Welcome to the AMGA Leadership Council Meetings!

AMGA

All Rights Reserved 2013

Thank You to the 2013 Annual Conference Platinum Host!

All Rights Reserved 2013

High Performing Health Systems

Donald W. Fisher, Ph.D.
dfisher@amga.org
American Medical Group Association, Inc
President and CEO
March 13, 2013

All Rights Reserved 2013

Past Efforts to Define High-Performing Health Systems

- Physician Self Referral Regulations
- Medicare Payment Advisory Commission (MedPAC)
- Commonwealth Fund
- Institute of Medicine
- Draft Language Re: In-Office Ancillary Services
- American Medical Association

All Rights Reserved 2013

Our Process

- Create four work groups of members
- Review and critique past work at a definition
- Peer review of work group products
- Consolidation of 70+ pages to a one page definition
- Public Policy approval
- AMGA Board of Directors approval

All Rights Reserved 2013

What Is a High-Performing Health System (HPHS)?

A multispecialty medical group or other organized system of care that is integrated or has partnerships with other care sites to provide patients with better services and care. HPHS successfully manage the per capita cost of health care, improve the overall patient experience, and improve the health of their respective populations.

All Rights Reserved 2013

What Are the Qualifications?

1. Provide Efficient Provision of Services
2. Function as an Organized System of Care
3. Conduct Quality Measurement & Improvement
4. Conduct Care Coordination
5. Use IT & Evidence-based Medicine
6. Assume Accountability
7. Conduct Certain Compensation Practices

All Rights Reserved 2013

Efficient Provision of Services

- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

All Rights Reserved 2013

Organized Systems of Care

- Continuum of care provided for populations
- Integrated or has partnerships
- Physician as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

All Rights Reserved 2013

Quality Measurement & Improvement Activities

- Preventive care & chronic disease management
- Patient outreach programs
- Continuous learning and benchmarking
- Research to validate clinical processes and outcomes
- External and transparent internal reporting
- Patient experience surveys

All Rights Reserved 2013

Care Coordination

- Team-based approach with team members working at the top of their field
- Single plan of care across settings and providers
- Shared decision making

All Rights Reserved 2013

Use of IT & Evidence-based Medicine

- Meaningfully use IT, scientific evidence and comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of pharmaceuticals

All Rights Reserved 2013

Accountability

- Shared financial and regulatory responsibility and accountability for efficient provision of services

All Rights Reserved 2013

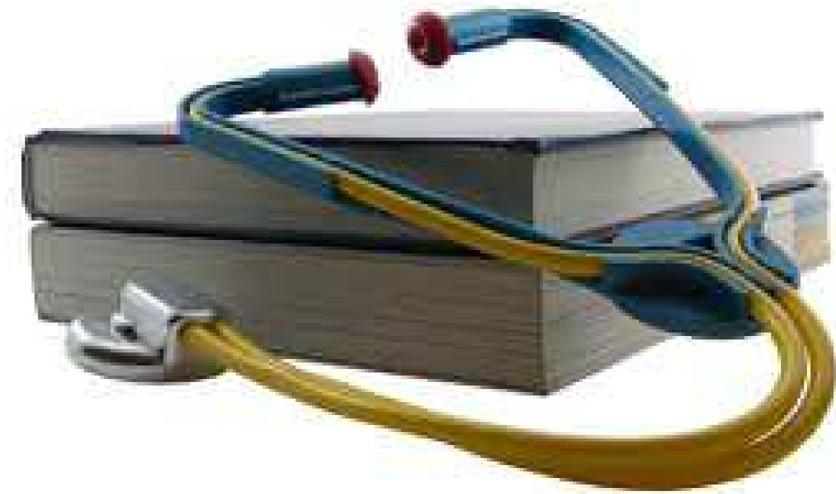
Compensation Practices

- Incentives improved health and outcomes of populations
- Affiliate with patient experience or quality metrics

All Rights Reserved 2013

What if My Group Does Not Meet the Qualifications?

AMGA will provide a Readiness Assessment tool and educational programs and other tools to help members attain this definition.



All Rights Reserved 2013

Using the Definition

- Legislative Action to Reward High-Performing Organizations
  - SGR
  - Stark Exemptions
  - Rules and Regulations
  - Other

All Rights Reserved 2013

Thank You

Donald W. Fisher, PhD, CAE

AMGA, President and CEO

Anceta, LLC, Chairman

(703) 838-0033

dfisher@amga.org

All Rights Reserved 2013

Welcome to the AMGA Leadership Council Meetings!

All Rights Reserved 2013

HIGH PERFORMANCE HEALTH SYSTEMS

THE FUTURE HEALTH CARE DELIVERY MODEL

AMGA 2013 Annual Conference

CEO/President/COB Leadership Council Meeting

Nicholas Wolter, M.D., CEO

Billings Clinic

March 13, 2013

Billings Clinic – Brief History and Description

Key Strategies and Tactics

Early Adoption and Innovation

Some Results and Short Comings

Critical Success Factors for Delivery Systems Going Forward

Billings Clinic
Billings Clinic

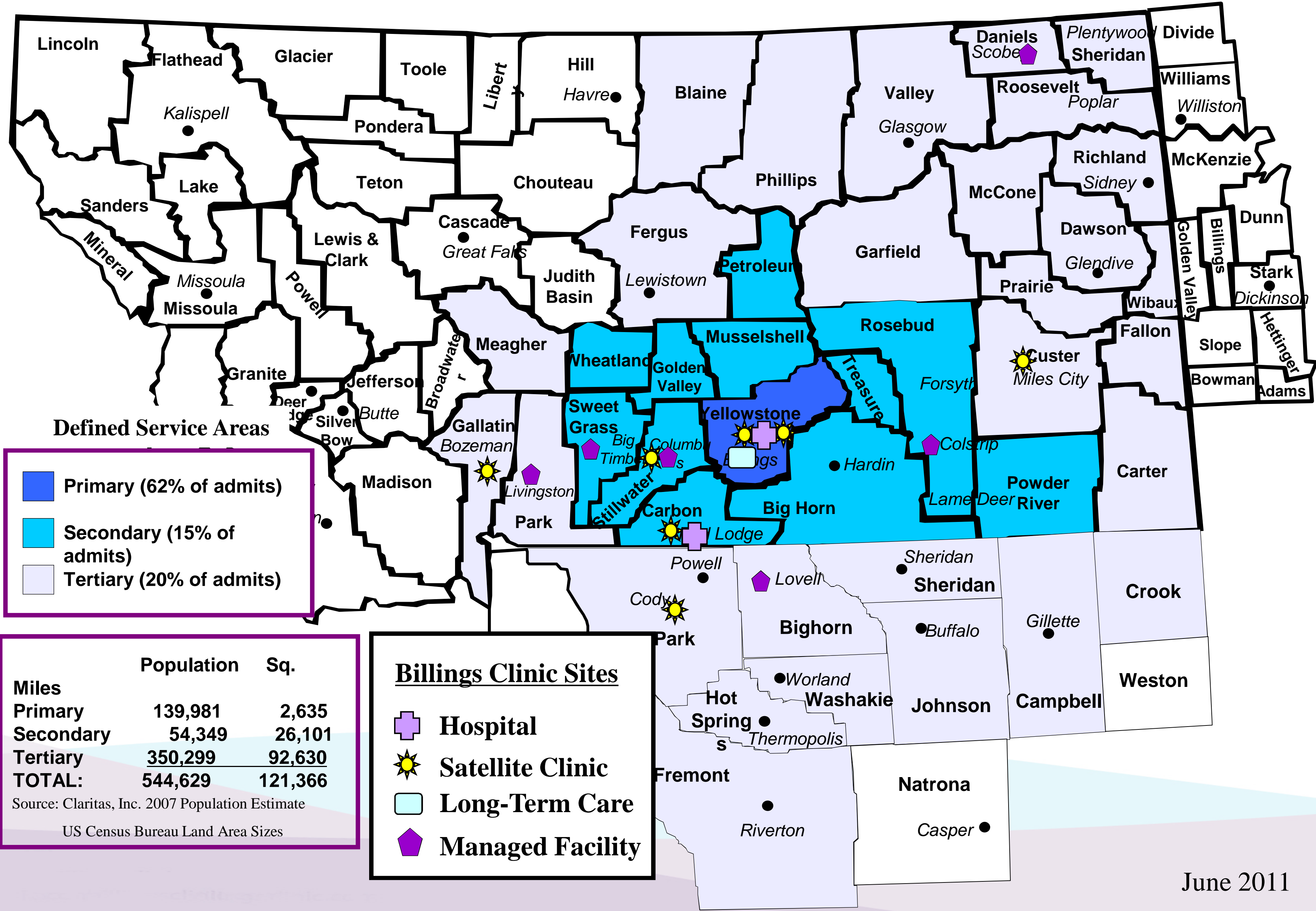
Who We Are

Multispecialty Group Practice at the Core

- Community governed, physician led, patient centric
- Merger/Integration of a **MSGP** and Community Hospital in 1993→NFP
- Organized clinical care
- One patient record (& bill)
- Multiple clinical providers, but one team
- **An obsessive dedication to quality and service**

- 3500+ Committed Employees
  - Group practice w/250 Physicians, 75 NPs and PAs, 10 clinic locations
  - 272 (230) bed level II trauma & tertiary referral hospital
  - Manage/support 10 CAHs
  - 3rd largest employer in Montana
- Board of Directors: Community-based w MDs included
- "Internal Board": Leadership Council
  - Physicians and Administrators

Service Area



	Population	Sq. Miles
Primary	139,981	2,635
Secondary	54,349	26,101
Tertiary	350,299	92,630
TOTAL:	544,629	121,366

Source: Claritas, Inc. 2007 Population Estimate

US Census Bureau Land Area Sizes

© 2000 Microsoft Corp. and/or its suppliers. All rights reserved.

Montana: 147,138 square miles and 922,002 people

© 2000 Microsoft Corp. and/or its suppliers. All rights reserved.

Brief History

1917 Billings Clinic Founded

1927 Billings Deaconess Hospital Built

1989 Billings Clinic Partnership had 90 MDs;
Represented 85% of Admissions to Deaconess Medical Center

1989 – 1993 Merger Discussions

June 30, 1993 Merger Completed

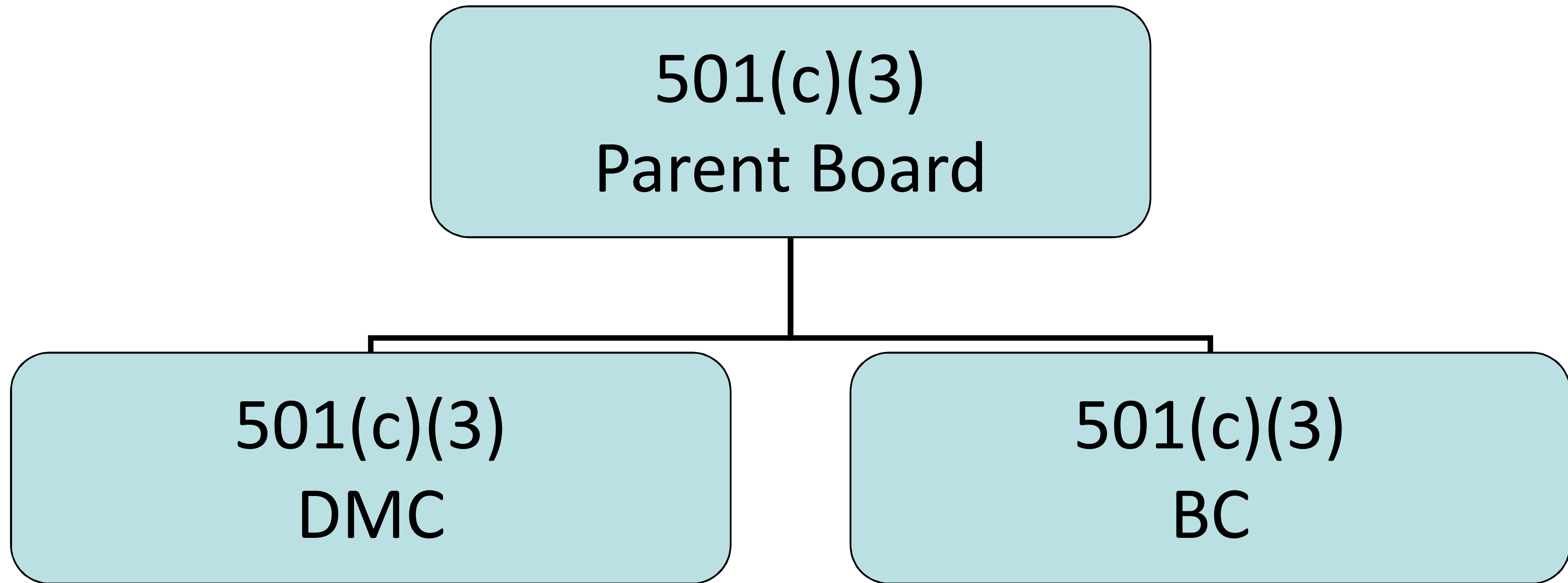
Rationale for Merger

- Clinic need for capital, income stabilization
- Hospital desire for non-duplication of services
- Infrastructure efficiencies
- Preparation for managed care (Clinton Health Reform Initiatives)

Merger Discussions

- Financial Pro Formas
- Legal and Regulatory Issues
- Vision and Culture

Initial Merger Structure



"Deaconess-Billings Clinic Health System"

Brief History

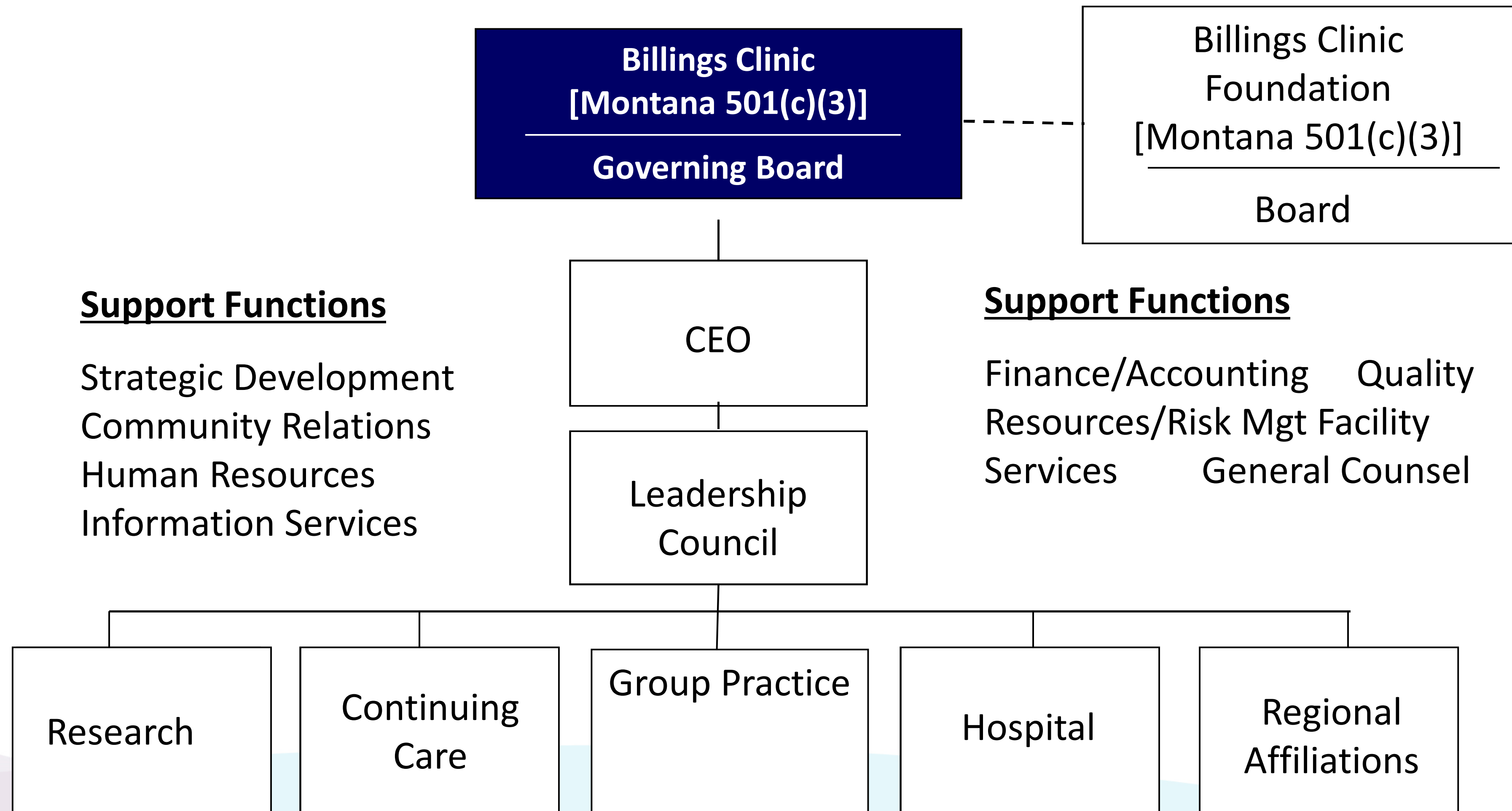
1993 – 1995	“Office of the CEO”
1995	Board/Physician Leadership Mediation
1995 – 1997	Co-CEOs
	Operating Council Formed
1997	Financial Losses
	Reduction in Force
	Turnaround Consultants
1997	Single CEO
	1 Budget

Brief History

1997 – 2013

- Financial Stability
- Physician Recruitment
- Physician Leadership Development
- Vision to Safety/Quality
- Personal Service Excellence
- Centers of Excellence Development
- Regional Strategy
- Operating Plan
- Balanced Scorecard
- Market Share Movement

Medical Foundation Model



Billings Clinic
Physician Group Practice

Decision Making Processes/Places

- Departments and Chairs
- Department Chair Meetings
- Divisions- Primary Care, Surgery, Region
- All Physician Meetings
- Hospital Clinical Units
- Physician Compensation Committee
- Leadership Council
- Administration (SET- Senior Executive Team)
- Physician Chief Executive Officer
- Board of Directors
- CMO Hospital, CMO Clinic, Chief Quality/Safety Officer

Who We Are

An outstanding medical foundation built upon the following cornerstones:

- A multi-specialty physician group practice in which a "community of physicians" work together in a collegial manner is at the core of this model.
- The partnering of physicians, excellent business managers, professional staff, and volunteers create a team whose synergies drive our success.
- Not-for-profit, community-owned and governed.
- Mission-driven decision-making dedicated to a higher purpose in the community and the region.
- An obsessive dedication to quality and service.

Who We Are

Cornerstone Principles

A Physician Led, Multispecialty Group Practice

Billings Clinic is, at its core, a multispecialty physician group practice, where a community of physicians work in a collegial manner to coordinate health care across a spectrum of services. Billings Clinic is a group employed model with salary paid to physicians based on incentives, which include productivity, safety, quality, service, research, education, community benefit, and other relevant activities. This is a salaried model where equity ownership is not in place. All aspects of physician compensation have third party benchmarking, with oversight provided by the Board of Directors. Operating margin success at the Billings Clinic allows for dollars to be reinvested in the needs of our patients.

Billings Clinic is a physician led organization with a physician CEO, and with physicians at all levels of leadership in the organization, including the Board of Directors, Leadership Council, which acts as an internal board, the Senior Leadership Team, and a variety of other clinical leadership positions.

As a physician led organization, physicians work together to be accountable around safety, quality, service, and cost, and commit to transparency in achieving appropriate measures for both quality and cost. Physicians commit to using the decision making structures which have been put in place at the Billings Clinic and to the policies, bylaws, and compact at the Billings Clinic.

Partnering Between Physicians, Nurses, Clinical and Support Staff

Physicians at the Billings Clinic are in a strong partnership with nurses, other clinical professional staff, excellent business leaders and administrators, all other staff, and volunteers. These synergies drive the success of the organization and best serve the needs of our patients and their families. Billings Clinic is strongly committed to all employees and supports their development as a key component of delivering on our mission and vision.

Nursing is a particularly significant part of Billings Clinic's success and drives excellence and compassion to our patients and families. We will always strive for best nursing practice and nursing very specifically is represented at the senior executive leadership levels, as well as in other key positions at the Billings Clinic.

Who We Are

Cornerstone Principles *(cont'd)*

Not-for-Profit, Community Governed

Billings Clinic is a not-for-profit, community governed organization. We are an economic, social and business leader in our region. We are a key resource held for the benefit of our patients and families and the communities we serve. We are financially responsible, avoid conflicts of interest, and allocate our resources wisely as we strive to meet the needs of our stakeholders. We are particularly committed to a wide range of regional community benefit activities, which help improve a variety of health needs in our communities and which serve all in need as best as we are able.

Dedicated to a Higher Purpose

Billings Clinic is a mission driven organization with all decision making dedicated to a higher purpose in our region. Decisions are driven above all by the needs of our patients. We commit to providing a broad array of services needed by our patients and their families, including our fair share of services where reimbursement is marginal or poor. We are committed to the highest levels of ethics, honesty and integrity.

Obsessive Dedication to Patient Safety, Quality, Service and Value

Billings Clinic is driven by an obsessive dedication to patient safety, quality, service, and value. We are committed to being one of the highest reliability organizations where "first, do no harm" is a key principle. We also try to provide the very highest quality outcomes based on evidence based medical studies and principles. We are also committed to the finest patient and family experience possible. This includes adhering to our belief in a healing environment and evidence based design in our facility development. It also includes outstanding service, friendliness, compassion and caring in our relationships with our patients and their families, as well as in our relationships with each other as co-workers and colleagues. We are extremely aware of the significant impact of health care costs on individuals and families, and dedicate ourselves to providing the highest quality care at the optimal cost levels which we can achieve. We are committed to transparency and accountability as we strive to reach these goals. Billings Clinic is completely committed to the Institute of Medicine's six aims: safety, effectiveness, patient centeredness, timeliness, efficiency and equity.

Physicians and Billings Clinic

- Collegiality
- Infrastructure Support
- Reasonable/Excellent Salary and Benefits
- Diversity of Professional Opportunities
- Physician Led Organization
- Quality of Clinic and Hospital Environment
- Quality of Non-Physician Staff
- Billings Clinic Strategy and Tactics
- Billings Clinic Reputation and Brand
- Opportunity to be Part of the "Best"
- Montana: "The Last Best Place", "State of Mind out West"

Themes

- Importance of Group Practice Model
- Physician Leadership
- Quality, Safety, and Service as Core Strategy
- Professionalism, Ethics
- Financial Stewardship, Producing Value
- Consistency of Purpose

Billings Clinic Quality and Patient Safety Awards, Recognition and Accreditations

Modern Health Care's Most Wired

2003, 2007

Mountain-Pacific Quality Health Foundation Quality Award

2003-2012

VHA National Leadership Award for Clinical Effectiveness

2004 – 2006

HealthGrades Distinguished Hospital Award for Clinical Excellence

2004, 2005, 2013

Solucient 100 Top Hospitals in America Modern Healthcare and Truven Health Analytics

2004, 2013

Solucient - Thomson Reuters 100 Top Hospitals in America for Cardiovascular Care

2004 – 2009

VHA National Leadership Award for Clinical and Operational Effectiveness

2005 – 2007

Employer of Choice

2005

Billings Clinic Quality and Patient Safety Awards, Recognition and Accreditations

Verispan 100 Most Highly Integrated Healthcare Networks in America

2005

Magnet™ Designation by the American Nurses Credentialing Center

2006 – 2010, re-designated 2011-2015

HealthGrades Distinguished Hospital Award for Patient Safety

2007, 2010, 2011, 2012

Beacon Award for Critical Care Excellence

2007-2010, 2013-2016

National Cancer Institute Community Cancer Centers Program

2008 – 2014

National Committee for Quality Assurance/American Diabetes Association

Diabetes Physician Recognition Program

2010-2013

Quest Top Performing Hospitals Award by Premier Healthcare Alliance

2011

Billings Clinic Quality and Patient Safety Awards, Recognition and Accreditations

"A" Rating for Hospital Safety by The Leapfrog Group

2011, 2012

Women's Choice Award – America's Best Hospitals for Patient Experience

2012

Accredited as an Accountable Care Organization by The National Committee for Quality Assurance

2012

Rated #1 in Nation for Patient Safety by Consumer Reports ®

2012

US News and World Report Best Regional Hospitals - #1 in Montana for Diabetes and Endocrinology, Gynecology, Nephrology and Pulmonology

2012-2013

US News and World Report Best Nursing Homes – Five Star Rating for Transitional Care Unit

2013

Early Adoption and Innovation

- Quality and Safety White Paper 2002
- Personal Service Excellence
- Collaboratives
  - AMGA
  - VHA
  - Premier
  - AHA
  - AMA

Early Adoption and Innovation

- Cerner IT Adoption 2004
- 2005 Best in Nation Vision
- Reinertsen Retreats
- Billings Clinic Brand Decision
- Scouting Missions
- Regional Health System Development

Early Adoption and Innovation

- CMS Physician Group Practice Demonstration and Transition Demo
- Magnet Designation
- Complexity Theory Initiatives
- Medicare Shared Savings Pilot
- Bundling: Hip & Knee

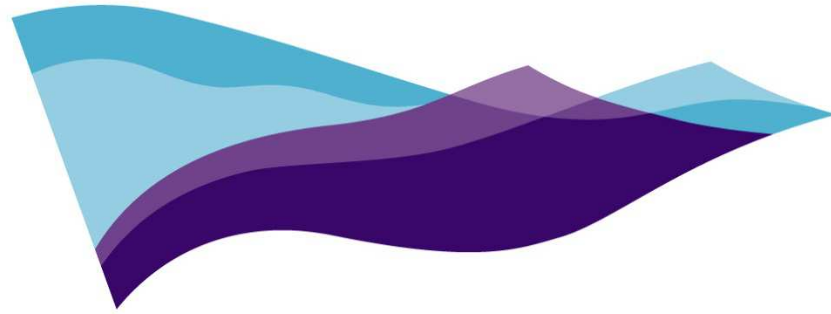
Early Adoption and Innovation

- Leadership Billings Clinic
- Physician Leadership HayGroup Project
- BCBS Medical Home Project
- NCQA ACO Designation
- Operational Excellence (Lean Six Sigma)
- Cerner Partnership

Early Adoption and Innovation

- Mayo Clinic Care Network
- New West Health Services (Medicare Advantage)
- Research and Center for Translational Research
- Board Quality and Safety Committee
- Internal Medicine Residency

Some Brief Examples



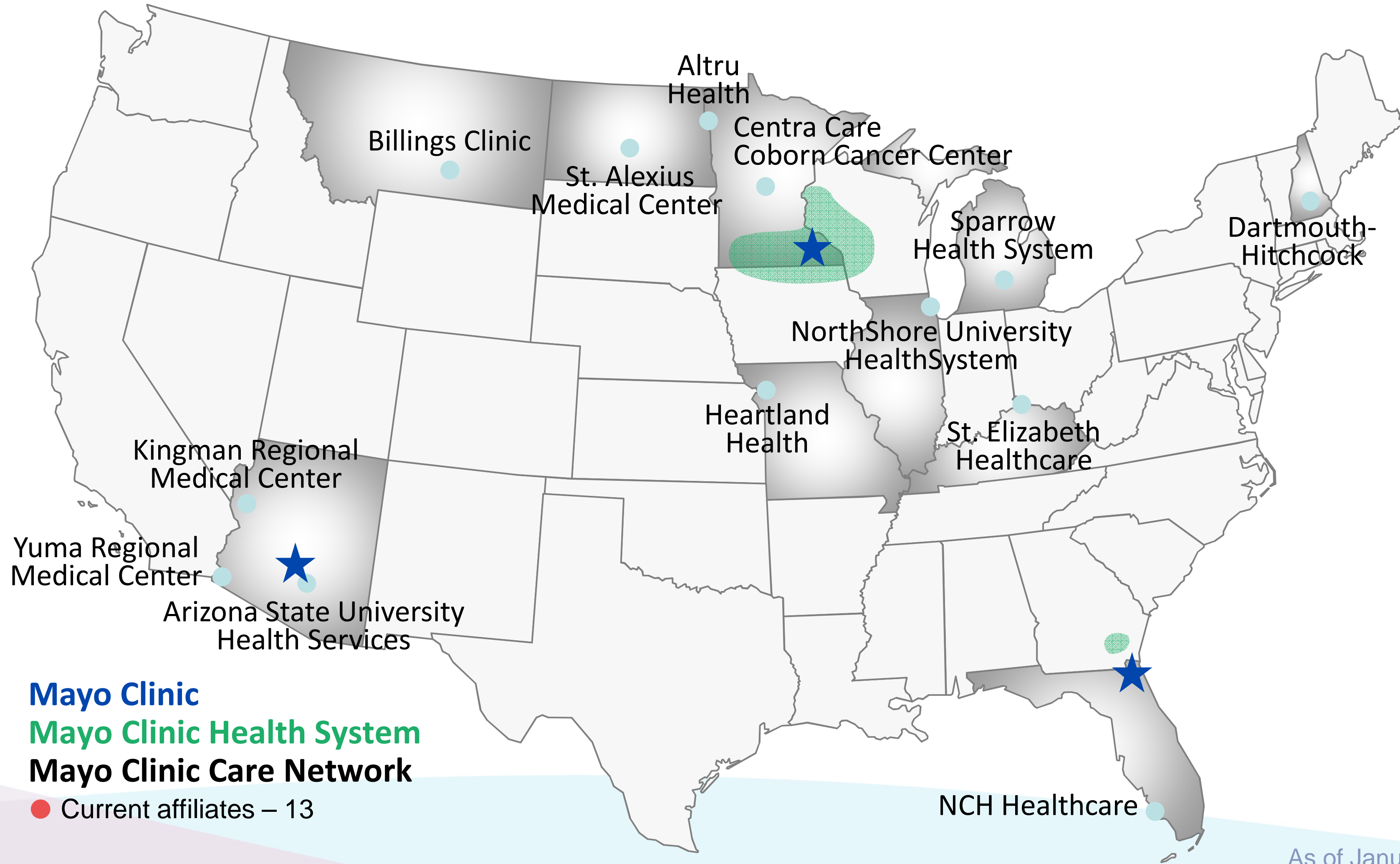
Billings Clinic

To Build a Strong Brand, You Must Go Deep!

Source: Monigle 2004

MAYO CLINIC CARE NETWORK

Current Affiliates by Location



As of January 2013

10 Key Strategies

Patient Safety and Clinical Excellence - The right care for each patient, the first time and every time.

Personal Service Excellence - Provide world class patient-centered service.

Innovation - Implement innovative medical technologies and apply clinical research to improve direct patient care.

Operational Improvement - Achieve operational performance targets and improve care and support processes.

Physician Leadership - Maximize the value of the group practice structure and develop physician leadership skills required to fulfill our vision.

Organizational Culture - Provide a workplace environment that attracts and retains talented physicians and staff.

Information Systems Solutions - Develop and implement strong and innovative information systems and technology which enable outstanding clinical care and a superior business model.

Our People - Strengthen and sustain physician, administrative, and staff capabilities to achieve service and operational performance excellence.

Financial Strength and Community Stewardship - Demonstrate financial stewardship by creating the financial capacity to ensure that the highest quality patient care and value are delivered to our community and region.

Net Revenue Growth - Focus on targeted service and market development to achieve an operational scale that enables clinical excellence, improved access to services and stronger financial performance.

Vision: Billings Clinic will be a national leader in providing the best clinical quality, patient safety, service, and value.

Patient Care

*As **customers** of the Health Care Organization's services, what do we want, need or expect?*

Personal Service Excellence

Provide world class patient-centered service.

Patient Safety and Clinical Excellence

The right care for each patient, the first time and every time.

Clinical and Business Processes

*As members of the **Health Care Organization staff**, what do we need to do to meet the needs of the patients and health care community?*

Operational Improvement

Achieve best practice operational performance targets to improve care and support processes.

Innovation

Implement innovative medical technologies and apply clinical research to improve patient care.

Learning and Support

*As a **Health Care Organization**, what type of culture, skills, training and technology are we going to develop to support our processes?*

Information Systems Solutions

Develop and implement strong and innovative information systems and technology which enable outstanding clinical care and a superior business model.

Our People

Strengthen and sustain physician, administrative, and staff capabilities to achieve service and operational performance excellence.

Organizational Culture

Provide a workplace environment that attracts and retains talented physicians and staff.

Physician Leadership

Maximize the value of the group practice structure and develop physician leadership skills required to fulfill our vision.

Growth and Development

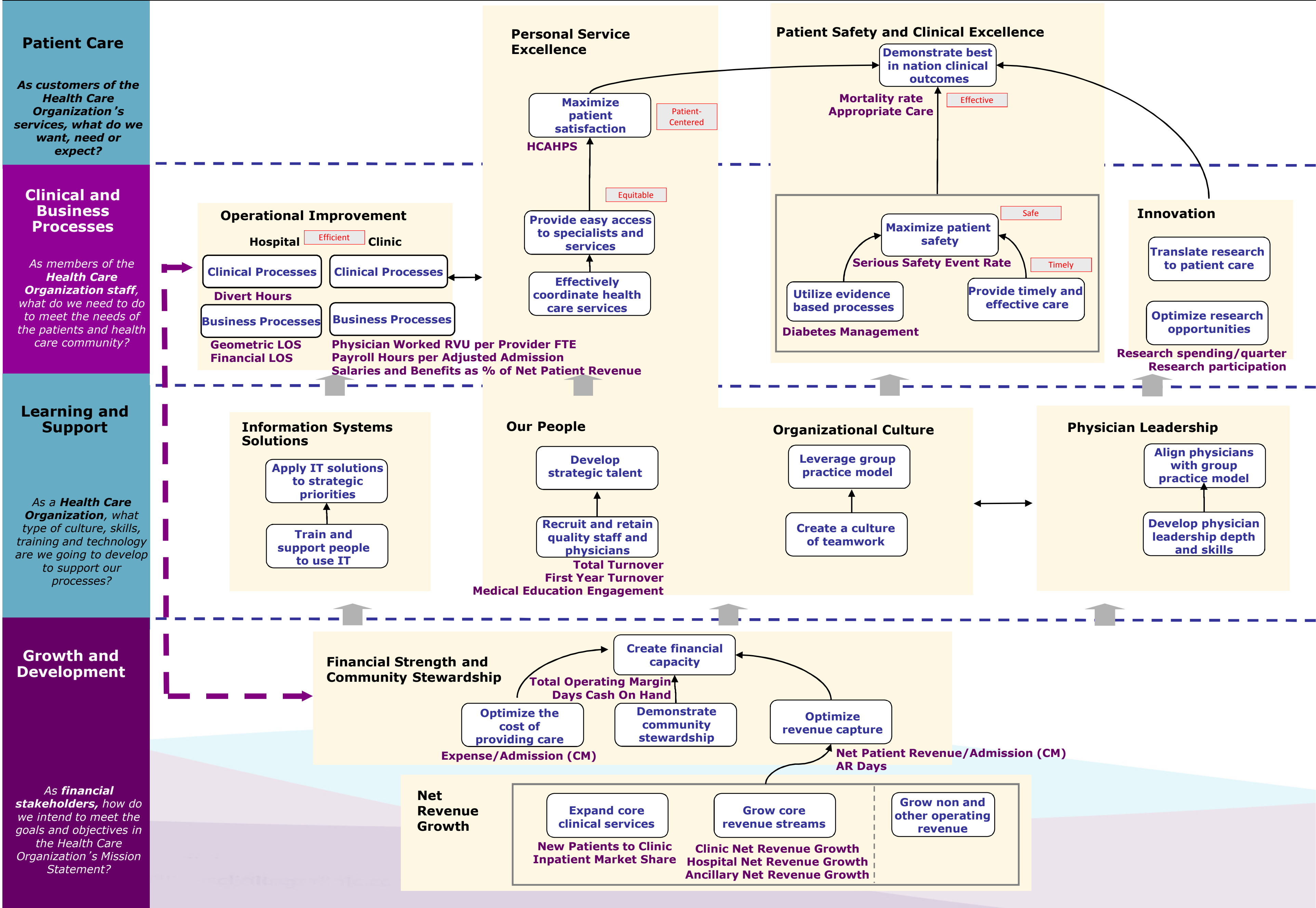
*As **financial stakeholders**, how do we intend to meet the goals and objectives in the Health Care Organization's Mission Statement?*

Financial Strength and Community Stewardship

Demonstrate financial stewardship by creating the financial capacity to ensure that the highest quality patient care and value are delivered to our community and region.

Net Revenue Growth

Focus on targeted service and market expansion to achieve an operational scale that enables clinical excellence, improved access to services and stronger financial performance.



Vision: Billings Clinic will be a national leader in providing the best clinical quality, patient safety, service, and value.
Patient Care
As customers of the Health Care Organization's services, what do we want, need or expect?
Personal Service Excellence
Maximize patient satisfaction
Patient-Centered
HCAHPS
Patient Safety and Clinical Excellence
Demonstrate best in nation clinical outcomes
Mortality rate
Appropriate Care
Effective
Clinical and Business Processes
As members of the Health Care Organization staff, what do we need to do to meet the needs of the patients and health care community?
Operational Improvement
Hospital
Efficient
Clinic
Clinical Processes
Clinical Processes
Divert Hours
Business Processes
Business Processes
Geometric LOS
Financial LOS
Physician Worked RVU per Provider FTE
Payroll Hours per Adjusted Admission
Salaries and Benefits as % of Net Patient Revenue
Equitable
Provide easy access to specialists and services
Effectively coordinate health care services
Safe
Maximize patient safety
Serious Safety Event Rate
Timely
Utilize evidence based processes
Provide timely and effective care
Diabetes Management
Innovation
Translate research to patient care
Optimize research opportunities
Research spending/quarter
Research participation
Learning and Support
As a Health Care Organization, what type of culture, skills, training and technology are we going to develop to support our processes?
Information Systems Solutions
Apply IT solutions to strategic priorities
Train and support people to use IT
Our People
Develop strategic talent
Recruit and retain quality staff and physicians
Total Turnover
First Year Turnover
Medical Education Engagement
Organizational Culture
Leverage group practice model
Create a culture of teamwork
Physician Leadership
Align physicians with group practice model
Develop physician leadership depth and skills
Growth and Development
As financial stakeholders, how do we intend to meet the goals and objectives in the Health Care Organization's Mission Statement?
Financial Strength and Community Stewardship
Create financial capacity
Total Operating Margin
Days Cash On Hand
Optimize the cost of providing care
Expense/Admission (CM)
Demonstrate community stewardship
Optimize revenue capture
Net Patient Revenue/Admission (CM)
AR Days
Net Revenue Growth
Expand core clinical services
New Patients to Clinic
Inpatient Market Share
Grow core revenue streams
Clinic Net Revenue Growth
Hospital Net Revenue Growth
Ancillary Net Revenue Growth
Grow non and other operating revenue

IT Strategy and Tactics

- Financial Sysytems shared across the rgion
- Single EMR clinic, hospital, regional clinics, CAH affiliates
- Early qualifier meaningful use
- In process: robust revenues cycle improvements, new general ledger and HR, data warehouse, decision support, real time clinical info and tools,
- Cerner partnership

2005

By 2010, Billings Clinic will be recognized as the health care organization providing the best clinical quality, patient safety, and service experience in the nation.

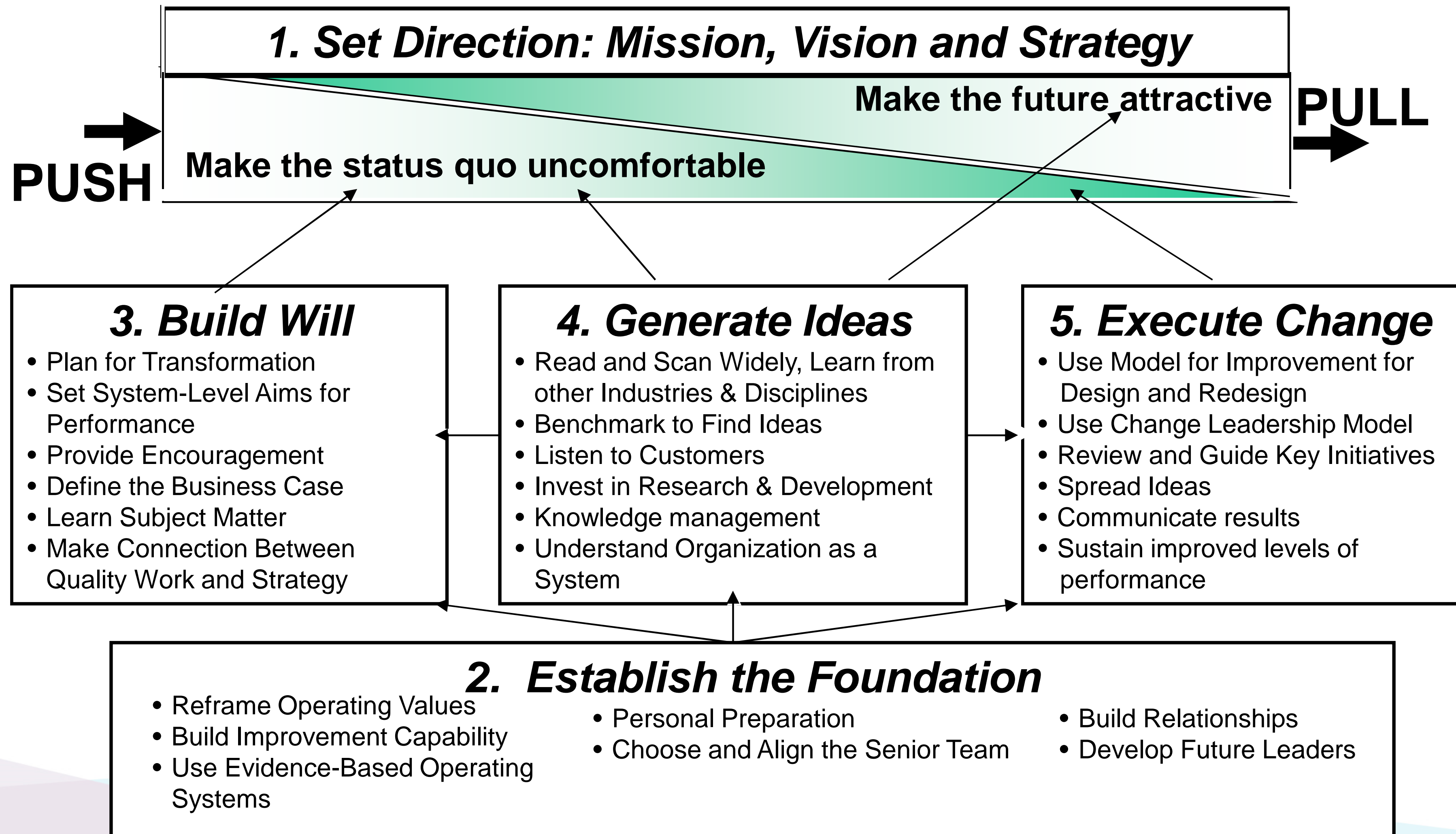
Quality Focus: Key Milestones

- 1997 - Clinic embraced an obsessive dedication to quality and service as a cornerstone to its future success
- 2001 - Billings Clinic's White Paper on Quality Adopted, "Right care for each patient, first time and every time"
  - Established focus of the system, department, budgetary commitment, dedication to alignment to the national quality agenda
  - Philosophy to pursue national collaborations
- 2004 - Restatement of the vision placing quality and patient safety as the core strategy of the organization
  - "A Theory for Leadership on the Transformation for Health Care Organizations" by Jim Reinertsen, M.D.
- 2005 - Billings Clinic White Paper on Patient Safety
- 2006 - ANCC Magnet Designation
- 2005- 2012 Diverse Recognition, most recently Consumer Reports Pt Safety

Billings Clinic Culture of Quality and Safety

- CMS PGP Demo
- Early Adopter CMS Core Measures
- ICU Bundles (Pronovost)
- MRSA Reduction Using Positive Deviance Technique
- Specialty Society Quality Data: STS, ACC, NSQP
- Chronic Disease Registries
- PACE
- Magnet/Beacon
- Center Translational Research
- NCCCP
- CMS PGP Demo
- Quest/Premier ACO Demo

Leadership for Transformation



© 2002 Institute for Healthcare Improvement

PGP Demo: Financial Outcomes

Savings:

- **Year 1: $9.5M, 2 org → $7.3M**
- **Year 2: $17M, 4 orgs→ $13.8M**
- **Year 3: $32.3M, 5 orgs→ $32.3M**
- **Year 4: $37.8M, 5 orgs→ $31.7M**
- **Year 5: $36.2M. 4 orgs→ $29.4M**

5 yr. Savings Total= $133M* $115M shared with 6 orgs

- **1 org captured >50% total**
- **5th year savings payment reflects 1.8% of net patient expend**

For most, savings < ↓ revenues/business costs of implement.

Risk adjustment was significant factor in performance

Data feedback problematic; reconciliation @ 18 months

True patient engagement hampered by retro attribution

Overall evaluation of success?

- **10 separate comparison groups and no national benchmark**

**Only amounts >2% threshold are recognized, actual net $218M*

PGP Demo: Clinical Outcomes

Clinical interventions applied to all patients, payer-neutral

Increased focus on population management and chronic disease

Increased outpatient utilization, decreased inpatient utilization. Examples from PGP organizations:

- *40% reduction of HF hospitalizations ($4M+ revenue) for 15% pop*
- *20% reduction in 1 day psych hospitalizations*
- *Planned visits , improved PCP access to reduce emergency visits*
- *Chronic condition management for anticoagulation, HF, lipids, diabetes, & 24/7 nurse triage*
- *Risk stratification with case management for complex patients*
- *Improved coordination for transitions in care*

Significant spending on EMR optimization & quality reporting/documentation

All 10 orgs with significant quality achievement (year 5, 7@100%)

Only Half of PGP[1] Participants Saw Significant Financial Upside

Physician Group Practice	Location	Year 1 ($)	Year 2 ($)	Year 3 ($)	Year 4 ($)	Year 5 ($)
Marshfield Clinic	Marshfield, WI	$4.8 M	$5.8 M	$13.8 M	$16.2 M	$15.8 M
University of Michigan Faculty Group Practice	Ann Arbor, MI	$2.8 M	$1.2 M	$2.8 M	$5.2 M	$5.3 M
St. John's Clinic	Springfield, MO	0	0	$3.1 M	$8.2 M	$2.6 M
Dartmouth-Hitchcock Clinic	Lebanon, NH	0	$6.7 M	$3.6 M	$0.3 M	0
Park Nicollet Clinic	St. Louis Park, MN	0	0	0	0	$5.7 M
Geisinger Clinic	Danville, PA	0	0	$2.0 M	$1.8 M	0
Everett Clinic	Everett, WA	0	$0.1 M	0	0	0
Billings Clinic	Billings, MT	0	0	0	0	0
Forsyth Medical Group	Winston Salem, NC	0	0	0	0	0
Middlesex Health System	Middletown, CT	0	0	0	0	0

© The Advisory Board Company

Summary Results

	PY1	PY2	PY3	PY4	PY5	Average Annual	5 year Expenditures
	1.21%	2.00%	2.56%	3.63%	2.37%	2.39%	
			5 Year	Savings		**$218,573,184**	**$9,161,179,345**

How The PGP (2005-2010) Influenced the Development of ACOs

Accountable Care Act-2010: ACO provisions include

- Primary Care Attribution
- National comparison targets
- Target is absolute spending increase over base
- Retains risk adjustment

Transition Demo (2011-12)

- Incorporated changes in ACA provisions
- Improved data reporting from CMS
- Quality Measures 32→45
- Discussions/development led to first ACO proposals that ignored some PGP recs
- The national consensus supported the PGP groups recommendations

Final ACO Regs

- Quality Measures 65→33
- Eliminate 25% withhold
- First Dollar sharing after minimum savings threshold
- Allows for 1 or 2-sided risk
- Preliminary prospective assignment

Comparison of Shared Savings Models

	PGP	TD	ACO	Pioneer
Attribution	retrospective All Specialty	retrospective Primary Care	retrospective Primary Care	retrospective Primary Care
Base	Prior Year (2004)	3 -year wt. Averaging	3-year wt. Averaging	3-year wt. Averaging
Term (before re- basing)	3-->5 years	2	3	3
Comparison	Local Rate of growth	National Absolute amount	National Absolute amount	National 50% amount + 50% rate growth
Threshold (MSR)	2%	1.47%-4.65%	2-3.9% or 2%	1%
Savings	80% above MSR	50% first dollar	50% above MSR or 60% first dollar	50% first dollar
Quality Gate	50%	80%, 90%	100%	100%
Quality Measures	32	45	33	33
Loss Risk	No	No	No (1 sided) Yes (2 sided)	Yes
Risk Adjustment	retrospective updated yearly	prospective adjusted yearly	prospective fixed for term	prospective fixed for term

MSSP: Billings Clinic View

- Attribution improved- still retrospective, 60% stayer rate
- Threshold a problem for smaller poulations (BC 12,000+ bens, 3.4% threshold)
- Quality/safety measures reasonable- reporting vs achieving benchmark issue
- Risk adjustment fixed for 3 years
- Beneficiary notification
- HCAHPS, CCAHPS

Bundled Payment Initiative

Major joint replacement or reattachment of lower extremity w/o MCC

	Billings Clinic	Compare Group
Count of Anchor Admissions:	187	1,878
0-90 days post discharge spend:		
Total Post Acute Care - Part A and B	$5,665	$5,073
Readmissions	$156	$408
Skilled Nursing Facility	$4,419	$2,328
Home Health	$737	$990
All Other	$353	$1347

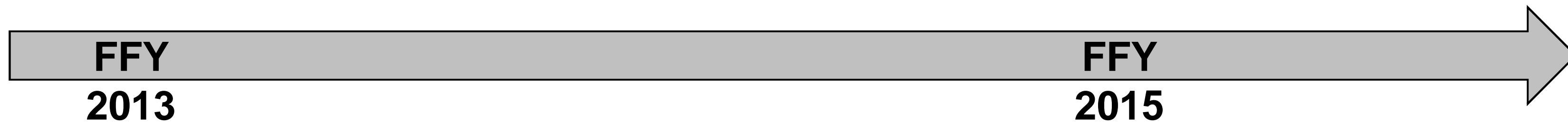
Strengths/Opportunities

Readmissions: Billings Clinic's cost for readmissions are well below the compare group and national benchmarks for high performing facilities.

Skilled Nursing Facility: Billings Clinic cost for post acute skilled nursing facilities is well above compare group and national benchmarks for high performing facilities.

Opportunity is to shift post acute discharge to home health or outpatient rehabilitation when clinically indicated. Both settings provide cost savings for Medicare.

VBP in Context:
Mandatory Delivery System Reforms for Hospitals



VBP	Readmissions	HACs	EHR Meaningful Use (ARRA)
• Begins October 1, 2012 (FFY 2013) • Redistributes inpatient payments • Budget neutral	• Begins October 1, 2012 (FFY 2013) • Cuts Medicare inpatient payments • $7 billion cut /10 years nationwide	• Begins October 1, 2014 (FFY 2015) • Cuts Medicare inpatient payments • $1.4 billion cut / 10 years nationwide.	• Incentives for qualifying hospitals now • Cuts Medicare inpatient payments in FFY 2015 for hospitals that do not meet "meaningful use" standard

Implications of Mandatory Delivery System Reforms

- Hospitals will be competing against each other
- Play or pay

VBP	Readmissions/HACs	EHR Program
• Best performers win • Others break even or lose	• No winners, only losers	• Carrot and stick

Medicare DRG $$$ at Risk for Quality Performance

	2013	2014	2015	2016	2017
Value Based Purchasing	1% of All DRGs	1.25% of All DRGs	1.5% of All DRGs	1.75% of All DRGs	2.0% of All DRGs
Hospital Acquired Conditions			1% of All DRGs	1% of All DRGs	1% of All DRGs
Re-admissions	1% of All DRGs	2% of All DRGs	3% of All DRGs	3% of All DRGs	3% of All DRGs
Total:	**2% of All DRGs**	**3.25% of All DRGs**	**5.5% of All DRGs**	**5.75% of All DRGs**	**6% of All DRGs**

Physician Quality Reporting System

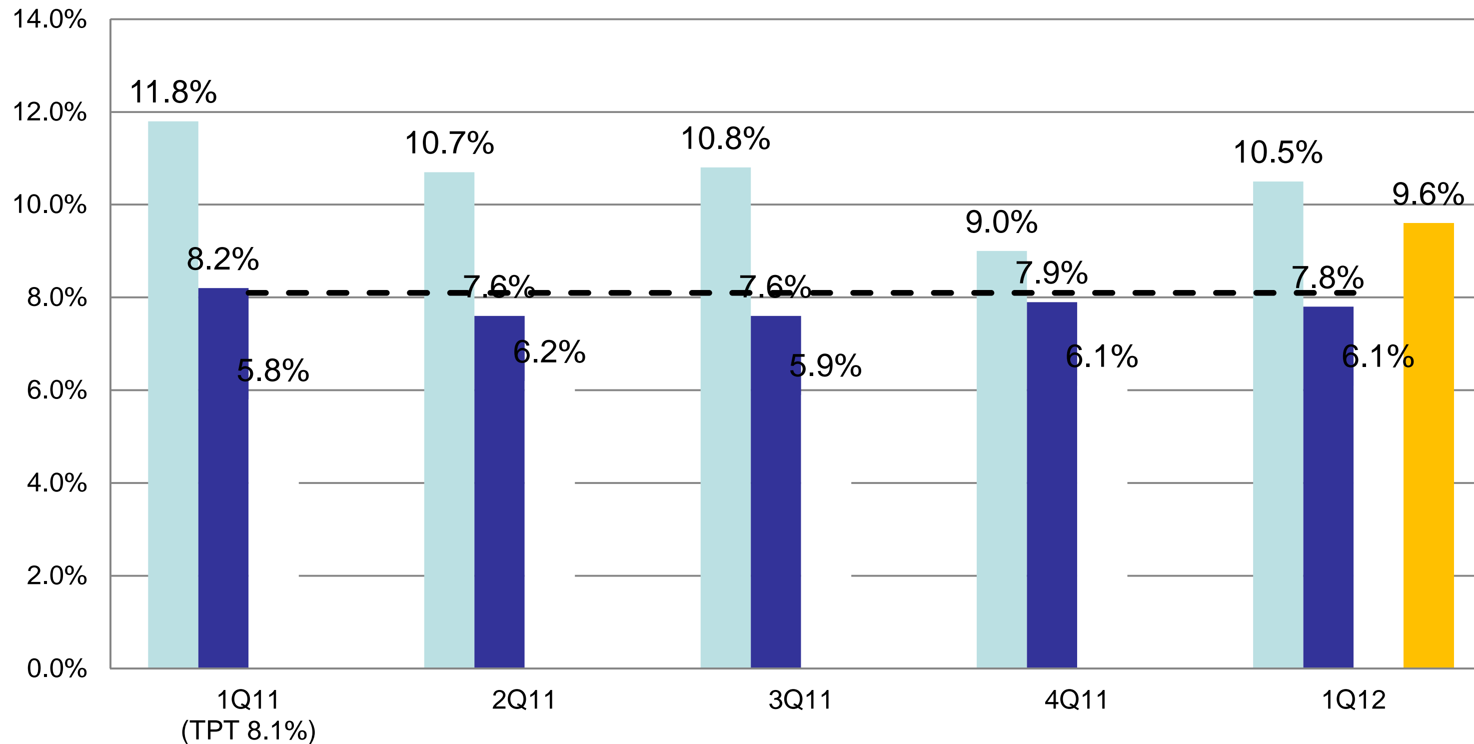
(Formerly know as Physician Quality Reporting Incentive [PQRI])

Incentive to Penalty

2008	2009	2010	2011
1.5% of Medicare B PFS	2% of Medicare B PFS	2% of Medicare B PFS	2% of Medicare B PFS
2012	**2013**	**2014**	**2015**
1% of Medicare B PFS	.5% of Medicare B PFS	.5% of Medicare B PFS	Penalty to be enacted for non-reporting (1.5-2%)

QUEST
Charter Member Performance Report

30-day Readmission - All Cause
(lower is better)



Data Source: Premier QUEST
End user: QUEST Charter Members
Frequency: Quarterly

Why PCMH within ACO?

- Emphasizes prevention
- Encourages cognition/relationship over technology
- Less variation in utilization
- Allows for most efficient delivery methods: allied professionals, phone, e-mail, web-enabled
- Proven concept in other modern nations, staff-model HMOs
- Access closest to patients
- Promotes shared decision making
- Leverage point for post-hospital care

Common Elements of PCMH

- Patient Registry to establish a population served.
- Identifying and correcting gaps in care.
- Chronic disease monitoring.
- Reporting quality metrics using common data elements (HEDIS, AHRQ, CMS).
- Reporting to providers on performance.

PCMH-Physician Groups (*=active)

Physician Group	Number of Physicians
Billings Clinic*	77 MD (16 IM, 25 FP, 18 Peds, 18 OB), 23 Midlevel
Western Montana Clinic*	31 MD (8 IM, 14 FP, 5 Peds, 4 OB), 7 Midlevel
St. Patrick's Hospital*	15 MD (6 IM, 9 FP), 5 Midlevel
Benefis	14 MD (7 IM, 3 FP, 4 OB), 5 Midlevel
St. Peters Hospital	14 MD (2 IM, 12 FP)
Kalispell Regional MC*	20 MD (3 IM, 6 IM-Peds, 11 FP), 11 Midlevel
Comm. Medical Center*	20 MD (5 IM, 11 FP, 4 Peds), 7 Midlevel
Bozeman Deaconess*	26 MD (9 IM, 6 FP, 6 Peds, 5 OB), 7 Midlevel
Northern Montana Hosp.	10 MD (3 IM, 5 FP, 2 OB)
St. Vincents*	9 MD (7 IM, 2 FP)
Holy Rosary Healthcare	4 MD (1 IM, 1 FP, 2 OB)
Total Phys./Midlevels	**240 MD (67 IM, 99 FP, 6 IM-Peds, 33 Peds, 35 OB), 65 Midlevel.**

2012 BCBSMT PCMH Program

Chronic Diseases

- Asthma
- Ischemic Vascular Disease
- Depression
- Diabetes
- Hypertension

Preventative Care

- Preventative exam
- Smoking status
- BMI
- BP
- Breast cancer screening
- Cervical cancer screening
- Colon cancer screening
- Immunizations

PCMH PMPM Financial Trending

(Total Cost of Care for Attributed Members Expressed as Allowed Amounts)

PCMH

(16,459 BCBSMT Attributed Members)

	2009	2010	2011	Trend
Total PMPM	$329	$366	$349	3.08 %
Risk Adjusted PMPM	$260	$277	$262	0.34 %
$100,000 Stop-Loss, Excess Risk Adjusted	$334	$349	$352	2.6%

All Other PCP

(36,254 BCBSMT Attributed Members)

	2009	2010	2011	Trend
Total PMPM	$321	$337	$368	7.08 %
Risk Adjusted PMPM	$248	$253	$255	1.42 %
$100 ,000 Stop-Loss, Excess Risk Adjusted	$319	$345	$366	7.24 %

Individual PCMH Groups
(3 year average trend)

PCMH Group	Comment	Attributed Patients	PMPM Trend	RA PMPM Trend	$100 K SL With Excess RA
Billings Clinic	**3 year PCMH**	**5,429**	**-0.14%**	**-3.74%**	**0.79%**
PCMH Group 2			-1.65%	-6.67%	0.59%
PCMH Group 3			11.72%	15.13%	10.68%
PCMH Group 4			9.90%	14.32%	6.29%
PCMH Group 5			5.81%	11.29%	0.94%
PCMH Group 6			-8.67%	-10.02%	- 8.25%
PCMH Group 7			11.27%	7.64%	12.26%

Cultural Assessment 2012

Safety Attitudes Questionnaire (SAQ)

Teamwork and Safety Climate Version

Comparative Feedback Report

Departments Surveyed & Response Rates

Survey Year	# Departments Surveyed	Response Rate
Spring 2005	13 (Hospital)	80%
Fall 2006	11 (Hospital)	54%
Spring 2008	20 (Hospital)	90%
Spring 2010	75 (Clinic, Long Term Care, Hospital)	93%
Fall 2012	78 (Clinic, Long Term Care, Hospital)	91%

Respecting the Wisdom Of Frontline Caregivers: *"The way we do things around here"*

- Frontline caregiver assessments of safety culture are measurable using the Safety Attitudes Questionnaire (SAQ)

- SAQ is the most widely used and thoroughly validated instrument in healthcare.

- SAQ results are:
  - ✓ reliable
  - ✓ responsive to interventions
  - ✓ and predictive of clinical and operational outcomes.

Pascal Metrics
The Social Apgar™ Group

Culture is related to clinical & operational outcomes

1. Medication errors
2. Back injuries
3. Patient satisfaction
4. Nurse turnover & absenteeism
5. AHRQ Patient Safety Indicators
6. Nurse satisfaction
7. Urinary tract infections
8. Malpractice claims

...and more.

Useful References for Culture-to-Outcomes Linkage:

- Hofmann & Mark (2006)
- Katz-Navon et al. (2005)
- Mark et al. (2007)
- Naveh et al. (2005)
- Singer et al. (2008)
- Vogus & Sutcliffe (2007)

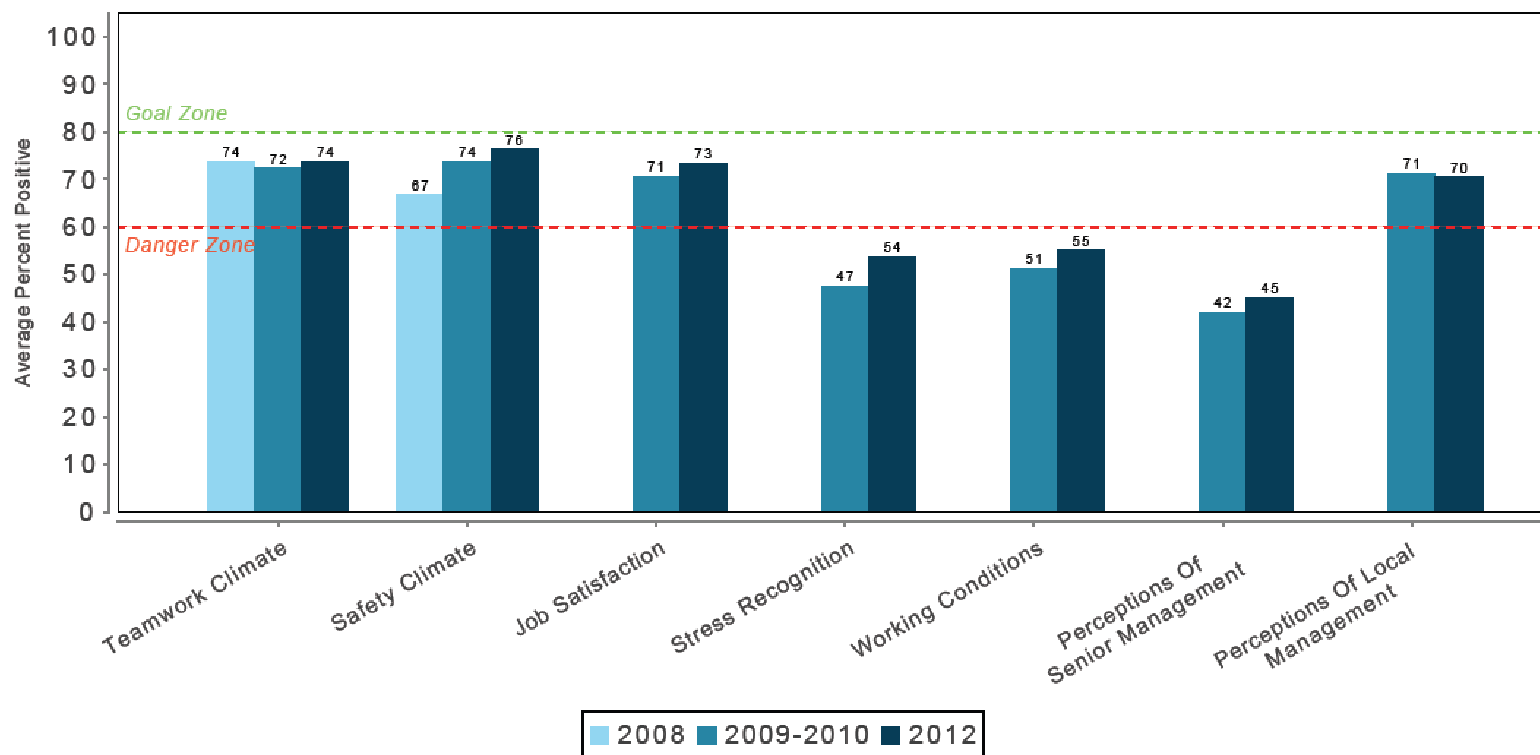
 Confidential © 2009 Pascal Metrics

Survey Interpretation

- Target Culture of 80% or higher: Threshold of excellence at 80%, or when 4 out of 5 people agree that teamwork climate is good, the consensus is strong and stable over time.
  - Further improvements from 80% to 100% is not associated with the same improvements in outcomes as improvement from 50% to 70%
- Danger Zone (needs improvement): Threshold of risk below 60%, or when fewer than 3 out of 5 people agree that safety climate is good.
- The lack of consensus in assessments of frontline caregivers indicates substandard clinical and operational outcomes
- Culture Goals:
  - Improve by 10 points or more on an item or overall domain score
  - Get out of the Danger Zone (<60% consensus)
  - Reach 80% consensus on perception of teamwork & safety climate

How Healthy Is Our Culture?

Safety Attitudes Questionnaire Domain Scores



*Facility and System scores may differ based on the facility and work setting permissions that have been granted to the user that is downloading the reports.
**See Sources Appendix
Pascal Metrics Patient Safety Organization #0047 -- Privileged and Confidential Patient Safety Work Product: Not Subject to Discovery and Cannot be Used as Evidence.

TEAMWORK CLIMATE RESULTS

Definition
The perceived quality of teamwork and collaboration within a given unit.

Items
1. Nurse input is well received in this clinical area.

2. In this clinical area, it is difficult to speak up if I perceive a problem with patient care.

3. Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).

4. I have the support I need from other personnel to care for patients.

5. It is easy for personnel here to ask questions when there is something that they do not understand.

6. The physicians and nurses here work together as a well-coordinated team.

Intervention
A low teamwork climate stems from persistent interpersonal problems among the members of a given unit. When teamwork climate is low, employees feel that their coworkers are not cooperative, that their voices are not heard by management, and that their efforts are not supported. These feelings can deeply affect employee performance and patient outcomes. During interventions, encourage employees to support each others' work and help their fellow coworkers when problems--such as work overload or a problematic patient--arise. Through conversation, try to understand why they might feel that they can't speak up or aren't being listened to when they do, and seek to address their concerns directly.

Teamwork Climate

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.

75th %ile = 80

50th %ile = 67

25th %ile = 52

Average Percent Positive

*Calculations in benchmark reporting may change on a regular basis as Pascal's benchmarking databases are updated in real-time with new client data.

SAFETY CLIMATE RESULTS

Definition

The perceived level of commitment to and focus on patient safety within a given unit.

Items

1. I would feel safe being treated here as a patient.
2. Medical errors are handled appropriately in this clinical area.
3. I know the proper channels to direct questions regarding patient safety in this clinical area.
4. I receive appropriate feedback about my performance.
5. In this clinical area, it is difficult to discuss errors.
6. I am encouraged by my colleagues to report any patient safety concerns I may have.
7. The culture in this clinical area makes it easy to learn from the errors of others.

Intervention

When employees indicate that they don't perceive a good safety climate, they are messaging that they don't see a real dedication to safety in their unit. Safety climate is significantly related to both caregiver safety (e.g,. needlesticks, back injuries) and patient safety (e.g,. bloodstream infections, decubitus ulcers) and so low safety climate is critical to address. During interventions, emphasize the importance of keeping lines of feedback and communication open. Let employees know that it is OK to bring errors to the attention of managers and clinical leaders. And, let managers and clinical leaders know that they need to be responsive to error reports and show appreciation for having errors brought to their attention.

Safety Climate

Note: Use the multicolored bars to see how you fit with the benchmark archive. If you have less red and more green than the benchmark, you are more positive than the benchmark. If the colors all match up, you are about the same as the benchmark.

75th %ile = 82

50th %ile = 70

25th %ile = 57

Average Percent Positive

What is Patient Safety?

- IOM: Defined as the prevention of harm to patients, with emphasis placed on the system of care delivery that
  - prevents errors
  - learns from the errors that do occur
  - is built on a culture of safety[1]
- AHRQ: Freedom from accidental or preventable injuries produced by medical care[2]
- HPI: "Safety is a dynamic, non-event"[3]

1. Institute of Medicine
2. Agency for Health Care Research and Quality
3. Healthcare Performance Improvement, LLC

High Reliability Organizations

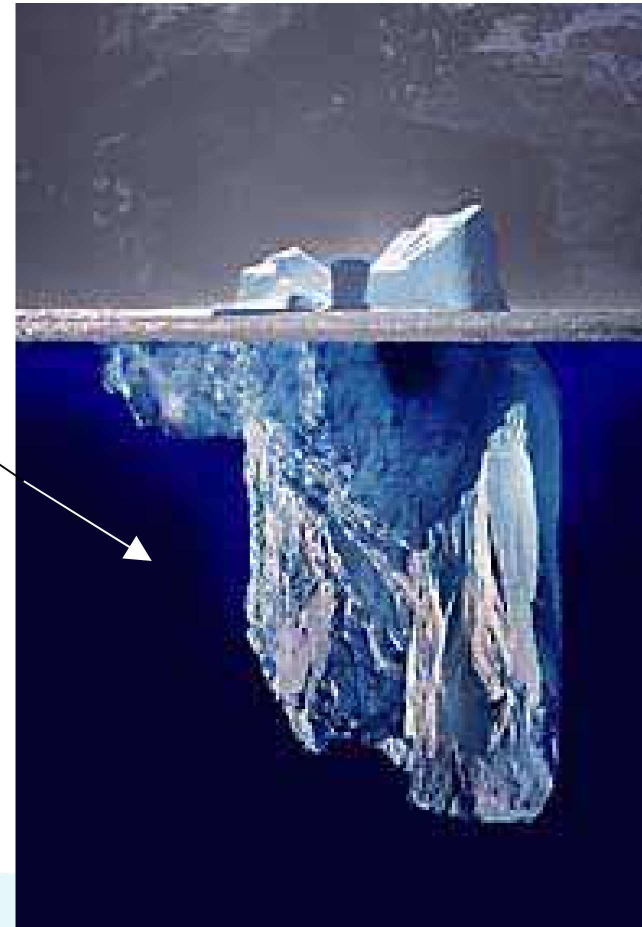
- Known to be complex and risky ~ yet safe & effective
- Acknowledge their complex systems
- Create an environment where people can communicate openly about concerns
- Design systems where it is difficult for failures to occur
- Effective communication, teamwork, shared learning are inherent properties

Highly Reliable Organizations

Analyze Harm Events

•Root Cause Analysis (RCA) ~ a process that identifies causal factor(s) that underlie variation in performance. Is initiated post event or occurrence (retrospective).

•Failure Modes Effects Analysis (FMEA) ~ engineering technique used to proactively identify potential failure modes & develop action plans to mitigate areas of potential process gaps. Ideally performed when new services introduced, new equipment purchased, high risk processes, Joint Commission-issued Sentinel Event Alerts.



~ Ultimate Goal ~

Eliminate Preventable Harm

High Reliability ~ The Patient's Perspective

1. Don't Harm Me
2. Heal Me
3. Be Nice to Me

… in this order

Billings Clinic

Patient Safety Goals 2012

Universal Protocol

- Perform time-out site verification for procedures at bedside, procedural areas, clinic and ORs
  - » Use safe surgical checklist
  - » Practice team briefing/pause

Patient I.D.

- Use two identifiers for all procedures/specimens
  - » Name
  - » Date of birth
- Eliminate blood and blood product transfusion errors
  - » Two person verification of blood required
  - » Include patient in process

Communication of Critical Test Results

- Get test results to the right person on time
- X-rays, labs, other diagnostic tests

Medication Safety

- Label all medications and solutions handed off including on and off sterile fields (hospital and clinic)
- Anticoagulation therapy
  - » Educate patients about safe anticoagulation therapy
- Safe injection practices

Infection Prevention

- Clean hands, every time
- Contact precautions for:
  - » MRSA, C. diff, ESBL-producing gram-negative bacteria
- Educate patients about hand and respiratory hygiene
- Teach patients and visitors about isolation and document
- Implement best practices for surgical site and central line-associated infection prevention
- Implement best practices for catheter-associated urinary tract infection prevention
  - » Use urinary catheters only when necessary
  - » Evaluate daily the need for urinary catheters and remove ASAP
- Get your flu shot

Reconcile Medications

- Obtain accurate medication history
- Compare home medication list to current medication orders
- Patients discharged / departed with an updated medication list

Fall Prevention

- Hourly rounding
- Teach patients to call and not fall
- Outperform NDNQI mean
- Reduce injuries from falls

Pressure Ulcer Prevention (PUP)

- Achieve zero avoidable healthcare-associated pressure ulcers
- Use Braden Risk Assessment (inpatient adult/pediatric)
- Obtain prevention modalities
- Use treatment guidelines/protocol

Suicide Risk Assessment

- Early recognition, assessment and intervention
- Refer to crisis hotline: 1-800-266-7198

2012 Categories of Harm

(January - June 2012)

92 People Harmed

- Serious Safety Events
- Medication Errors
- Med-Surg Oversedation
- Surgical Site Infections (SSI)
- Clostridium difficile Infections
- MRSA Transmissions
- MRSA Infections
- Falls with Moderate Injury
- Falls with Major Injury
- Pressure Ulcers

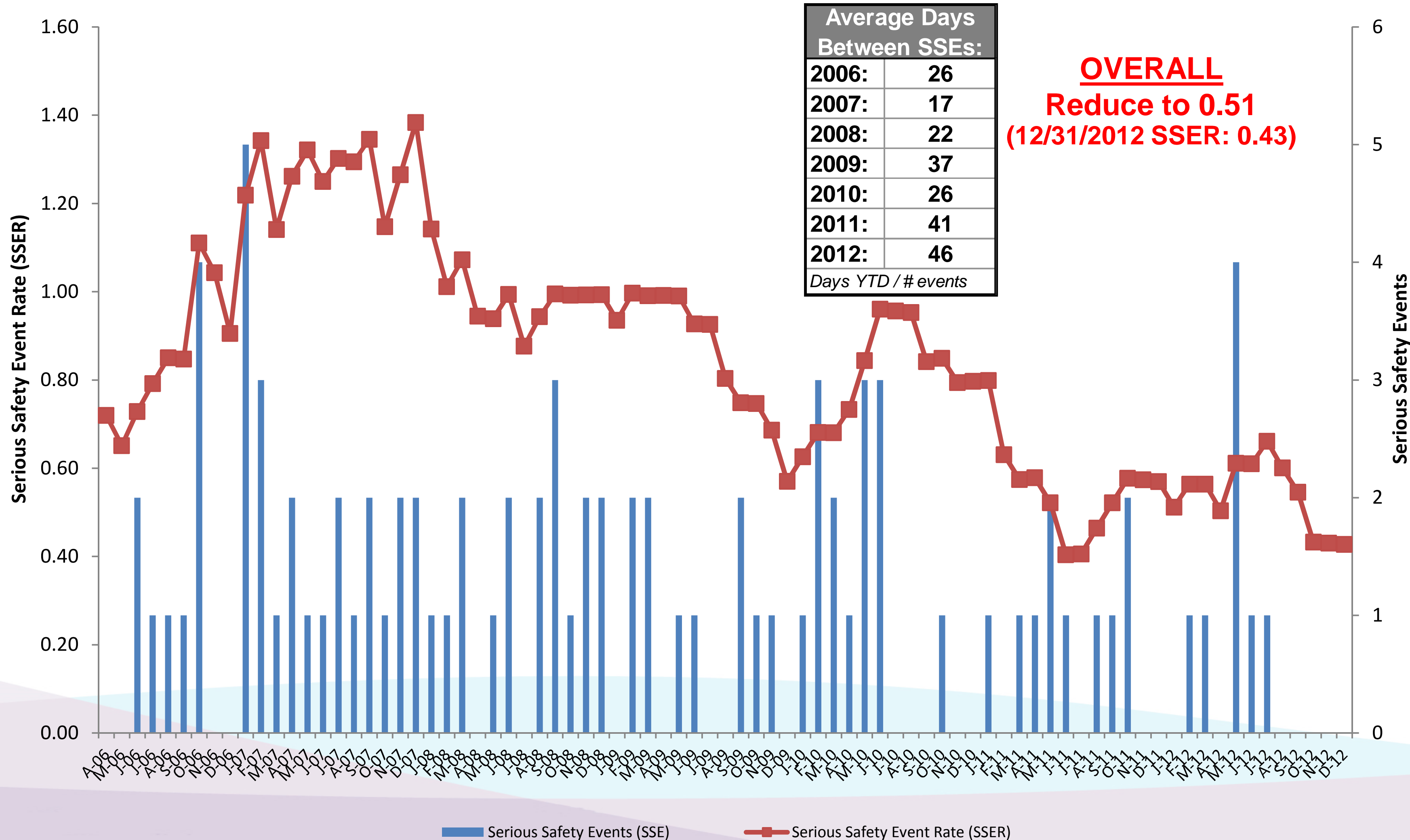
5 17 9 13 33 11 9 5 1 1

Serious Safety Event Rate

Billings Clinic Overall

(Hospital, Clinic, Long-term Care)

Rolling 12-month rate of Serious Safety Events per 10,000 adjusted patient days

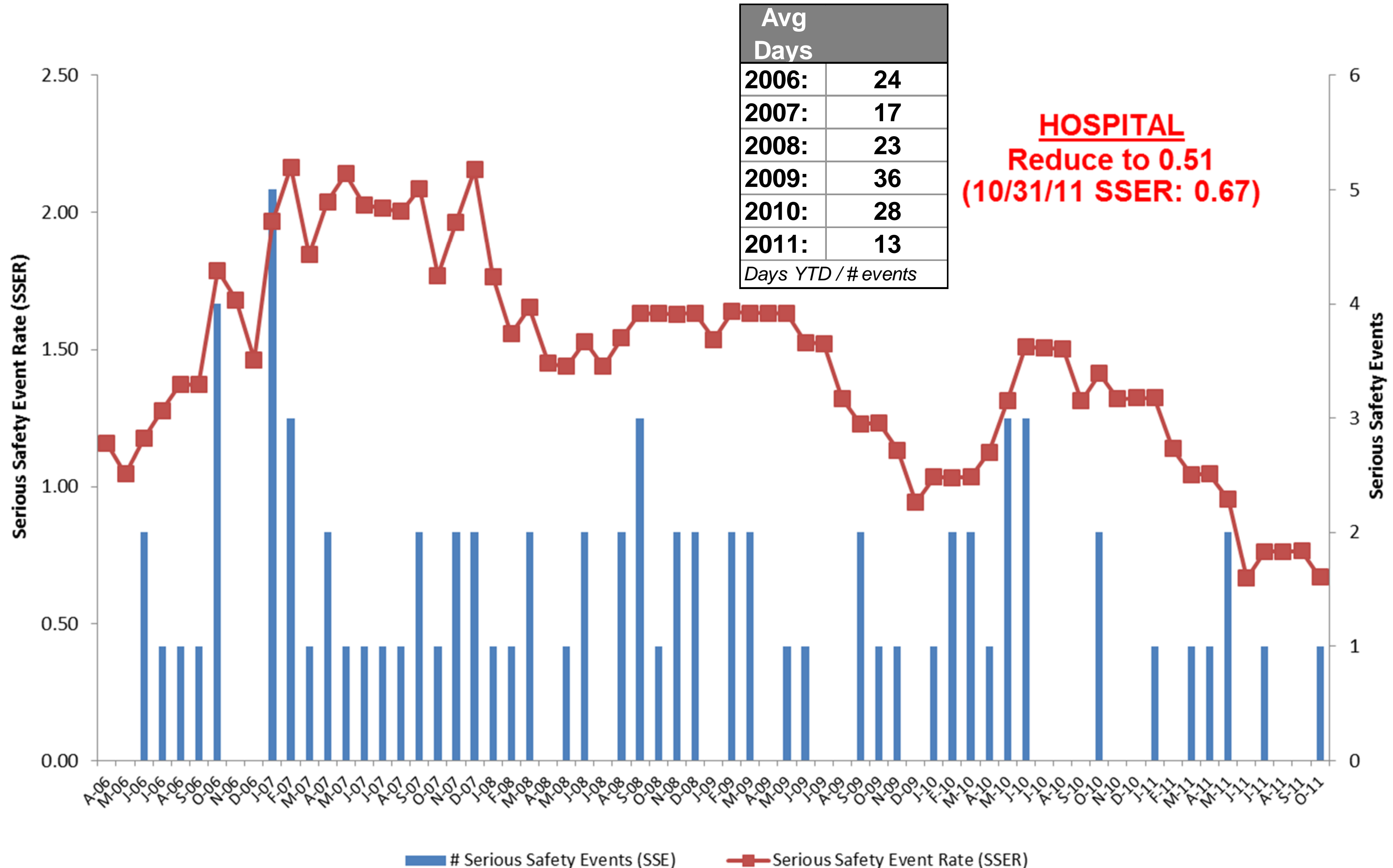


Average Days Between SSEs:	
2006:	26
2007:	17
2008:	22
2009:	37
2010:	26
2011:	41
2012:	46
Days YTD / # events	

Serious Safety Event Rate

Billings Clinic Hospital

Rolling 12-month rate of Serious Safety Events per 10,000 adjusted patient days

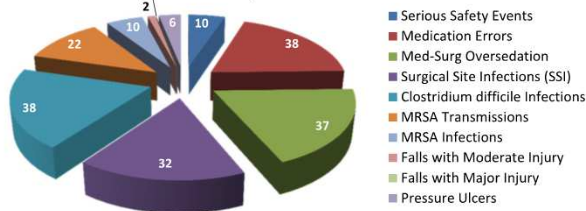


Billings Clinic

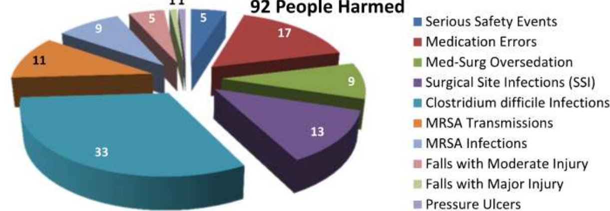
Patient Safety Dashboard

Indicator	Target	National Benchmark	Quarterly (by calendar year) Q1 09	Q2 09	Q3 09	Q4 09	Q1 10	Q2 10	Q3 10	Q4 10	Q1 11	Q2 11	Q3 11	Q4 11	Q1 12	Q2 12	Year to Date (Q3 11 - Q2 12)	Monthly May-12	Jun-12	Jul-12	Aug-12	Quarterly Trend (Q1 '08 - Q2 '12)
Preventable Harm																						
Number of Serious Safety Events	0	Not Available	4	2	2	2	6	7	0	1	2	4	2	2	2	3	9	2	1	0	0	
Serious Safety Events Rate Overall	0.51	Not Available	0.99	0.93	0.75	0.57	0.68	0.96	0.84	0.80	0.57	0.40	0.52	0.57	0.56	0.50		0.50	0.50	0.50	0.44	
Mortality																	Year to Date (July '11 - June '12)					
Mortality: Case Count	≤ 63 / qtr ≤ 21 / mo	Not Available	82	74	88	80	77	90	65	66	78	81	71	62	58	64	255	21	23	16	NA	
Mortality: Rate (# inpatient deaths/# inpatient discharges)	1.50%	Not Available	2.3%	2.0%	2.3%	2.1%	2.0%	2.3%	1.7%	1.7%	2.1%	2.1%	1.9%	1.7%	1.6%	1.8%	1.7%	1.7%	1.9%	NA		
Mortality: Observed to Expected	0.75	0.8 (Premier Quality Advisor)	1.00	0.91	1.00	0.88	0.74	1.79	0.68	0.68	0.95	0.91	1.03	0.78	0.71	0.69	0.75	0.69	0.67	NA		
Reported Medication Errors																						
Reported Medication Errors: Category A-C	0	Not Available	288	255	227	258	216	253	236	192	169	188	139	112	125	100	476	34	36	30	35	
Reported Medication Errors: Category D	0	Not Available	8	11	14	10	5	6	8	6	8	12	4	6	6	8	24	5	2	0	2	
Reported Medication Errors: Category E - H	0	Not Available	1	1	1	3	7	3	2	2	4	3	1	0	1	2	4	1	1	0	1	
Med-Surg Oversedation (by number)	≤ 9 /qtr (≤ 36 / year)	Not Available	24	14	27	14	18	20	23	14	9	7	14	7	3	6	30	3	0	NA		
Med-Surg Oversedation Incidence Rate	1	Not Available	2.56	1.46	2.91	1.52	1.94	2.09	2.32	1.55	0.95	0.73	1.47	0.74	0.32	0.63	0.79	0.97	0.00	NA		
Infection Related																						
Number of Surgical Site Infections (SSI) - targeted procedures (e.g. cardiac CABG, colon, hips, knees, lami, fusion, pacemakers)	0	Not Available	12	7	8	4	6	6	12	8	9	5	11	7	11	2	31	NA				
Surgical Site Infections by Standardized Infection Ratio (SIR)	SIR ≤ 1	SIR ≤ 1 (NHSN)	NA						1.40	0.98	1.20	0.75	1.50	1.08	1.38	0.41	1.187 (Q2 11 - Q1 12)	NA				
Clostridium difficile infections	≤ 3 / qtr	≤ 6 / 10,000 pt days (SHEA)	9	13	8	2	10	4	15	12	11	6	9	12	10	23	54	6	11	2	2	
Hand Hygiene: Prior to Patient Contact	95%	100% (CDC)	89%	88%	86%	88%	89%	92%	93%	93%	95%	95%	96%	96%	96%	97%	96%	96%	98%	97%	97%	
Hand Hygiene: After Patient Contact	95%	100% (CDC)	92%	89%	90%	91%	92%	94%	95%	96%	97%	96%	97%	96%	97%	98%	97%	98%	98%	97%	99%	
Hand Hygiene: After Glove Removal	95%	100% (CDC)	92%	92%	91%	95%	93%	94%	94%	96%	97%	97%	99%	98%	97%	99%	98%	98%	99%	98%	99%	
MRSA Transmission	1	Not Available	9	4	5	3	5	8	7	8	4	9	4	5	4	7	20	4	3	2	1	
Healthcare-associated MRSA infections	≤ 2 / qtr (≤ 8 / year)	Not Available	3	8	2	1	2	7	5	2	2	2	2	4	6	3	15	1	0	0	0	
Patient Falls																						
Number of Falls (ATU, ICC, ICU, IPM, IPS)	≤ 24 / qtr. (≤ 8 / mo.)	Not Available	NA				39	41	39	47	43	36	43	28	27	22	120	8	8	9	13	
Number of Falls with Injury (Moderate level)	0	Not Available	NA				1	0	1	0	0	0	1	1	5	0	7	0	0	0	0	
Number of Falls with Injury (Major level)	0	Not Available	NA				1	0	0	0	0	0	0	0	1	0	1	0	0	0	1	
Pressure Ulcers																						
Hospital Acquired Pressure Ulcers	≤ 1	Below NDNQI mean	8	7	5	3	2	3	1	0	1	1	1	3	1	6	11	NA				

2011 Categories of Harm
195 People Harmed



2012 Categories of Harm
(Quarter 1 & 2)
92 People Harmed



Critical Area of Focus

- *Reported Medication Errors*
- *Clostridium difficile* infections
- Environmental & Hand Hygiene
  - Inter-rater reliability study completed; study results released in October

Patient Safety in Action
"Not on our Watch"

Summer 2010
Volume 1 Issue 2
A publication from the Patient Safety Committee

Did you know? Billings Clinic has had wrong site / wrong patient procedures?

	Number of Actual Events	Type	Location	Near Miss Events
2008	4	1. Wrong level laminectomy 2. Pacemaker generator 3. Wrong side urinary stent 4. Wrong level laminectomy	1. OR 2. Cath Lab 3. OR 4. OR	1
2009	5	1. Cervical diskectomy 2. Nerve block 3. Femoral nerve block 4. Epidural ~ wrong patient 5. Excision of skin lesion	1. OR 2. Radiology 3. PACU 4. ATU 5. Dermatology	50*
2010	0			15

*increase due to active surveillance for near miss events

Contributing Factors Identified

- Non-standardized time-out process
- Not following time-out or site verification process
- Handoff communication breakdown
- No reconciliation of written & CPOE orders
- Scheduling errors, wrong site on consent
- Team consensus not obtained before proceeding
- Staff feeling "rushed"

Changes Implemented to Prevent Wrong Site Procedures

- Completed FMEA standardizing site marking process
- Updated time-out / site verification policy to include new universal protocol. Policy supports employees to speak up, stop and clarify (PCGM 142 & PCGM 162)
- Monitor near misses for common themes
- Implemented time-out verification process for pain management in anesthesiology
- Acknowledge & address cultural issues (emphasis on teamwork to provide safe patient care)
- OR Walkrounds Pilot with action steps

Personalizing Safety

John's Story

John, an 80-year-old patient, was admitted for a pacemaker implantation due to syncopal episodes. John has a history of right-sided hemiplegia as a result of a head injury in his teen years. Due to his right-sided hemiplegia, John made a special request to have his pacemaker generator placed on his right side (normally, pacemaker generators are placed on the left side). Despite his request, John's pacemaker generator was placed on the left side of his chest.

Shirley's Story

Shirley, a 73-year-old patient, received a right femoral nerve block following her left total hip arthroplasty. During Shirley's admission to the PACU, the handoff between the OR nurse and the PACU nurse was interrupted. The PACU nurse assigned to Shirley had to leave PACU to transfer a patient to the floor. In the meantime, the anesthesiologist independently performed the nerve block on the right side. When the PACU nurse returned to assume care of Shirley, she noted a dressing

AUG 12

BEST & WORST RESTAURANTS
PAGE 14

TIDE CLEANS UP
PAGE 50

SHOWDOWN: BMW vs. MERCEDES
PAGE 56

5 WAYS TO SLEEP BETTER
PAGE 29

AUGUST 2012 | CONSUMERREPORTS.ORG

ConsumerReports®

HOW SAFE IS YOUR HOSPITAL?
Page 20

Tablets
Smart phones
Laptops
E-book readers
Cameras

▶ 150+ recommended models

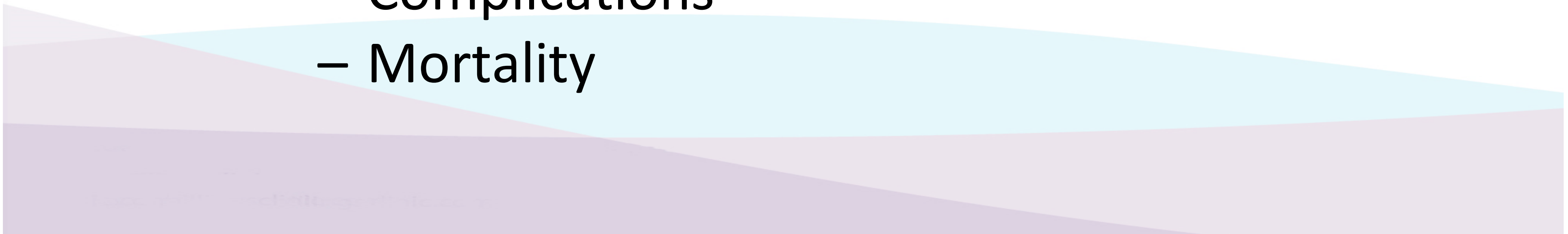
PLUS Gas-saving do's and don'ts PAGE 55

Safety Ratings of the Consumer Report

- 1,159 of 6,268 US Hospitals were included in the measurement
- Includes Hospitals from 44 states
- Equals 18% of US Hospitals

Safety Ratings of the Consumer Report

- Rating Score 1 to 100
- Billings Clinic Score = 72
- Score combines the six following categories:
  - Infections
  - Readmissions
  - Communication
  - Scanning
  - Complications
  - Mortality



FY2012 Value Streams

Operating Margin FY2012
Budget 3%= $16M
OpEx Improvement = $7.5M

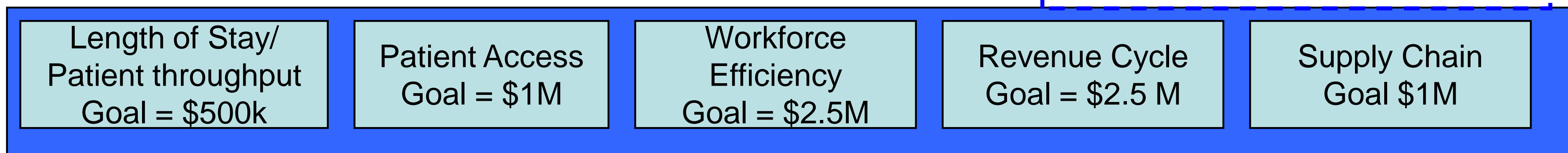
Removed:
Primary Care, Supply Chain
Added:
Cancer Center, SDC, Pharmacy, Aspen, Med-Surg, Neuro,modified Ortho to include PM&R and Therapies,

Workforce 2012

Targets based on 5% improvement from FY 2011 Actual

- SDC - $50k included in VS
- Pharmacy - $165k included in VS
- Radiology - $140k included in VS
- Lab
- ICU - $190k included in VS

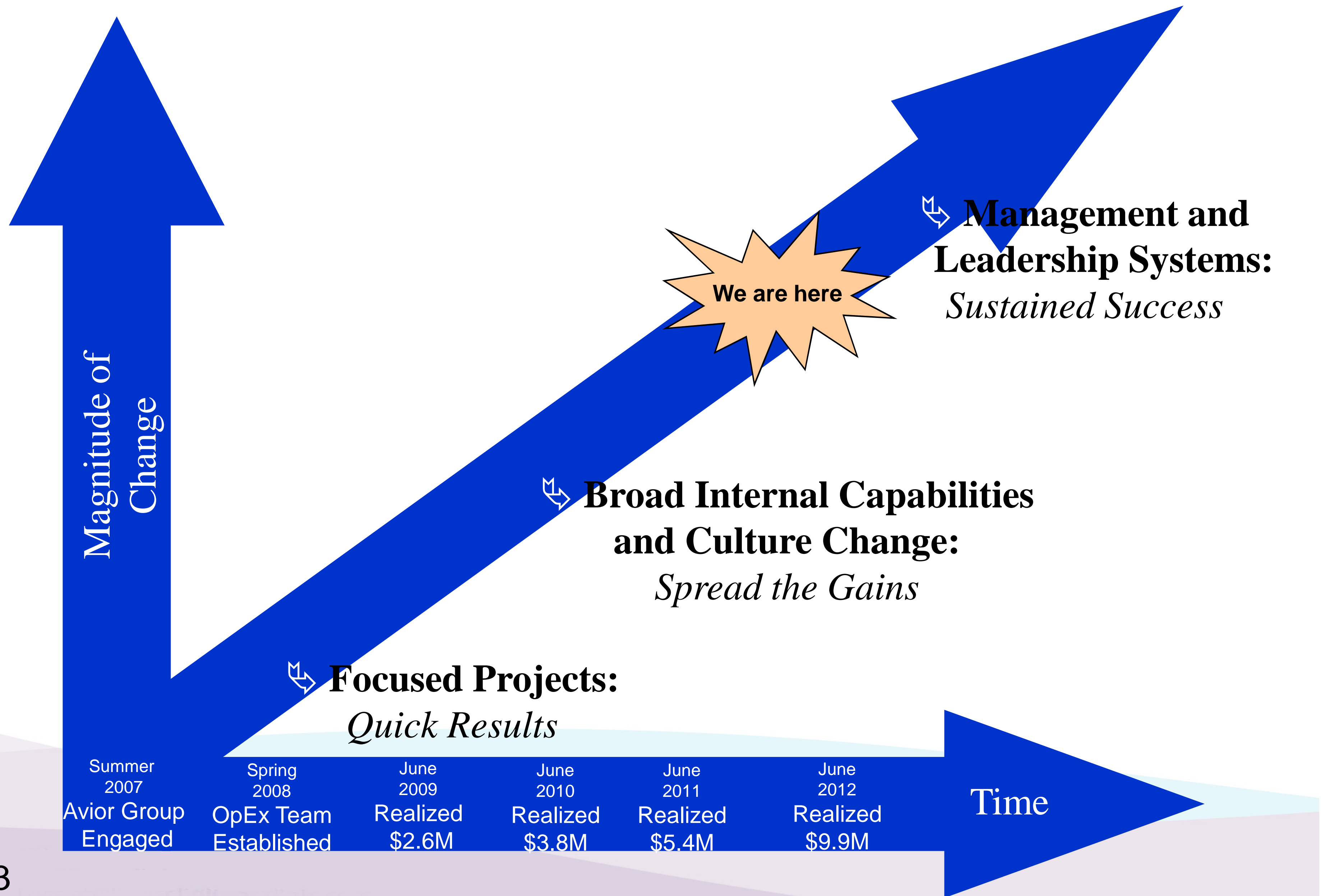
Value Groups



Value Streams

BB	Value Stream	Lead	Amount
BB = Tom	Cardiology	Diana Parker	$600k
BB = Stacey	Same Day Care	Craig Hepp	$150k
BB = Chelsea	Pharmacy	Kyle Townsend	$415k
BB = Shane	Critical Care (ICU, ED, Med Flight)	Dave Bunkers	$440k
BB = Chelsea	Lab	Mark Lubbers	$200k
BB = Julie	Reg./Admit.	Beth Kolberg	$500k
BB = Gordon	Radiology	M. Wright	$640k
BB = Ray	Workforce 2012	PRC	$955,000
BB = Stacey	Women & Children's Services	Celeste Dimon	$150k
BB = Sandy	Hospital Surgical Services	Jackie Hines	$300k
BB = Chelsea	Psychiatric Services	Lyle Seavy	$150k
BB = Julie	Patient Financial Services	Jeff Ogletree	$1.5M
BB = Brian	Information Services & HIM	Chris Stevens	$350k
BB = Tom	Cancer Services	Jo D.	$600k
BB = Stacey	Ortho,PM&R Therapies	Chad M.	$300k
BB = Shane	Aspen Meadows	Cheryl Nelson	$100k
BB = Sandy	IP Med. and Surg.	Lori Jens	$150k
BB = Shane	Neuro/ENT	Brian Fiechtner	$150k

Increasing Rewards of OpEx



Financial Benefits Realized by Billings Clinic

TOTAL BENEFITS REALIZED SINCE 2009 ARE ~ $21.9 MILLION

Total benefits realized in fiscal year 2012 through June are approximately $9.9 million. These are preliminary until the year end financials are audited.

Month	Actual Realized Savings on Projects (cummulative)
July	446,021
August	954,896
September	1,621,208
October	2,363,269
November	3,521,243
December	4,647,805
January	5,382,840
February	6,390,523
March	7,332,555
April	8,137,779
May	9,127,992
June	9,945,136

Y-axis: $- to $10,000,000 in steps of $500,000

Legend: Actual Realized Savings on Projects (cummulative) · Projected Annual Savings from Active Projects · Cummulative Savings Required to Achieve Goal

Eliminating the Transmission of Methicillin Resistant *Staph aureus* (MRSA) by Using the Positive Deviance (PD) Approach to Behavior and Social Change

What is Positive Deviance?

- Approach used to solve problems requiring social and behavioral change
- Achieves sustainable results by changing cultural norms

Participating Sites

- Albert Einstein Medical Center, Philadelphia, PA
- Billings Clinic, Billings, MT
- Franklin Square Hospital Center, Baltimore, MD
- The Johns Hopkins Hospital, Baltimore, MD
- University of Louisville Hospital, Louisville, KY
- VA Pittsburgh Healthcare System, Pittsburgh, PA
- Al Tunal Hospital, Bogota, Colombia*

*CDC Partner

Example 1:

Eliminating the Transmission of Methicillin Resistant *Staph aureus* (MRSA) by Using the Positive Deviance (PD) Approach to Behavior and Social Change

Key Interventions ~ The "Science" Bundle

- Hand hygiene
- Decontamination of the environment and equipment
- Active surveillance cultures (ASCs)
- Contact precautions (isolation) for infected and colonized patients

PD Tools

- Discovery and Action Dialogues (DADs)
- Improvisational theater-style learning
- Role Playing
- Briefings
- Fish Bowl

Theatre In the Round

A diverse audience, from many units across the clinic, assembles in the conference room… now an inpatient medical room.

For the next 60 minutes, no one knows what to expect.

The "Cultural" Bundle

- **M**ake the invisible, visible

  ~ chocolate pudding to simulate contamination ~

- **R**einforce with Feedback

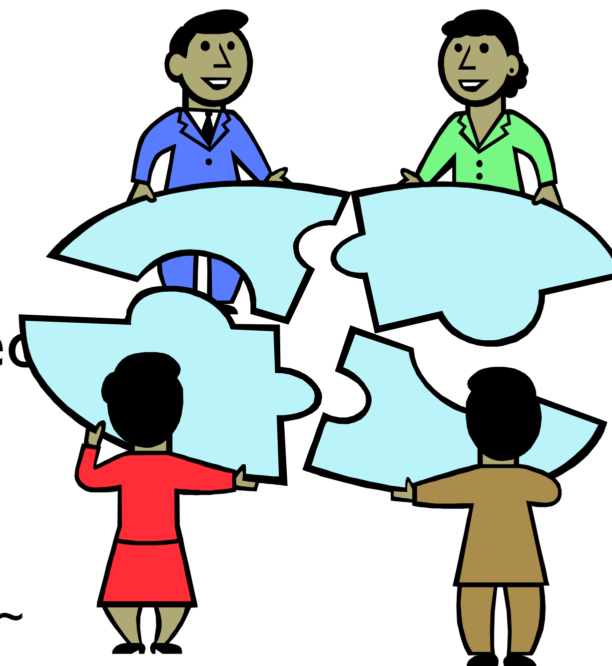
- **S**olutions that are co-created and owned

  ~ ownership vs. buy-in

  ~ discovery & action dialogues

- **A**ct your way to a new way of thinking ~

create experiences that allow self-discovery



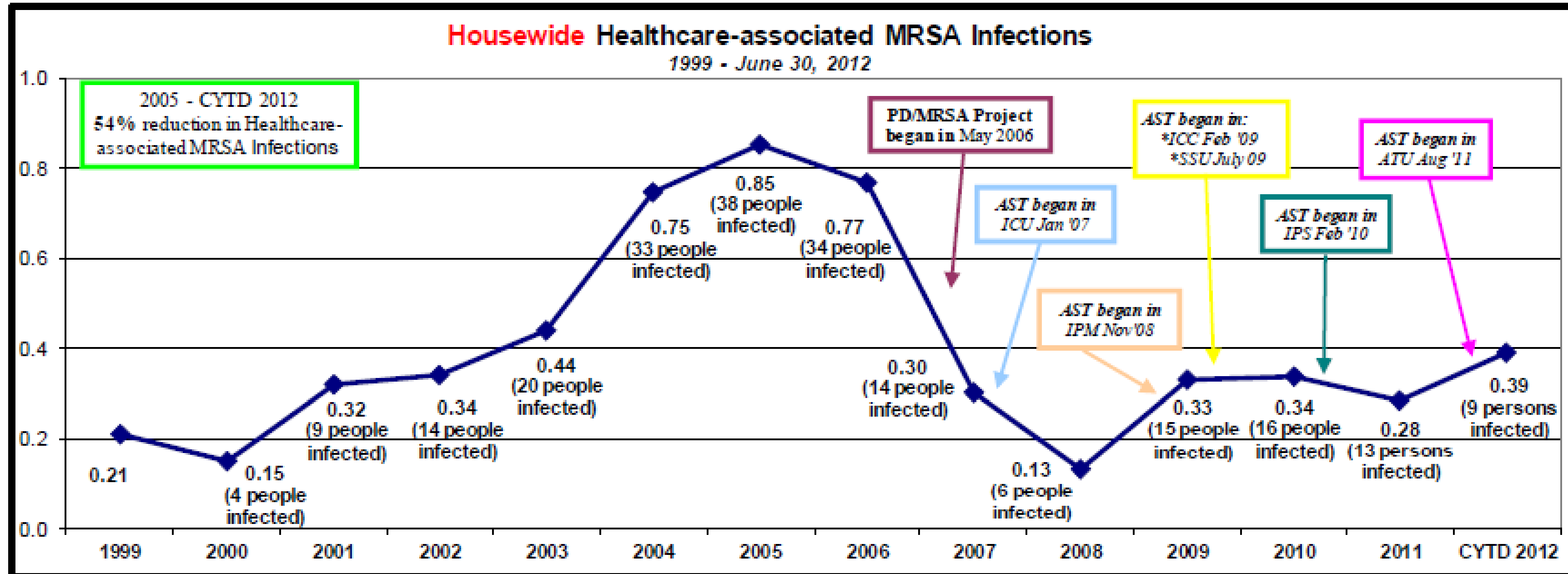
Measurements

- Prevalence Survey
- Active Surveillance – nares culture on admission, discharge, transfer or death
  - Measuring MRSA Transmission (colonization)
- MRSA Infections (tissue invasion of MRSA w/ signs/symptoms)
- Compliance with hand hygiene and contact isolation

Infection Control Surveillance Report

MRSA Clinical Cultures

2nd Quarter 2012 (April, May, June)



Incidence Rate =

\# cases / patient days X 1,000

Case is defined as healthcare-associated infection.

Healthcare-associated MRSA Infections

PD MRSA Intervention Unit ~ICU~

January 1, 2004 - December 31, 2009

Jan 1, 2006 - June 30, 2009
86% reduction in HA MRSA Infections
p = < 0.05

PD/MRSA Project beganMay 2006

Active Surveillance began in ICU Jan '07

2006-2007
86% decrease

2007-CYTD 2009
100% decrease

2.61 (13 people infected)

2.72 (14 people infected)

2.76 (14 people infected)

0.38 (2 people infected)

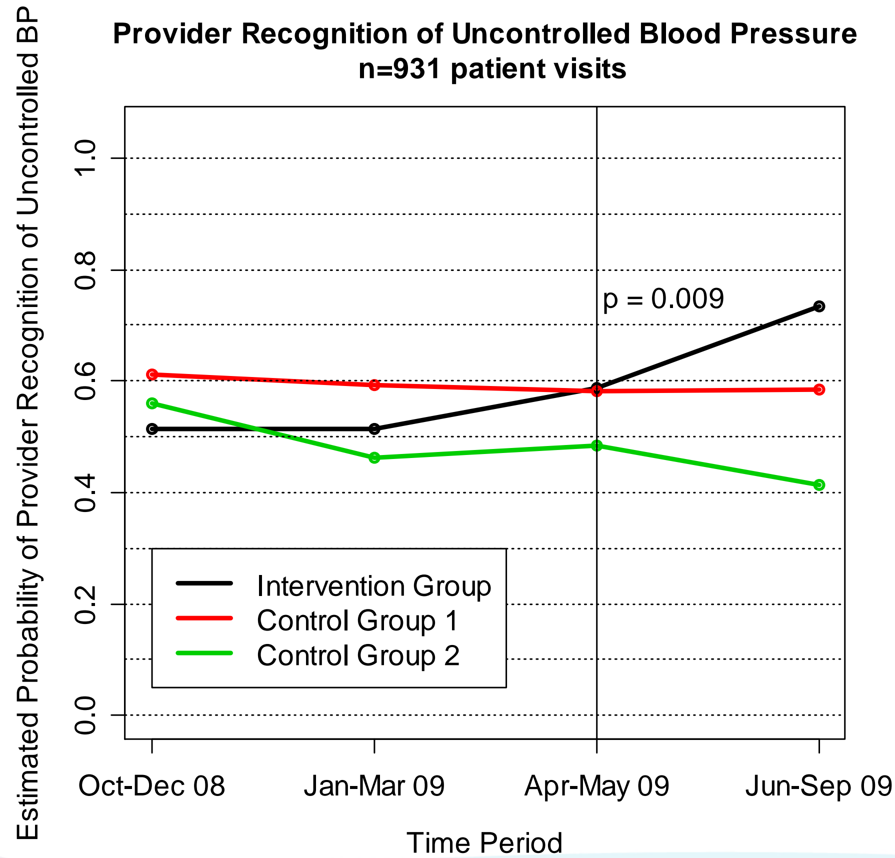
0.20 (1 person infected)

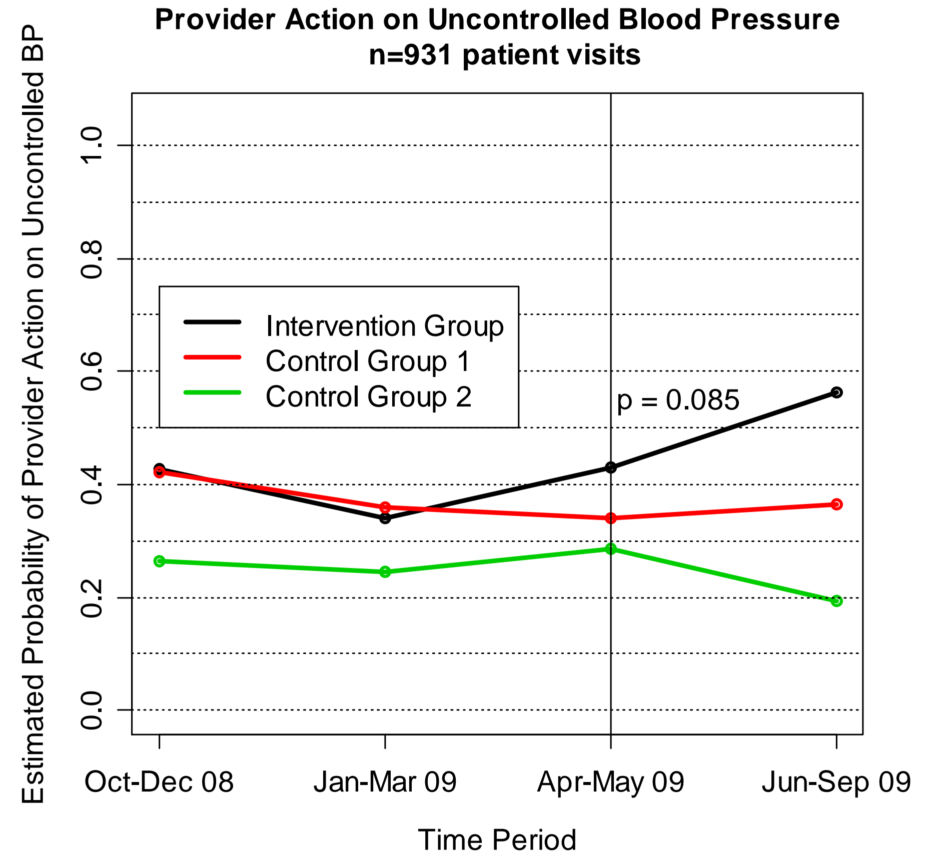
0.00

4.00
3.00
2.00
1.00
0.00

2004 **2005** **2006** **2007** **2008** **CYTD 2009**

Results





Billings Clinic Gaps/Opportunities

- Enhance physician leadership development and culture
- Compact broader, deeper, stronger
- Enhance administrative leadership development
- Improve cost accounting
- Better data and analysis
- Manage cost at the episode, encounter and unit level
- Breakeven on Medicare payment
- EMR which facilities physician efficiency

Billings Clinic Gaps/Opportunities…

- EMR which helps embed clinical pathways, appropriate standardization and population management
- Support a patient experience which is coordinated across departments, post acute care, and home
- Better use of service recovery as an improvement tool
- Better coordinated care with our regional affiliates
- Advance a change transformation and continuous learning culture

Billings Clinic: Gaps/Opportunities

- Partnerships
- Capital Needs
- Shared infrastructure
- Shared intellectual property
- Shared change and transformation skills

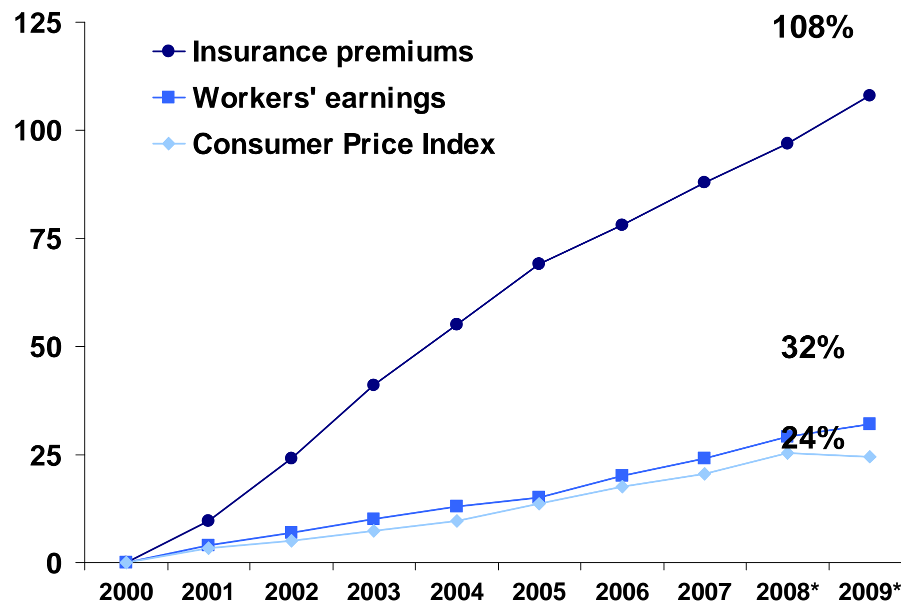
Total U.S. Spending

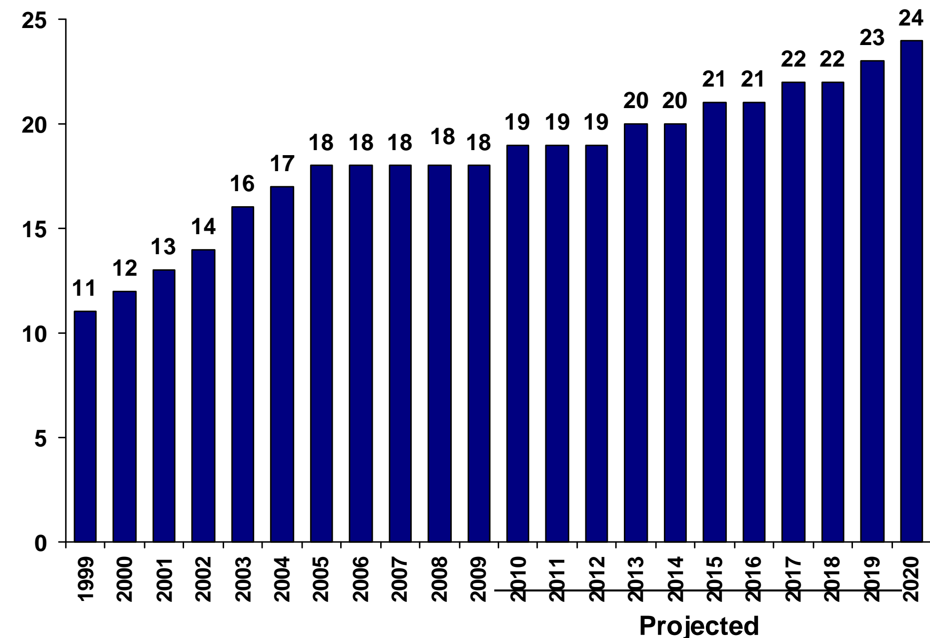
- 1999 1 Trillion
- 2010 2.6 Trillion 16% of GDP
- 2006-2016 will grow 6.9% per year
- 2016 4 Trillion 20% GDP

National Health Expenditures

- Grew 4.3% in 2012
- 3.9% per year 2009-2011
- 4 consecutive years record low growth for the first time in 50 years
- ? Recession and/or health system delivery changes

Exhibit 10. Premiums Rising Faster Than Inflation and Wages





* 2008 and 2009 NHE projections.

Data: Calculations based on M. Hartman et al., "National Health Spending in 2007," *Health Affairs*, Jan./Feb. 2009 and A. Sisko et al., "Health Spending Projections Through 2018," *Health Affairs,* March/April 2009. Insurance premiums, workers' earnings, and CPI from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2009*.

Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums* (New York: The Commonwealth Fund, Aug. 2009).

SMI Services

- Currently 10% of Personal and Corporate Income Tax Revenue
- 25% by 2030

Impact on Beneficiaries

- Part B premiums increased annually 11% 2000-2007
- Social Security benefits growing 3%/year
- Part B premium increases absorb 30-40% of Social Security increases
- 2002: 50% of beneficiaries have incomes less than $20,000
- Social Security benefits 75% of income for 60% of beneficiaries

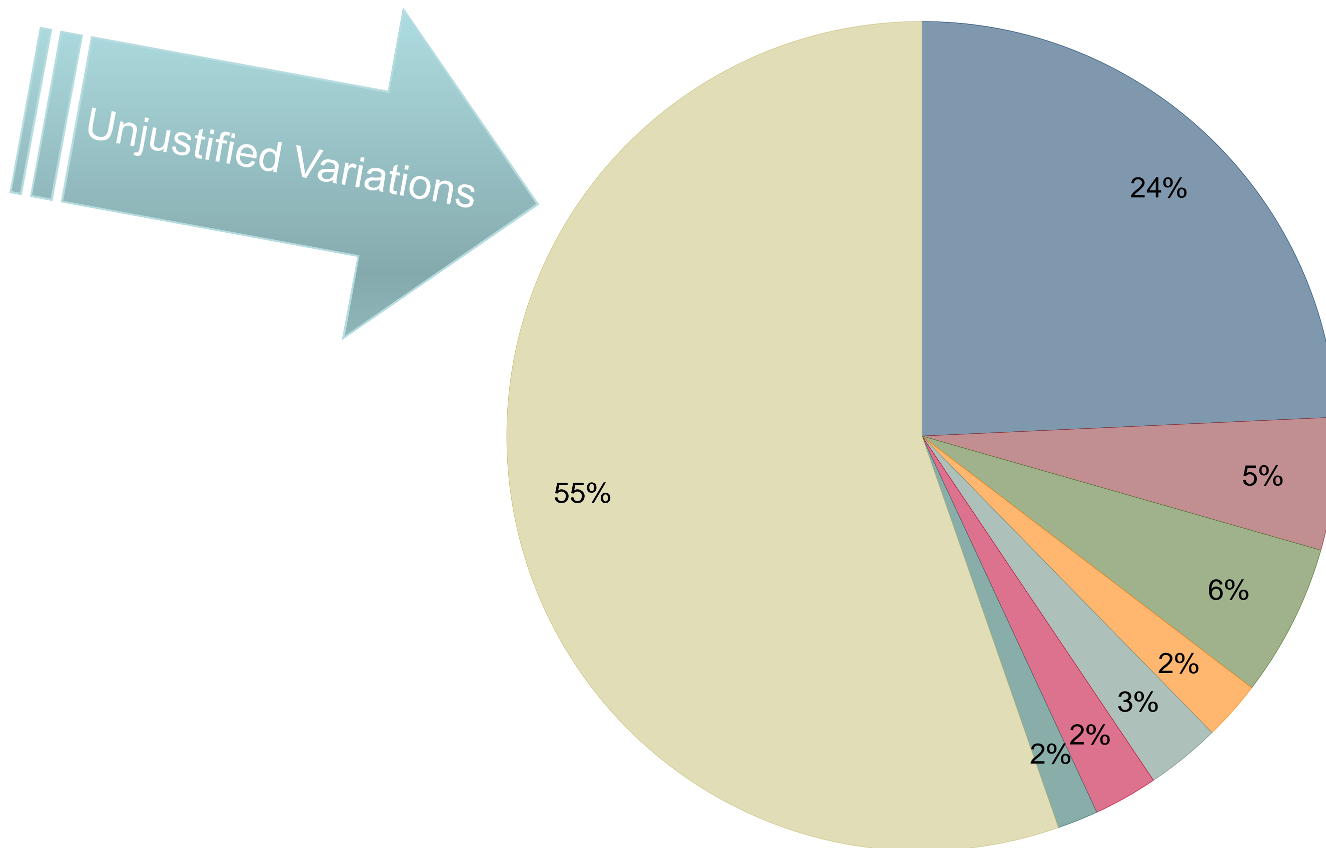
Impact on Beneficiaries

2030: Beneficiary cost sharing will exceed 40% of a typical beneficiary's social security benefit

IOM September 2012

- $750 billion waste in healthcare per year
- Unnecessary services $210 b
- Inefficient care delivery $130 b
- Excess admin cost $190 b
- Inflated prices $105 b
- Prevention failures $55 b
- Fraud $75 b

External Forces Influencing the Current Payment Environment



Source: AHA, January 10, 2011 Report of the Task Force on Variation in Health Care Spending

- Medicare population health status
- DSH/GME/IME
- Medicare wage adjustments
- Healthcare supply
- Population characteristics
- Population socioeconomic status
- Population lifestyle, behavior
- Unexplained variation

The current model leads to waste and overuse

1. Unexplained variation in the intensity of med/surg services.
   Potential annual savings: $600 billion

2. Misuse of drugs and treatments resulting in preventable adverse effects.
   Potential annual savings: $52.2 billion

3. Overuse of non-urgent ED care.
   Potential annual savings: $21.4 billion

4. Underuse of appropriate medications, such as generic hypertensives, asthma controllers
   Potential annual savings: $5.5 billion

5. Overuse of antibiotics for respiratory infections
   Potential annual savings: $1.1 billion

Source: NQF report Waste Not Want Not, July 2009

2013

- Sequestration
- Additional major medicare reimbursement cuts on the table

To Err is Human ~ Findings

- Estimated 44,000 - 98,000 preventable deaths each year from medical errors
  - *More people die from medical injuries than from breast cancer, or AIDS, or motor vehicle accidents*

Brennan et al. *New Engl J Med 1991*

- Majority of problems are system problems and not the fault of individuals

- Only 2-5% errors are related to individuals

- Human factor research shows that errors are inevitable

IOM, 1999

How good is American health care?

March, 2001 IOM Report - *Crossing the Quality Chasm*

- *"Between the care we have and the care we could have, lies not just a gap, but a chasm"*
  - *Not because of poor science, but in inadequate delivery*
- *Six Aims*
  - *Patient-centered, Effective, Timely, Equitable, Safe, Efficient*

- 2001 IOM Report - *Envisioning the National Health Care Quality Report*
  - *Agency for Healthcare Research & Quality (AHRQ)*
    - *to apply uniform criteria for measures*
    - *Serve as advisory body to assess improvements*

U.S. Health Care

Urgent need to:

- Slow cost growth
- Reduce cost curve growth
- Improve quality and safety
- Provide universal access

Figure 4. Direction for payment and delivery system reform

Current FFS payment systems

- Physician
- Inpatient & outpatient - hospital
- LTCH
- IRF
- Psych
- SNF
- Home health
- DME
- Lab
- Hospice
- Dialysis Services

+

Recommended tools

- Comparative effectiveness
- Reporting resource use
- Pay for Performance
- Individual services “bundled” within a payment system
- Readmissions
- Gain sharing
- Creating pressure for efficiency through updates
- Price accuracy (e.g. primary care adjustment)
- Disclosure of financial relationships

+

Potential system changes

Pay across settings and across time

For example:
- Medical home
- Payments “bundled” across existing payment systems
- Accountable care organization (e.g. PGP demo)

“The Checklist”

- “the fundamental problem with the quality of Amercian medicine is that we have failed to view delivery of healthcare as a science”
- “3 buckets: understanding disease biology, finding effective therapies, insuring they are delivered”

Atul Gawande, The New Yorker, Dec, 2007

Affordable Care Act 2010

- Medicare and Medicaid
- Insurance Reform and Access
- Delivery System Reform

Exhibit 2. System Improvement Provisions of Affordable Care Act of 2010

	Affordable Care Act of 2010, 03/30/09
Insurance Standards, Plans, and Premium Review	State or regional exchanges; private and co-op plans offered; essential health benefits 60%–90% actuarial value, four tiers plus young adults policy; insurers must meet medical loss ratio of 80 percent for individual and small groups, 85 percent for large groups; review of premium reasonableness
Primary Care, Prevention, and Wellness	Primary care 10% bonus for 5 years; Medicaid payment rates to primary care physicians no less than 100% of Medicare rates in 2013 and 2014; annual wellness visit and/or health risk assessment for Medicare beneficiaries; preventive services without cost-sharing; local and employer wellness programs
Innovative Provider Payment Reform	CMS Innovation Center; Medicaid medical home designation; test bundled payment for acute and post-acute care; value-based purchasing
Accountable Care Organizations	ACOs to share savings in Medicare
Controlling Health Spending	Independent Payment Advisory Board recommendations to meet Medicare expenditure target; total system spending non-binding recommendations; productivity improvement update factor
Quality Improvement and Public Reporting	Direct HHS to develop national quality strategy, public reporting
Medicare Private Plan Competition	Level the playing field between Medicare Advantage and traditional Medicare FFS plans
Cost-Conscious Consumers	Introduce a 40% excise tax on high premium health insurance plans beginning in 2018

Note: ACO = accountable care organization; PCP = primary care physician; AHRQ = Agency for Healthcare Research and Quality. HHS = Department of Health and Human Services
Source: Commonwealth Fund analysis.

Health Reform Delivery System Initiatives

- Accountable Care Organizations
- Pioneer Demo
- Bundling Demos

CMS Standalone Initiatives

- Readmissions
- Value Based Purchasing
- Hospital Acquired Conditions

2010 Health Care Reform

- Financing and universal access
- However, fundamental reform without delivery system organization and accountability is not possible
- Payment reform, including pay for performance, value purchasing, and quality transparency will drive delivery system reorganization

Delivery System Fragmentation

- Culture of Autonomy
- Entrepreneurship
- Technology Advances
- Payment Policy: FFS, Physician Equity Models
- Law and Regulation
- Hospital Capability and Co-Dependency
- Professionalism and Ethics

Why clinical integration?

- Coordinate care across silos and over time
- Deliver evidence-based medicine at 100% levels
- Develop system approaches to the safest and most reliable care
- Manage cost of care optimally
- Provide access to all in a timely manner

IOM Crossing the Quality Chasm

Re-engineering the delivery system to meet six challenges

- Evidence based care processes
- Effective use of information technology
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time
- Use of performance and outcome measurement for continuous quality improvement and accountability

National Academy of Sciences, 2001

IOM's Description of Key Delivery System Characteristics

"Can be seen as a virtual blueprint for expansion of the multispecialty group model."

Frances J. Crosson, M.D.
The Delivery System Matters
Health Affairs
November/December 2005

Importance of the Delivery System

- IOM
- MedPAC
- Commonwealth Fund
- Mayo Clinic Health Policy Center
- AHA
- AMGA and CAPP
- HFMA
- HC4HR

Commonwealth Fund Commission

Accountable, Coordinated Care

"To end the current fragmentation, waste, and complexity, physicians and other care providers should be rewarded, through financial and non-financial incentives, to band together into traditional or virtual organizations that can provide the support they need to practice 21st century health care."

November 2007

Exhibit 13. Illustrative Health Reform Goals and Tracking Performance

1. Secure and Stable Coverage for All
    - Percent of population insured
    - Percent of population with premiums and out-of-pocket expenses within affordability standard
2. Slowing Growth of Total Health Spending and Federal Health Outlays
    - Annual growth rate in total health system expenditures
    - Annual growth rate in Medicare expenditures
    - Impact on federal budget: new spending, net savings, new revenues
3. Health Outcomes and Quality
    - Percent of population receiving key preventive services or screenings
    - Percent of population with chronic conditions controlled
    - Percent reduction in gap between benchmark and actual levels of quality and safety
4. Payment and Delivery System Reform
    - Percent of population enrolled in medical homes
    - Percent of physicians practicing in accountable care organizations
    - Percent of provider revenues based on value

Commonwealth Fund

Where Are We Today?

***Best Care at Lower Cost**: The Path to Continuously Learning Health Care in America*

IOM Report ~ September, 2012

"…*explosion in knowledge, innovation, and capacity to manage previously fatal conditions;*

American health care falls short on quality, outcomes, cost, and equity… that result in missed opportunities, waste, and harm to patients"

Best Care at Lower Cost

Recommendations & Strategies

- Digital Infrastructure
  - Capture clinical, process, and financial data for improvement
- Data Utility
  - Use clinical data for improved care, coordination and knowledge while protecting privacy
- Clinical Decision Support
  - Accelerate integration of best knowledge into care decisions; new tools & incentives for use
- Patient-Centered Care
  - Involve patients & families
- Community Links
  - Promote community partnerships
- Care Continuity
  - Reward effective communication and coordination between teams
- Optimized Operations
  - Reduce waste, streamline care delivery, focus on improvements
- Financial Incentives
  - Structure payments to reward continuous learning and care improvement at lower cost
- Performance Transparency
  - Increase availability of information on care quality, cost, and outcomes
- Broad Leadership
  - Make continuous learning and improvement a core priority

Professional Identity

- Physicians and hospitals
- Fighter pilot to astronaut
- Acute care to coordinated care across silos
- Personally and organizationally extremely challenging

Interrelated Determinants of Healthcare Quality

- Aims: better experience of care (STEEEP), better health for the population, lower total per capita costs
- Design of care processes that affect the patient: clinical microsystems
- The health care organization that houses the microsystems: care of patients across silos and over time
- The environment: policy, payment, regulatory, legal, education

Fisher, Berwick, Davis: Achieving Health Care Reform- How Physicians Can Help NEJM June 11, 2009

A Few Thoughts

- Physician/Hospital Collegiality and new organizational approaches imperative
- Multispecialty and cross specialty collegiality coordination/collaboration a needed ingredient
- New care models will involve other partners: post-acute care etc.
- Invest in your vision, strategy, structure, relationships and culture

A Few Thoughts

- MA and employee populations ripe areas for new coordinated care, chronic disease management, and new payment model innovations
- Get started: medical home, bundling
- Multipayer strategies: commercial market beginning to move too, medicaid
- Service excellence, patient engagement
- Lean cost structure an imperative

A Few Thoughts

- Business and Community relationship
- Advocacy and policy involvement and leadership
- The new science of healthcare delivery

Health Reform

Physicians Should Lead the Way by Extending their Professionalism to the New Science of Health Care Delivery

Charles H. Mayo

The past 50 years have been marked by advances in the science of medicine. The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered.

January 1913

High-Performing Health System

Organized System of Care
- Continuum of care provided for populations
- Integrated or has partnerships
- Physicians as principal leaders of medical care
- Shared responsibility for non-clinical activities
- Accountable for care transitions

Efficient Provision of Services
- Manage per capita cost of care
- Improve patient care experience
- Improve health of populations

Quality Measurement & Improvement Activities
- Preventive care & chronic disease management
- Patient outreach programs
- Continuous learning & benchmarking
- Research to validate clinical processes & outcomes
- External & transparent internal reporting
- Patient experience surveys

Care Coordination
- Team-based approach with team members working at the top of their field
- Single plan of care across settings & providers
- Shared decision making

Compensation Practices
- Incentivize improved health & outcomes of populations
- Affiliate with patient experience or quality metrics

Use of IT & Evidence-based Medicine
- Meaningfully use IT, scientific evidence, & comparative analytics
- Aid in clinical decision making
- Improve patient safety
- Aid in the prescribing of Rx

Accountability
- Shared financial & regulatory responsibility & accountability for efficient provision of services