controlled headache, with a one-time payment for a 3-month period, Category 2: Continued Care for Difficult-to-Manage Headaches, with monthly bundled payments, and Category 3: Continued Care for Well-Controlled Headaches, an add-on service that could continue indefinitely as-needed. The Medicare Shared Savings Program (MSSP) Track 1+ is an advanced APM, with least risk of the MSSP Advanced APMs. It includes 5% bonus plus any MSSP savings, and includes only Primary Care, Hospitals and SNFs. Track 1+ tracks metrics and takes action on items such as: Ambulatory Care Sensitive (ASC) Discharges (admissions that should have been avoided), advanced smaging (CT and MRI), hospital discharges, 30-Day readmissions and ED visits.

The ultimate goal is Population Health management, which includes innovative care models and coordinates care across all settings (home, SNF, clinic, and hospitals) and aggregates and manages risk in large populations. There is an opportunity to expand service lines and develop Task Forces to identify gaps, phone and electronic communications, determine timeframes, sort priorities, straighten workflows, automate processes, and ensure everyone is working at top of license. To realize savings, APMs depend on standardization and centralization, which are not typical of academic institutions. This requires control of patient access and referrals and needs large primary care programs. Universities traditionally depend on flexibility and individuality and are dominated by specialists who order expensive tests and have high hospital charges. Transition will complicate the academic triple mission of patient care, education, and research. APMs are resource intensive, as systems need organization and cost management to align clinical performance and coordinate patient care. It is difficult for physicians to remain independent and there is heightened pressure for faculty to work effectively with community practitioners. Health system physicians and administration need to work togetherto achieve success in Population Health. Steps include Developing dashboards, task forces, and specific action items, ensuring evolution of care redesign within all specialties, enhancing performance on quality metrics, closing “care gaps” and optimizing resource use (Admissions/readmissions/ED, laboratory and imaging, high-cost drugs), enhancing diagnostic coding, enhancing patient experience, optimizing the EHR, identifying high-risk patients, and using team-based care coordination. Department chairs can prepare for APMs by appointing physician and/or manager champions, developing department-specific clinical, analytic, quality goals, finding care gaps, supporting workflow and process changes, working with system population health teams on analytics, care transformation and care management, optimizing the EHR platform to support population health management, and participating in Bundle development.

Evaluation: This lecture was rated highly with scores ranging from 4.5 to 4.83. Drs. Newer and Jones also received high marks with average scores of 4.69 and 4.80, respectively.

1. Comments included:

> “Excellent content - Most enlightening of AUPN Sessions directed to departmental Chair education”
>
> “this was too dry”
>
> “excellent speakers”
>
> “Becoming more conversant in a very important topic.”

"Excellent"

"This was the most cogent, articulate, understandable discussion of MIPS and AAPMs I have ever heard. (And I have heard many, many such discussions.) But MACRA includes "CHIP Reauthorization" - not once discussed in this session. It was a presentation of "MAA" without the CR. That is not MACRA and I am hoping that, after having been Secretary/Treasurer of and a faithful attendee at the ANA, I will someday not be invisible to its leadership and programming."

2. 73% of respondants reported that they would bring information back to their departments, including:

"mostly knew about MACRA but some additional information from the Q&A"

"Need to be involved at the institutional level in decisions involving MACRA strategy"

"The importance of understanding your institutions current reimbursement model and having a seat at the table when modifications are made."

"Greater understanding of how MACRA reimbursement will affect the individual practitioner"

"billing issues"

"this was a useful and practical update on macra"

"Got a better outline of what the pathways for MACRA are."

"Educate rest of department about MACRA and MIPS"

"Allow me to better explain MARCA to faculty and inform institutional planning"

"Hints about integrating a department into the new institutional initiatives"

"learned about how quality standards are applied and will be applied in the future"

"better and type of documentation"

3. How the information you obtained during the presentation will directly impact patient care/outcomes:

"survival of academic neurology"

"Attention to coding will improve reimbursement and develop more resources for the clinic."

"Will affect my billing presentation"

"billing"

"important to be aware of the changing environment for practice."

"no immediate impact"

"Understand the payment system"

"Not sure but it will definitely require us to change practice to comply"

"Appoint task forces to find care gaps, improve access and satisfaction, reduce ED visits and re-admissions"

"It probably will influence the departments of the adult neurologists in the room, but this session was one of many over the years in which pediatric neurologists and pediatricians were treated as "other" and only rarely referred to, and when they were, it was as "our child neurology colleagues", as if it couldn't be the case that any child neurologists were actually in the room attending the ANA meeting."

"knowledge of MACRA choices"

"more details"

4. What barriers may prevent you from applying knowledge and/or techniques to practice?

"institutional barriers to practice change"

"Opacity of the intentions of the medical centers goals and approach. Competing interests with primary care."

"Lack of autonomy as an individual practitioner in an institutionally-focused academic medical practice plan"

"Depends on my specific role within the institution to develops plans for the macra implementation."

"Hard to change and especially with a 2 year delay between act and reward/punishment"

"Resistance to changing habits"

"All of my patients are around 50 years away from being eligible for Medicare."

"hospital politics"

<u>Suggestions for topics to be covered in future sessions</u>:

Compensation session:

politics (local, not national)

another session on compensation!

faculty burnout-- how to minimize

How to avoid burn-out

review this one again [Compensation]

Showing the value to a neurologist to hospitals and practice plans.

Chair burnout

fund raising

Methods for attracting faculty

Updates on the same [compensation] given evolving healthcare system

Continued discussion of faculty compensation

this [compensation] should be repeated

How to avoid diagnostic errors.

Negotiating with hospital/clinic/healthcare/medical center administration for faculty compensation, incentives and appropriate strucuring of effort distribution.

Challenges of getting funded in modern era

APP

evaluation of different subspecialties

how ANA can effectively change rules and regulations and policies for payment and reimbursement

consulting fees

Politics lecture:

politics (local level, not national) E.G., experience chairs can share 'case studies' of their own successes and/or failures

Ways to improve access

How to interact with "senior leadership" (Dean for College of Medicine, Executive Vice President for Health Affairs, Hospital Chief Executive Officer)

Institutional politics

Best methods for faculty retention

Managing down and up.

same speaker [Kronick], with an update. Fantastic

faculty compensation metrics

MACRA session:

"more practical guides, tips, etc as well as a format to share information across departments"

"Per AUPN Leadership"

"Repeat same topic with focus on what programs are currently in use and success/failure."

"patient satisfaction strategies"

"Big Pharma and their impact on how we manage patients. Commercialization of Neurology."

"More medical economics as it affects departments"

"Transitions from childhood to adult neurological care. Importance of preventive medicine in childhood for health in the Medicare years. Futility of trying to bend the cost curve at the point of damage control in the already obese, sedentary, hypertensive adult - need for effective population health models from birth."

"compare and contrast financial structures and financing faculty in neurology departments by chairs"