

CIN

CONNECTIONS



Spring 2019 Issue:

Managing Financial Risk and Total Cost of Care

CALIFORNIA
IMPROVEMENT NETWORK:

BETTER IDEAS
for CARE DELIVERY

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Get Involved and Join Us

Reflections from a CIN Managing Partner



Essayist Charles Dudley Warner said, “Everybody talks about the weather, but nobody does anything about it.” All of the stakeholders in health care (hospital systems, payers, medical groups, and patients) have spent a great deal of time trying to address concerns about the total cost of care, but it remains one of our greatest challenges.

At most health care organizations, including my own, there is little to no integration of clinical, financial, and administrative data. Many of us are left to make decisions in an information vacuum. Without these types of data, how do leaders and decisionmakers know where to best concentrate our efforts?

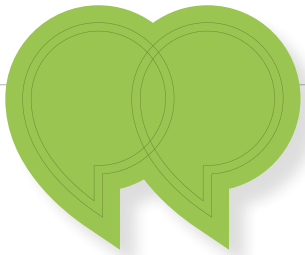
When it comes to the individual provider’s contribution to the total cost of care, my experience reminds me of another quote, this one by Steven Levitt, author of *Freakonomics*. He said, “When people don’t pay the true cost of something they tend to consume it inefficiently.” I think this applies to both providers and patients. It’s very hard to make progress in cutting the cost of care when you don’t understand the cost structure of a service process.

Frequently, the complicated cost structures of the various hospital systems in which we

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Reflections from a CIN Managing Partner



Cost transparency
is a crucial part of the
solution.”

operate pits supposed partners in the same system against each other. During my time in primary care practice, I might have been working hard to provide coordinated and cost-effective care, while unknowingly incurring large costs out of my control because of particular arrangements worked out in our health system. For example, our hospital, which is capitated for the care delivered, preferred that my patients have their colonoscopies performed in the hospital's own outpatient surgery center, rather than pay a fee to a more cost-effective ambulatory surgery center to have the procedure done there.

Similarly, it was difficult to know the prescription costs my practices incurred due to varying medication arrangements with health plans and pharmaceutical companies. I recall in my practice that when a patient was told of their co-pay and they found it unaffordable, the pharmacist wouldn't be able to suggest a more economical choice because cost information wasn't available to them. The cost structure for patients' medications is often so complex that the only thing the pharmacist can do is ask the provider to substitute a different medication and type it into the system to discover the new co-pay.

Most of us who focus on these cost challenges will need to spend a great deal of time to understand the cost drivers. Cost transparency is a crucial part of the solution. Only after we've delivered on that can we determine how (and if) we can align the various stakeholders in our individual organizations to successfully achieve progress on that important third arm of the triple aim — the control of cost.

In this issue of *CIN Connections*, you'll learn about strategies to manage total cost of care. You'll hear from Mitch Katz, head of the largest public health care system in the country, about transitioning to a value-based payment model, and you'll learn about CIN's upcoming technical assistance opportunities, including a lexicon on this very topic.

We hope these resources help shed some light for you on this topic and encourage you to take action in your own organization.

Sincerely,

A handwritten signature in black ink, appearing to read "Lloyd S. Kuritsky".

Lloyd Kuritsky, DO

CIN Managing Partner
Medical Director,
Sharp Community Medical Group

VIDEO:

**“How to Succeed
in Risk-Based
Payment” with
Mitch Katz, MD**



[This talk](#) by Mitch Katz, MD, president and CEO of NYC Health + Hospitals, provides strategies for managing the total cost of care while improving quality and patient experience. He spoke at the California Improvement Network partner meeting at the California Community Foundation in Los Angeles on March 13, 2019, to a group of health care leaders representing commercial and safety-net provider organizations, health plans, and quality improvement groups across the state.

Honest Discussions About Health Costs

By:

Veenu Aulakh, MSPH

President,
Center for Care Innovations

A

t the March 13 [California Improvement Network](#) (CIN) meeting, I had the opportunity to learn more about a topic I don't know a great deal

about — managing financial risk and total cost of care. I thought it would be a wonderful opportunity to learn from some of the best and brightest.

The highlight of the meeting for me was hearing from Mitch Katz, MD, president and CEO of NYC Health + Hospitals. Katz is the former head of the Los Angeles County Health Agency and was the director and health officer at the San Francisco Department of Health. He has a deep understanding of how public systems work and about total cost of care as it relates to quality and outcomes.

Katz started by pointing out how difficult it is to truly decrease costs while also improving patient experience and outcomes. While we all aspire to achieve both goals, that doesn't happen very often. Many providers find it uncomfortable to discuss lowering costs. Most of us got into this work to make people's lives better, not to focus on the bottom line. But we have to have honest discussions about the underlying costs and their relationship to



overall health system spending. It's up to all of us to engage openly with these issues.

There are many reasons to care about the high-level issue of skyrocketing spending, but one reason is particularly compelling. Health care spending is consuming a significant proportion of state and national budgets; this means it is challenging for us as a society to make all the necessary investments essential to a high-functioning society — in education, social services, and the environment, to name a few. Research shows that even if we're comfortable with the status quo, we're not getting good value for the money we are spending.

So, how do we start changing this trajectory? Katz shared a number of ways to think about this.

Honest Discussions About Health Costs

First, we need to focus on the highest-cost population and be clear about how we define that population. This has been a huge challenge for safety-net health systems, since our populations are often shifting, and our data systems and capabilities have not historically been strong and accurate enough to allow us to identify and predict who these patients will be. We have to get better at collecting and analyzing data, so we'll know whom to target.

Second, we have to recognize that health systems won't save money by spending more of it. Adding layers of care, like case management, for example, requires new staff

and new costs. While case management can help improve health care quality and patient experience, it doesn't always result in savings. In addition, we need to find ways to reduce unnecessary care. This is easier said than done, as it requires tough conversations with patients and providers alike about what is necessary care versus nice-to-have care.

Right now, I'm left with more questions than answers. But I am certain about one thing: We need to continue these honest discussions. Because first and foremost, controlling costs and overall spending in the health care system requires a shift in thinking.



Most of us got into this work to make people's lives better, not to focus on the bottom line. But we have to have honest discussions about underlying costs and their relationship to overall health system spending.

Four Steps to Transition to a Value-Based Payment Model

Featuring:

Mitch Katz, MD

President and Chief Executive Officer,
NYC Health + Hospitals

The adoption of a value-based payment model is underway across the health care landscape. In a [recent survey](#), clinical leaders, clinicians, and executives at US-based

organizations that deliver health care said a quarter of reimbursements at their organizations are based on value, on average, and nearly half (46%) of respondents said value-based contracts significantly improve the quality of care. But how can organizations effectively transition to a value-based payment model? It's not easy, according to Katz, but it is possible. At the CIN partner meeting on March 13, he spoke to a group of health care leaders from across the state of California and shared four recommendations for making the transition to value-based care.



Determine your current costs and the population you are targeting.

If you don't know what it costs to deliver care in your current fee-for-service system, it will be very hard to transition to a value-based payment model.

This involves defining your target population, including its size and demographics. Are you moving everyone to a value-based system or is this a program for frequent users of the health care system? What are their current usage patterns and costs?

Many health care organizations, especially safety-net systems, have typically not made the kinds of investments in data collection, data analytics, and computerized systems needed to determine costs. If you're running your health care delivery system as a business, you should be capturing factors like market share, the services that have losses, and the services that produce net income. Not having good baseline data can be a huge problem — you have to understand your starting point.



Implement evidence-based, effective interventions.

A successful value-based arrangement requires knowing which interventions are effective, for whom, and under what conditions.

People need to think deeply about creating value-based programs: How strong is the evidence base that this program will achieve the goals identified for it?

Four Steps to Transition to a Value-Based Payment Model

The question that is often missing in discussions about value is: Value to whom? Can we achieve a value-based payment model if we don't agree on definitions of value?

Not all interventions created to address the needs of a given population necessarily work. Multiple studies of case management, for example, involve a charismatic physician and a charismatic nurse who together manage patients with congestive heart failure and decrease their hospitalization rate. However, when you try to generalize the findings to a large system, the gains don't hold up because not all practices have the same charismatic doctor and nurse. You can't build programs assuming that everyone will be extraordinary.



Define what value means.

The question that is often missing in discussions about value is: Value to whom? Can we achieve a value-based payment model if we don't agree on definitions of value?

There is no question that you can cut costs by decreasing hospital stays or stays at skilled nursing facilities following hospitalizations. However, a patient who feels you've pushed them out of the hospital or who feels lonely and desolate back in their apartment, unable to get out because of their injury, might be

less satisfied with the result of such measures. Is that part of the definition of value?

As a primary care doctor, I took care of a couple, both of whom had diabetes. Both thought I was a wonderful doctor, but neither had good diabetes control because they didn't believe in the Western model of medicine. They liked me because I supported them. I believe in the healing power of relationships; I focus on a client-centered approach. So in such a case, what is value? Should my system have been penalized because I didn't tightly control my patients' blood sugar? Or should the system have rewarded me because they were very satisfied with my care? Those aren't easy questions to answer, even for me. And I took care of them.

Another example regularly comes up in my clinic. After two weeks of pain, a patient says, "I want to know why my shoulder hurts." I say, "It's a musculoskeletal injury, I can assure you of that. I want you to go to physical therapy, and I'm sure it will continue to get better." The person responds, "Yes, I hear what you're saying, but I want to know what's wrong with me. I would like an MRI." Yet ordering a shoulder MRI for someone with two weeks of

Four Steps to Transition to a Value-Based Payment Model

Patient-centered care, quality improvement, and cost management can conflict with one another, so it's important to identify: What does value mean to you and your organization?

musculoskeletal pain that will almost certainly get better on its own is definitely low-value care. Nobody will operate on a shoulder for two weeks of pain. The right treatment is rest, physical therapy, and time. Still, many patients want to know.

Patient-centered care, quality improvement, and cost management can conflict with one another, so it's important to identify: What does value mean to you and your organization?



Set expectations for stakeholders.

As you improve outcomes and decrease costs under value-based payments, what is the reimbursement plan for after costs go down? If you choose your population and intervention well, you'll be able to demonstrate major improvements in care, but this will lead to new problems.

For example, take a group of people with high expenses and poor outcomes because they're homeless. You help them secure housing, dramatically drop their cost of care, and improve their outcomes. In year one, you produce a large savings from your baseline. The interesting question then for policymakers and providers of health care is: What happens

next? Is it your expectation that the payer will keep reimbursing you based on historic costs? That's not an easy question to answer. Surely we don't think reimbursements should continue to be based on the person's initial costs, since you're not spending the same sum any more. On the other hand, there will be no further shared savings if reimbursements cover only the current costs of care.

NYC Health + Hospitals' Accountable Care Organization (ACO) has produced Medicaid shared savings five years in a row. It's the only public ACO that has done so. However, the shared savings are shrinking. Is it because we're doing a worse job? No, it's because we're building on our success and we've exhausted the opportunity. Also, the administrative costs of interventions are a continuing expense that cut into any further net savings. The federal government is considering changing the baseline from "what it cost you before" to "what it costs other systems that are not running an ACO." Maybe that's the appropriate baseline. You're still saving money — not against historical averages, but against other providers.

In the end, these discussions are humbling. None of us should feel like we have all the answers.

Four Steps to Transition to a Value-Based Payment Model



About Mitch Katz

Mitch Katz, MD, is the president and chief executive officer of NYC Health + Hospitals, the largest public health care system in the United States, with 11 acute care hospitals, five skilled nursing facilities, and numerous community health centers.

Previously, Katz was the director of the Los Angeles County Health Agency, an agency that combines the Departments of Health Services, Public Health, and Mental Health into a single entity to provide more integrated care and programming within Los Angeles. In this role, he moved over 4,000 homeless patients with complex care needs out of hospitals and emergency



departments and into independent housing, giving them the dignity of a place to live off the streets, while also eliminating costly hospital care. Before he came to Los Angeles, Katz was the director and health officer of the San Francisco Department of Health for 13 years. He is well known for funding needle exchanges, creating Healthy San Francisco, outlawing the sale of tobacco at pharmacies, and winning ballot measures to rebuild Laguna Honda Hospital and San Francisco General Hospital.

He is the deputy editor of *JAMA Internal Medicine*, an elected member of the National Academy of Medicine, and the recipient of the Los Angeles County Medical Association's 2015 Healthcare Champion of the Year award.

He is a graduate of Yale College and Harvard Medical School. He completed an internal medicine residency at UCSF School of Medicine and was a Robert Wood Johnson Foundation Clinical Scholar.

How a Medi-Cal Plan Transitioned to a Risk-Based Payment Model

Featuring:

Genia Fick, MA

Senior Director of Quality Systems,
Inland Empire Health Plan

The Inland Empire Health Plan (IEHP), a nonprofit health plan, is one of the state's Medi-Cal plans that has pushed the furthest into risk-based payments. Established in 1996, IEHP organizes health care for 1.2 million members in San Bernardino and Riverside Counties. At the CIN partner meeting on March 13, IEHP Senior Director of Quality Systems Genia Fick provided attendees with an overview of the plan's shared savings program and of its top lessons learned.

For IEHP, improving quality and managing costs were equally important and were integrated throughout the entire process of developing a shared savings program.

Program Overview: Aligning Cost and Quality

For IEHP, improving quality and managing costs were equally important and were integrated throughout the entire process of developing a shared savings program. The health plan has focused on reducing cost increases while improving quality and protecting patients. These ideas hold the promise of improving care and at the same time ensuring that health care dollars are spent wisely.

Value-based care for IEHP is based on two broad ideas:

1. **Aligning incentives** between providers and payers so that providers are rewarded for improving quality while controlling costs.
2. **Aligning the interests** of patients and providers by increasing provider accountability for the full spectrum of care — across office visits, hospital stays, and pharmacy use.

IEHP started small in January 2018, launching its shared savings program with 8,900 members. Since then, the program has grown rapidly; it now serves 113,000 members and encompasses five medical groups.

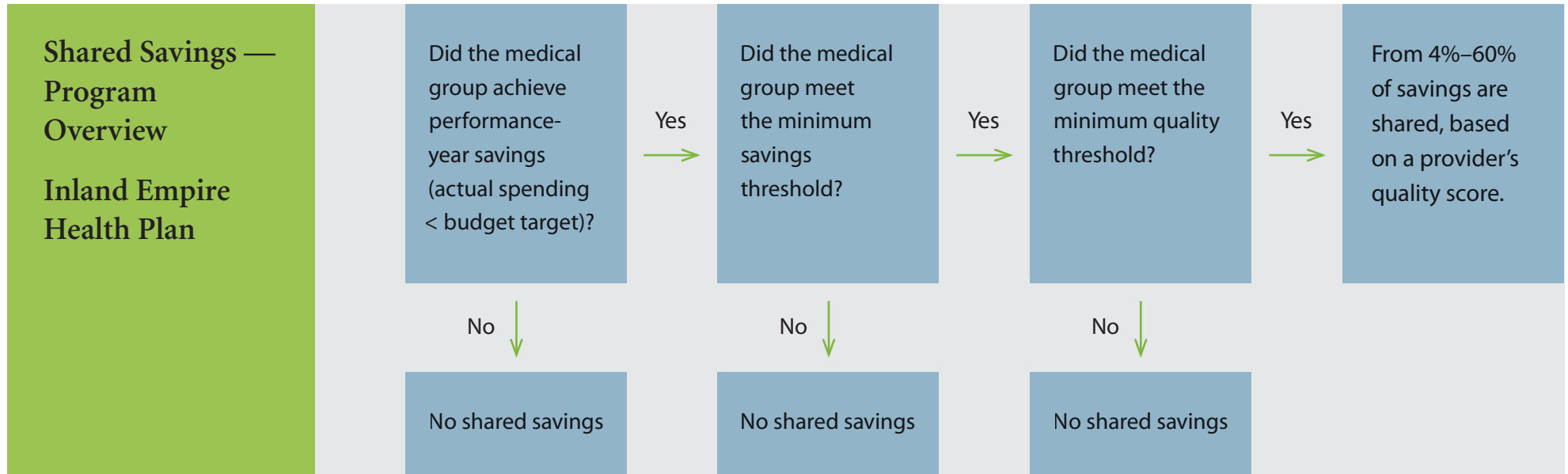
How a Medi-Cal Plan Transitioned to a Risk-Based Payment Model

How Shared Savings Works

The decision matrix for payment (Figure 1) involved simple questions: Did the medical group achieve performance-year savings? Did the medical group meet the minimum savings threshold? Did the medical group

meet the minimum quality threshold? If the answer is yes to all three questions, providers can earn from 4% through 60% of shared savings. But if any question is answered “no,” no shared savings are earned.

Figure 1. Inland Empire Health Plan Shared Savings Program Decision Matrix



Source: Genia Fick, presentation at the CIN partner meeting, Los Angeles, CA, March 13, 2019.

How a Medi-Cal Plan Transitioned to a Risk-Based Payment Model

IEHP created an algorithm (Table 1) to establish the percentage of earnings a given provider receives if there are shared savings. The higher a provider's quality score, the higher the percentage of shared savings that provider would be eligible to receive. If a provider's quality score is greater than 10 points,

the eligible shared savings sum rises above 40%, up to a maximum of 60% of shared savings dollars. In this program, provider groups are awarded a shared savings payment only if they maintain their quality performance (i.e., do not do worse) compared to the baseline year.

Table 1. Inland Empire Health Plan Algorithm for Shared Savings Program

Shared Savings — Program Overview Inland Empire Health Plan	Quality Score	Quality Adjustment	Shared Savings Percentage	Per Member Per Month Cap on Shared Savings
	0–4	0%	None	NA
	5	10%	4%	\$3.00
	6	20%	8%	
	7	40%	16%	
	8	60%	24%	
	9	80%	32%	
	10	100%	40%	
	11	110%	44%	\$3.30
	12	120%	48%	\$3.60
	13	130%	52%	\$3.90
	14	140%	56%	\$4.20
	15	150%	60%	\$4.50

How a Medi-Cal Plan Transitioned to a Risk-Based Payment Model

Lessons Learned

Fick highlighted three key lessons from her work implementing IEHP's risk-based payment model:

1. **Strong partnerships and leadership are essential.** The group has meetings at least quarterly, and often monthly, with leadership, clinical teams, and data teams to discuss progress and challenges. This allows the participating medical groups to share ideas with one another and also ensures that they keep the overarching goals of the payment model in mind.
2. **Data are foundational.** Properly implementing and maintaining a risk-based payment model requires complex data-analysis capacity. IEHP regularly reviews the data needs of all its medical groups and is committed to providing them with data in formats that they can easily use to inform ongoing quality improvement efforts. The plan expects that refining its data capabilities will be a continual process.

3. **Be intentional.** Often, one of the medical groups participating in IEHP's risk-based payment model will request a new data report or a new format for an existing report. In such cases, the plan's leaders ask the other participating groups for their input on the request. Their goal in doing so is to be intentional about all additions and changes — so that data processes are standardized whenever possible across all the participating practices.



How Two CIN Partners Approach Risk-Based Payment Models

Featuring:

Christine Castano, MD

Vice President and Medical Director,
HealthCare Partners Medical Group

Lloyd Kuritsky, DO

Medical Director,
Sharp Community Medical Group

HealthCare Partners Medical Group: Four Levers for Managing Costs

Christine Castano, MD, vice president and medical director of HealthCare Partners Medical Group (HCP), recounted her organization's consistent pursuit of risk throughout its over 20-year history. Located in greater Los Angeles and Orange County, HCP is a high performer in seeking quality and cost savings, in collaboration with their health plan partners. Over the years, HCP has achieved this success with interventions that focus on one or more of these four levers for managing costs:

1. **Quality of care and of the patient experience**
2. **Careful management of high-cost cases, including inpatient care, specialty medications, and the last six months of life**
3. **Influencing and supporting providers and patients who make care decisions every day**

4. **Efficient use of resources, including standardization of medical visits and of referrals**

To better manage high-cost care, HCP employs hospitalists and care managers who work in the hospitals that serve the most HCP members. After their discharge, high-risk, high-cost patients receive house calls from HCP clinical staff. HCP also has a palliative care program that supports both its members and providers.

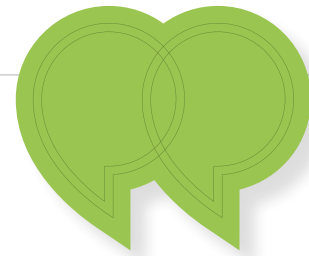
Emphasizing the power of prevention, in conversation with patients during medical visits, is the strategy that requires the longest time before cost savings are apparent. However, HCP is committed to making the effort. Preventive care has been shown to be a worthy investment by the Institute for Healthcare Improvement. "One of the most effective interventions to control costs of care is 10 more minutes with a smart provider," Castano said.

How Two CIN Partners Approach Risk-Based Payment Models

Maximizing Provider Time with Patients

HCP makes a concerted effort to equip providers with the tools and knowledge they need to provide high-quality and cost-effective care. A key part of that effort is supporting providers' ability to engage in shared decisionmaking with patients. This includes supplying them with point-of-care decision support tools; direct access to medical literature; and a new program using other providers as peer coaches, who shadow providers and offer constructive feedback.

Another strategy is to focus on administrative efficiency. For example, HCP identified the kinds of referrals for which the medical group's denial rate was very low and changed those referrals to "auto-approval" status. This had the effect of both lessening the administrative burden and shortening the amount of time that patients have to wait to receive those services.



One of the most effective interventions to control costs of care is 10 more minutes with a smart provider."

Christine Castano, MD
Vice President and Medical Director,
HealthCare Partners Medical Group



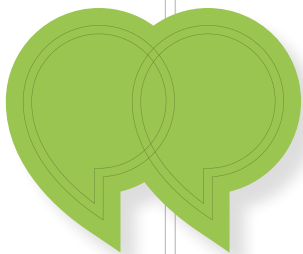
How Two CIN Partners Approach Risk-Based Payment Models

Sharp Community Medical Group: Patient Outreach and Engagement

Lloyd Kuritsky, DO, medical director of Sharp Community Medical Group (SCMG), stated that his group uses many of the same strategies as HCP. SCMG works with about 200 primary care providers and 800 specialists in San Diego. Its strategies include a collaborative, integrated approach to ambulatory care, using a robust case management program; this includes a post-discharge call program, complex case management, and medication therapy management. In addition, SCMG establishes connections with patients through outreach

and engagement initiatives, to help ensure that patients receive recommended preventive care and screenings and remain within the SCMG network.

Kuritsky and his team believe that providers need to be better educated about the costs of treatment, as part of a movement toward more price transparency. "Many physicians don't know what things cost, and neither do the patients. If you don't know the price of a resource, it tends to get used inefficiently," he said.



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Lloyd Kuritsky, DO
Medical Director,
Sharp Community Medical Group



Sutter Health: Leveraging Technology to Scale Patient-Centered Care

Featuring:

Albert S. Chan, MD, MS

Vice President and Chief
of Digital Patient Experience,
Sutter Health

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Albert Chan, MD, MS, chief of digital patient experience at Sutter Health, shared a success story from his work leading digital health in

Sutter's large Northern California system; the group partners with more than 12,000 physicians and provides care for over 3 million people. Recently, Sutter's senior leadership challenged Chan to make a system-wide change within three months, as part of the organization's focus on quick "no-regrets moves" to benefit patients and also to offer efficiency and cost savings to the business. His solution was not novel, but the pace of the change and its impacts were. Within three months, Chan helped Sutter implement a text message reminder system for appointments.

Next steps include standardizing scheduling practices across all providers, with a focus on online scheduling to create efficiencies for both patients and Sutter staff.

A more novel primary care model, still in the planning stages, is a "virtual first" approach. Once this program is live, patients will opt in to a provider's panel. Then the patient's first contact will be not with the provider, but with an artificial intelligence agent that will triage patients to the appropriate level of care to cut costs.

The results of this change were impressive:

- The appointment no-show rate dropped from 19% to 9% across all sites.
- The filled appointment rate went up by 2%.
- Patients and providers were delighted to have visits available, on average, 15 days earlier for primary care and 23 days earlier for specialty care.

VIDEO:

CIN Partner Voices



California Improvement Network (CIN) partners include a range of provider groups and coalitions, health plans, and quality improvement organizations. As leaders of the network, they shape network activities, build connections, translate lessons to actions, and encourage others to engage with CIN in an effort to improve health care delivery in California. At CIN's recent partner meeting, they shared insights on why the total cost of care is an important issue to them and what they value most about the partner meetings.

"We as health care providers and experts need to solve this crazy health care conundrum that exists in our society together. We need to look at the whole continuum of care."

Paul Durr, CEO

Sharp Community
Medical Group

"I love being here. I love the networking. As someone in the Central Valley, we tend to feel very isolated. ... Being part of a larger network that is looking at both urban issues and rural issues is incredibly valuable to me as a person and to our organization."

Ellen Piernot, MD, MBA

Chief Medical Officer,
Golden Valley Health Centers

"We're not getting the value for our health care dollars that we should be. If we look toward most other industrialized countries in the world, [we see that] their health outcomes are so much better than ours, yet the cost to provide health care both to our country and in California is so much greater than in these other places. ... We can have an impact on that by providing better value for the dollars we do spend."

April Watson, MPH

Director, Practice Transformation Initiative,
Pacific Business Group on Health

"I really appreciate being here to learn from the members of the California Improvement Network. It's a gathering of such dedicated, thoughtful, smart providers and thinkers who are really organizing their thinking around the critical issues that face our delivery systems."

Erica Murray, MPA

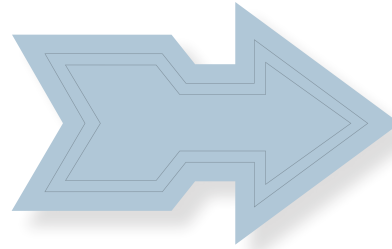
President and CEO, California
Association of Public Hospitals
and Health Systems

FOLLOWUP:

Progress Integrating Primary Care and Substance Use Disorder Treatment



CIN partners discuss substance use disorder treatment and primary care integration at the partner meeting on September 28, 2018 in Oakland, CA.



Since the fall partner meeting on integrating primary care and substance use disorder (SUD) treatment, CIN partners have been busy taking action on this issue. Below are a few highlights of the inspiring work they've done to close the divide between primary care and SUD treatment.

"We are planning a workshop for public health care system leaders that will focus on strategies to address social determinants of health in primary care. The topic is broad, as we are still in the early planning phase, but we expect to cover SUD screening, treatment, and/or referral in some way."

Giovanna Giuliani, MBA, MPH

Executive Director, California Health Care Safety Net Institute

"We are preparing a series of webinars for primary care providers on various topics related to managing SUD in the primary care setting."

Robert Moore, MD, MPH

Chief Medical Officer,
Partnership HealthPlan of
California

"CCI launched a learning collaborative this month with 40 primary care sites. The goal of the program is to provide a range of technical assistance to support sites in integrating SUD treatment services, specifically for opioid use disorder, into their primary care workflows."

Tammy Fisher, MPH

Senior Director,
Center for Care Innovations

"We continue to work with our primary care team to plan for SUD treatment within our practice and hope to start offering these services in the spring of 2019. Additionally, we support the local Opioid Safety Coalition and its work with practices to integrate SUD treatment. The coalition and our partners are planning an opioid summit on April 26, with a portion of the agenda focused on this topic."

Rosemary Den Ouden, CEO

Humboldt Independent
Practice Association

Get Involved and Join Us

Since the last issue of *CIN Connections*, the network delivered technical assistance to support these critical priority areas:

- Making improvements in behavioral health care, with an emphasis on cost management
- Addressing social needs that impact health, with an emphasis on cost management
- Understanding the fundamentals of managing financial risk and the costs of care
- Preventing burnout and promoting provider and staff resilience
- Leading change

Making Improvements in Behavioral Health Care, with an Emphasis on Cost Management

[CIN Toolkit: Three Strategies to Help Primary Care Teams Treat Substance Use Disorders](#)

This document is a guide for primary care organizations and care teams working to integrate SUD treatment services. The ideas suggested in the toolkit were gleaned from a variety of sources: evidence-based practices

and resources cited in literature, feedback from experts in the field, and interviews with experienced California health care organizations across safety-net and commercial settings.

[CIN Webinar \(recording\): How to Integrate Substance Use Disorder Treatment into Primary Care](#)

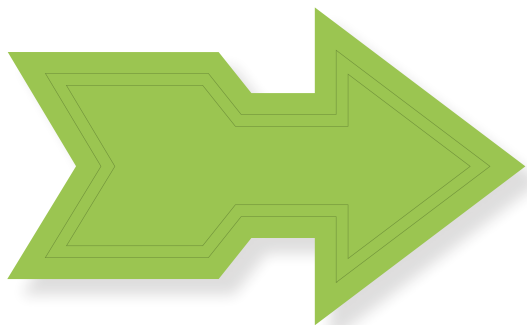
This webinar shared best practices on how to expand the confidence and capability of primary care teams. Two health care leaders answered questions and offered their unique perspectives on this issue.

Addressing Social Needs That Impact Health, with an Emphasis on Cost Management

[CIN Stories from the Field: Social Needs Screening and Referral Models](#)

What practices, tools, and workflows have leading health care organizations adopted to assess and address social needs that impact health? For this case study series, we interviewed four early adopters to identify the operational changes they made to successfully implement and sustain social needs screening and referral programs.

Get Involved and Join Us



Our [webinar](#) on social needs that impact health featured key leaders who are spearheading this essential work.

Understanding the Fundamentals of Managing Financial Risk and the Cost of Care

[CIN Webinar \(recording\): Understanding
Risk-Based Payment Models](#)

What are the main payment models in play nationally, and how can risk-based models help health care organizations manage the total cost of care? Learn about the common payment models in California, in both commercial and safety-net markets.

Coming Soon

- “Fundamental Concepts for Managing Risk and Understanding the Total Cost of Care” — Spring 2019

This primer provides the terms, definitions, and key concepts related to managing financial risk and total cost of care in health care settings.

- [Webinar on Staff and Provider Burnout](#) — May 24, 2019
- Partner Meeting on Leading Change — June 5, 2019

**[Sign up
here.](#)**

Join CIN

to get the latest quality improvement resources, tips, and tools delivered straight to your inbox.



Healthforce
Center at UCSF

CIN is a project of the California Health Care Foundation and is managed by Healthforce Center at UCSF.

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Have you tested out any of the quality improvement recommendations or tools included in this issue? Tell us how it went. We are here to answer your questions or connect you to additional resources. Email us at CIN@ucsf.edu.

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