Billings Clinic

Aligning Physician Compensation with Organizational Imperatives

Health Industry Forum

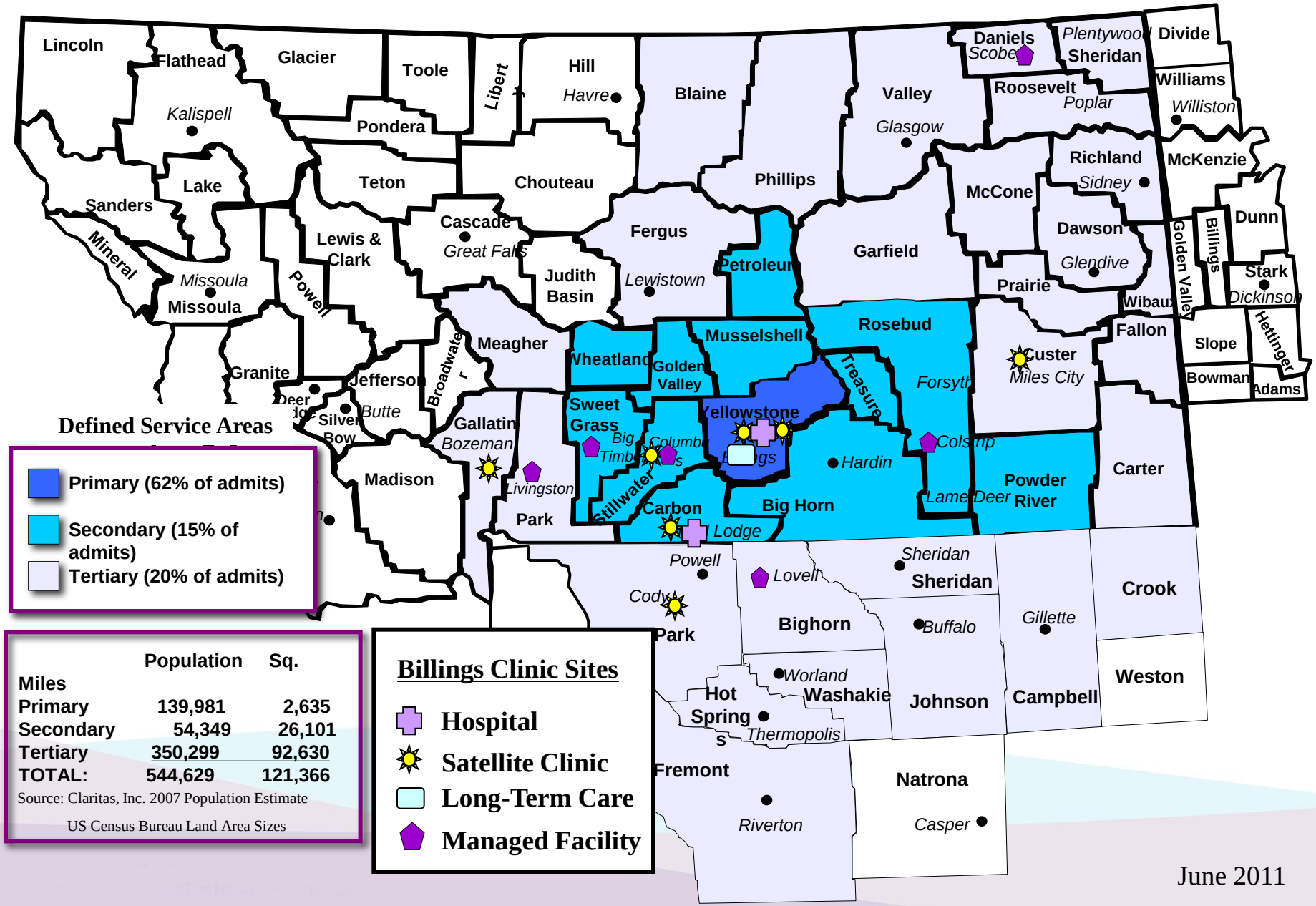
Comprehensive Health Care Reform:

What will it take to get there?

April 2, 2015

Nicholas Wolter, M.D.
Chief Executive Officer

Service Area



Defined Service Areas

- Primary (62% of admits)
- Secondary (15% of admits)
- Tertiary (20% of admits)

Miles	Population	Sq.
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

Billings Clinic Sites

- Hospital
- Satellite Clinic
- Long-Term Care
- Managed Facility

June 2011

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.

Strategic Operating Plan Design

4 Perspectives

- Patient Care
- Clinical and Business Processes
- Learning and Support
- Growth and Development

10 Key Strategies

- Clinical Quality and Patient Safety
- Personal Service Excellence
- Operational Improvement
- Innovation
- Information System Solutions
- Our People
- Organizational Culture
- Physician Leadership
- Financial Strength and Community Stewardship
- Net Revenue Growth

13 Initiatives

- Clinical Quality-Processes and Outcomes
- Patient Safety
- PSE & Patient Satisfaction
- Operational Excellence
- Clinical and Health Services Research
- People Development & Wellness
- Brand Position
- Clinical & Business Information Systems
- Physician Leadership
- Medical Education
- Financial Capacity
- Community Accountability
- Net Revenue Growth

Quality and Patient Safety Goals 2013 – 2015

- Improve Performance of Appropriate Care Scores (Core Measures) to 100%
- Decrease All-cause Hospital Readmissions by 20%.
- Improve the patient and family experience as measured by meeting CMS benchmark HCAHPS scores and AVATAR scores
- Advance the culture of safety by improving patient safety cultural assessment overall domain score to 80% agreement by December 2015.
- Reduce preventable harm by 50% by December 2015 with the ultimate goal of zero preventable harm.
- Reduce the observed to expected mortality ratio from 0.73 to 0.60.
- Population Health Goal:
  Composite Score for ACO Measures (8-33) for Care Coordination, Patient Safety, Preventive Care and Disease Management at Medicare Benchmark 90thile.

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Quality and Patient Safety Goals 2013 – 2015

GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Improve performance of appropriate care scores (e.g. AMI, HF, PN, SCIP, VTE, Stroke, Outpatient and Perinatal to 100% by July 2014)

Education Communication Plan

- Nurse and Staff Meeting Infrastructure
- Executive Rounds
- New provider orientation
- Updates as measures change

Decision Support

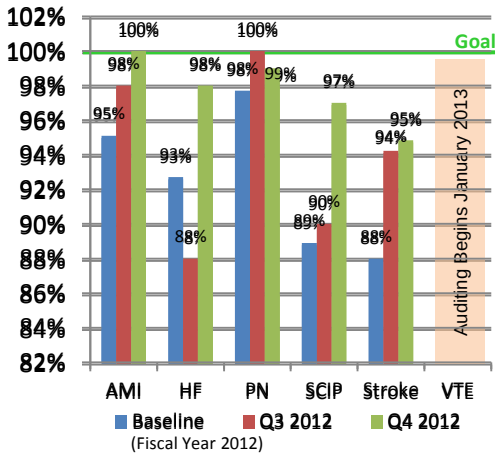
- Power plans and alerts
- Contraindications
- Advisors
- Concurrent review
- eQuality Check

VTE

- Equipment in every room
- Med Staff Best Practice Guidelines Updates: Medical, Surgical, Stroke
- Powerplan Updates & Discern Alert
- VTE Advisor Imbedded in Workflows

Proven changes to test for improvement

Core Measure Performance
Appropriate Care Score
Goal: 100% by July 1, 2014



Quality and Patient Safety Goals 2013 – 2015

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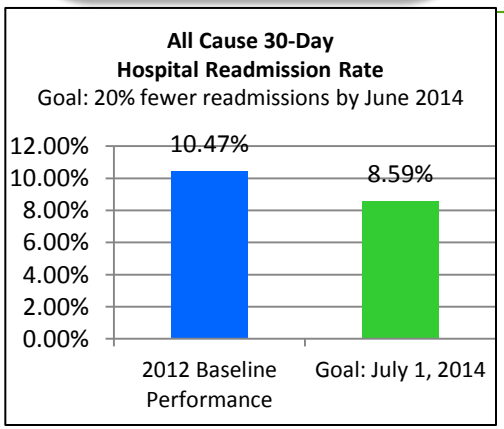
GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Decrease all-cause hospital readmissions by 20% by June of 2014 using 2012 as baseline performance period.



Observed to Expected

Baseline 2012	Goal: July 1, 2014
1.22	≤1

- **Medication Reconciliation**
  - 100% compliance with Meds History, Admission and Discharge Meds Rec
  - Phone call 24 hours post Discharge to reconcile
  - Inpatient and Outpatient Pharmacist Support
- **Risk Identification**
  - Predictive modeling tools to identify at risk populations
  - Interdisciplinary Plans of Care
  - Project BOOST or similar
  - "Hospital Syndrome" Prevention Project
- **Medical Home Care Navigation**
  - 24 hour phone call and 7 day appointment goals
  - Implement readmission preventionist work list
  - Best practice patient education strategies ("Teach Back")
- **Transitions of Care**
  - F/U Appt made prior to Discharge
  - Communication standards for transitions at discharge to PCP
  - Alignment of efforts across organization and region for nurse navigation
  - Discharge Summary within 5 days
- **Metrics**
  - RA rates to PCP's and Attending Services Monthly
  - Dashboards monthly to CMO's, Dept Chairs, Regional Partners

Proven changes to test for improvement

Quality and Patient Safety Goals 2013 – 2015

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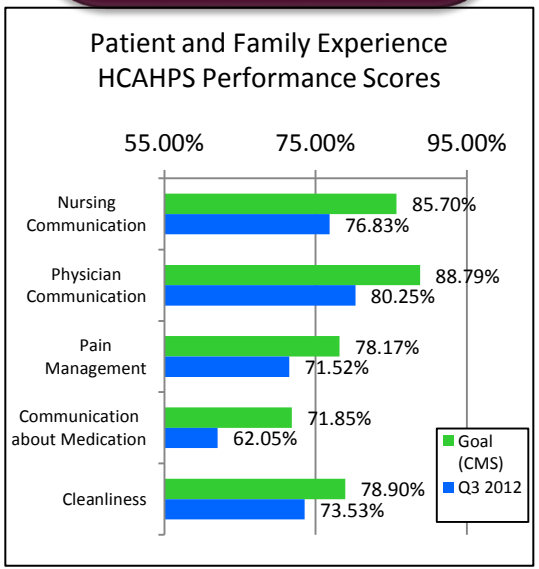
GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Improve the patient and family experience as measured by meeting CMS benchmark HCAHPS scores and AVATAR scores by January 2015.



- **Physician & Nurse Communication**
  - Internal Focus Group/ Survey
  - Studer HCAHPS Training/ Safety Culture Training
  - Internal leadership curriculum enhancement- pat sat focus
- **Medication Communication**
  - Pain Management team / training
  - Oversedation Team and training
  - Medication Reconciliation Team- inpatient and outpatient
- **Facilities & Technology**
  - Healing Environment Team- focus on cleanliness and noise
  - Pumps and Alarms- new technology
  - Phone image and policy
- **Patient Portal**
  - eMessaging & Results Communication
  - Patient Engagement and Education
  - Online Access Tools- eScheduling, eRegistration
- **Metrics & Leadership Accountability**
  - Monthly dashboards for executive level insights- Executive Committee
  - Department/ Unit level dashboards
  - Medical Director/ Manager Training

Proven changes to test for improvement

Quality and Patient Safety Goals 2013 – 2015

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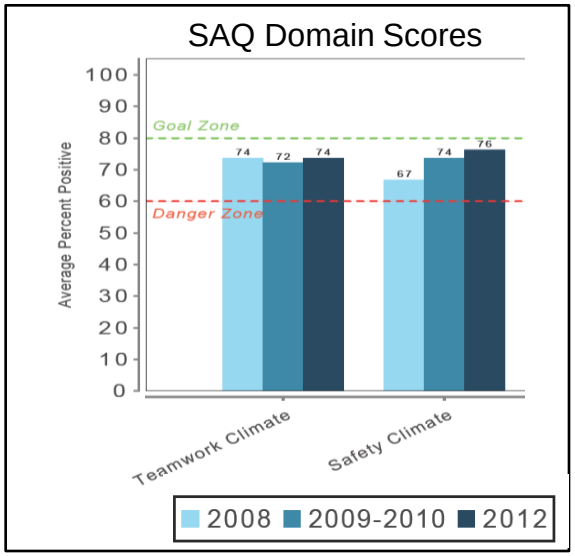
GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Advance the culture of safety by improving patient safety cultural assessment overall domain score to 80% agreement by December 2015.



- **Leadership Culture**
  - HPI Engagement
  - Process Design & Human Behavior Accountabilities
  - Teach / Adopt Just Culture
  - Patient Safety Leader WalkRounds
- **Reporting & Metrics**
  - Safety Event Reporting
  - Harm Investigation Process
  - HR Staffing Metrics (turnover, absenteeism, injuries, satisfaction)
- **Patient / Family Partnership**
  - Engaging in Bedside Rounds
  - Sharing care plans with family
  - Clinical Results Transparency- all results + patient portal
- **Effective Communication & Teamwork**
  - Pascal Metrics Engagement ~ Team-based Engagement Model (TEM) 3-5 clinical units
  - Patient Safety Training
  - Learning Board Implementation
- **Reliable Clinical Care**
  - Effective Process / System Design & Oversight
  - Use of Checklists

Proven changes to test for improvement

Quality and Patient Safety Goals 2013 – 2015

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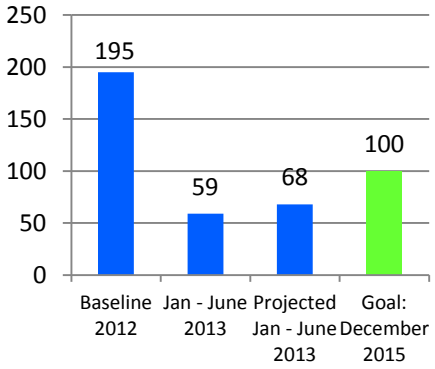
GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Reduce preventable harm by 50% by December 2015 with the ultimate goal of zero preventable harm.

Goal: Reduce Preventable Harm by 50%



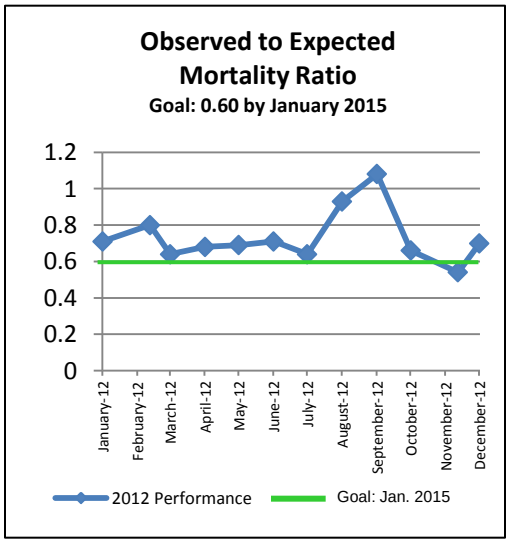
- **Healthcare-Associated Infections**
  - Hand hygiene
  - QIO LAN (CAUTI/ CLABSI/ C. diff/ SSI
  - MRSA / MDRO Reduction
- **Adverse Drug Events**
  - MUST Group Work
  - Pharmacy Medicine Reconciliation
  - Discern Alert Updates
- **Surgical/ Perinatal Harm**
  - Stop Bang and Oversedation
  - Capnography Post-op
  - Reduction of preterm delivery
- **Adverse Event Reporting & Investigation**
  - Phone Line/ Desk Top Icon
  - Safety Newsletter Updates
  - HPI Engagement
- **Hospital wide harm.** (serious safety events, retained foreign object, pressure ulcers, falls with injury)
  - Falls Reduction Project
  - Pressure Ulcer Reduction Project
  - Appropriate Coding of Harm Events

Proven changes to test for improvement

Quality and Patient Safety Goals 2013 – 2015

GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Reduce the observed to expected mortality ratio from 0.73 to 0.60 by January 2015.



- **Mortality Analysis**
  - Proper use of palliative care code V66.7 & DNR Code V49.86
  - Acuity Scores/ Documentation
  - Medical Staff case review
- **Sepsis and Rapid Response Team Management**
  - Early appropriate level of care
  - Early recognition and intervention
  - Use of sepsis bundle
  - Sepsis advisor- decision support
- **End of Life Care**
  - Appropriate setting: Acute care vs. Hospice care
  - Enhancing inpatient and outpatient palliative care services
  - Collaboration across the patient continuum
- **Metrics**
  - Data mining to determine top drivers of mortality
  - Examine Rapid response team data
  - Examine MEWS/ PEWS alerts

Proven changes to test for improvement

Quality and Patient Safety Goals 2013 – 2015

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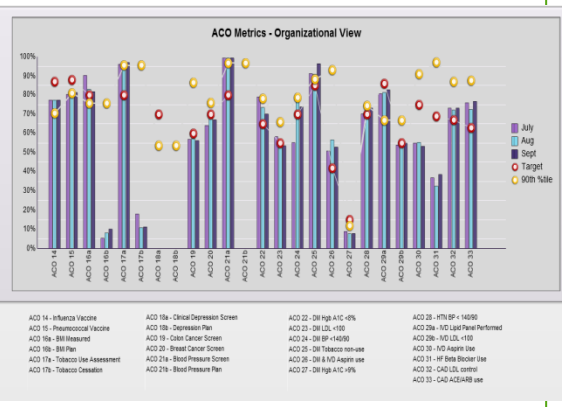
GOAL ← *PRIMARY DRIVERS* ← *SECONDARY DRIVERS*

Population Health Goal: Composite Score for ACO Measures (8-33) for Care Coordination, Patient Safety, Preventive Care and Disease Management at Medicare Benchmark Threshold by January 1, 2014, with 10% improvement by January 1, 2015



Medical Home Development
- RN Care Navigation for Gaps
- Team Meetings with Metrics
- Ambulatory Plans of Care Solution
- Mental Health Support Services
- Tobacco, BMI Coaching Support Services

Disease Management Registries
- DM, HF, HTN, IVD, Lung Dz Registry
- Immunization Registry
- Population Health Solution

Care Coordination/ Transitions in Care
- Medication Reconciliation Clinic
- Readmission Prevention Worklist
- PhD Pharmacy Support Meds Rec and Chronic Disease

Documentation Excellence Project
- Structured Data Gaps Assessment
- Acuity Scores Improvement Project
- Problem List Entry and Reconciliation

Metrics
- Monthly Report Cards to Care Teams
- Benchmarking Tools (Business Intelligence)

Proven changes to test for improvement

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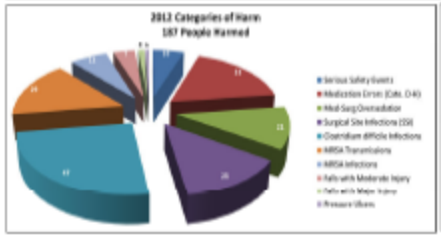
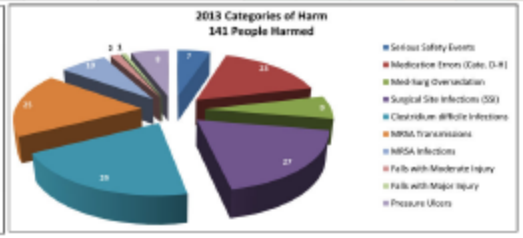
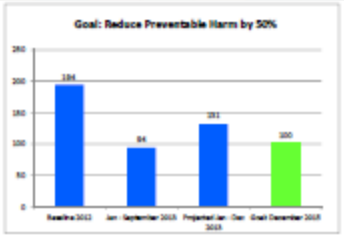
Patient Safety Dashboard

Indicator	Target	National Benchmark	Quarterly (by calendar year) Q1 11	Q2 11	Q3 11	Q4 11	Q1 12	Q2 12	Q3 12	Q4 12	Q1 13	Q2 13	Q3 13	Q4 13	Year to Date (Q1 13 - Q4 13)	Monthly Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Quarterly Trend (Q1 '08 - Q1 '13)
Preventable Harm																					
Number of Serious Safety Events	0	Not Available	2	4	2	3	3	5	1	1	0	4	3	1	8	2	0	0	1	0	
Serious Safety Events Rate Overall	0.51	Not Available	0.57	0.80	0.53	0.57	0.63	0.67	0.60	0.53	0.37	0.31	0.43	0.42	NA	0.42	0.43	0.42	0.47	0.42	
Mortality															Year to Date (Q4'12 - Sept'13)						
Mortality: Rate (# inpatient deaths/# inpatient discharges)	1.50%	Not Available	2.1%	2.1%	1.9%	1.7%	1.8%	1.8%	2.3%	1.7%	2.3%	2.1%	1.4%		1.80%	1.5%	1.5%	1.4%			
Mortality: Observed to Expected	0.75	1.0 (Premier Quality Advisor)	0.85	0.91	1.03	0.78	0.71	0.80	0.80	0.68	0.76	0.83	0.74		0.75	0.88	0.78	0.71			
Infection Related																					
Surgical Site Infections (SSI) - targeted procedures (e.g. cardiac, CABG, colon, hips, knees, lami, fusion, pacemakers, hysterectomy)	0	Not Available	9	5	11	7	11	5	5	6	8	6	7	8	27	3	4	6	1	1	
Surgical Site Infections by Standardized Infection Ratio (SIR) *does not include pacemakers and ICDs	SIR ≤ 1	SIR ≤ 1 (NHSN)	1.20	0.75	1.50	1.08	1.58	0.41	0.84	0.98	0.57	0.75	0.70	0.81	0.81	SIR available quarterly (cumulative metric)					
Colon Surgical Site Infections (SSI) Publically Reported	0	Not Available	2	2	3	2	2	1	1	1	3	0	0	1	4						
Hysterectomy (Abdominal) Surgical Site Infections (SSI) Publically Reported	0	Not Available					1	0	0	2	0	1	0	3	4						
Hip Prosthesis Surgical Site Infections (SSI) Publically Reported	0	Not Available	4	1	4	3	1	1	2	4	1	4	4	1	9						
Knees Prosthesis Surgical Site Infections (SSI) Publically Reported	0	Not Available	0	0	1	1	1	0	2	0	1	0	0	2	3						
Clostridium difficile Infections (IP case review) Measure tracked through December 31, 2013	< 3 / qtr.	≤ 2.65 / per 10,000 pt. days (Premier QUEST Top 25%)	11	6	9	12	10	23	5	9	4	9	10	6	29	2	4	1	1	4	
Clostridium difficile LabID Event by Number	< 3 / qtr.	≤ 2.65 / per 10,000 pt. days (Premier QUEST Top 25%)									8	12	17	11	48						
Clostridium difficile LabID Event by Standardized Infection Ratio (SIR)	SIR ≤ 1	SIR ≤ 1 (NHSN)	Public Reporting began January 2013. Will begin tracking on Dashboard January 2014.																		
MRSA Transmission	0	Not Available	6	5	5	5	5	8	5	11	6	8	8	7	65	4	5	4	6	5	
Healthcare-associated MRSA Infections	< 2 / qtr. (< 8 / year)	Not Available	2	2	2	4	8	5	1	2	0	0	1	5	10	0	0	5	0	0	
MRSA Bacteremia LabID Event	SIR ≤ 1	SIR ≤ 1 (NHSN)									2	6	4	9	22						
Central line associated blood stream infection (CLABSI) (Adult and neonatal ICU)	SIR ≤ 1	SIR ≤ 1 (NHSN)	Public Reporting began January 2011 for adult and neonatal ICU. Will begin tracking on Dashboard January 2014.																		
Catheter-associated urinary tract infection (CAUTI) Adult ICU only	SIR ≤ 1	SIR ≤ 1 (NHSN)	Public Reporting began January 2012 for adult ICU. Will begin tracking on Dashboard January 2014.																		
Hand Hygiene: Prior to Patient Contact Unit Submitted Data	95%	100% (UHC)	95%	95%	96%	96%	96%	97%	97%	98%	96%	95%	94%	95%	95%	93%	91%	96%	95%	96%	
Hand Hygiene: After Patient Contact Unit Submitted Data	95%	100% (UHC)	97%	96%	97%	96%	97%	98%	98%	97%	97%	96%	96%	96%	96%	94%	96%	96%	96%	95%	
Hand Hygiene: After Glove Removal Unit Submitted Data	95%	100% (UHC)	97%	97%	99%	98%	97%	99%	99%	98%	96%	97%	96%	96%	96%	94%	96%	96%	97%	95%	
Patient Falls															(Q4 12 - Q3 13)						
Number of Falls with Injury (Moderate level)	0	Not Available	0	0	1	1	5	0	1	1	0	2	0	0	2	0	0	0	0	0	
Number of Falls with Injury (Major level)	0	Not Available	0	0	0	0	1	0	1	0	0	1	0	0	1	0	0	0	0	0	
Number of Psychiatric Falls with Injury (Moderate level)	0	Not Available												1		1	0	0	0	1	
Number of Psychiatric Falls with Injury (Major level)	0	Not Available												0		1	0	0	0	0	
Pressure Ulcers																					
Hospital Acquired Pressure Ulcers (Quarterly Prevalence Study)	≤ 1	Below NDNQI mean	1	1	1	1	1	0	1	0	2	4	1	1	8		1			1	







Dashboards

- Dashboard updated monthly and published on the 2nd Friday of each month.
- Meetings for Dissemination and Discussion Monthly
  - Leadership Council
  - Department Chairs
  - Hospital Practice Committee
  - Patient Safety Committee
  - Population Health Steering Committee
  - Clinic and Hospital Leadership Meetings
  - Board and Board Committee for Quality and Patient Safety

Governance Structure & Initiatives that Contribute to Population Health

Population Health Steering Committee

- Patient Centered Medical Home & Referral Management
- Patient Engagement:
  - Patient Portal
  - Call Center
  - Retail Clinics
- Care Management
- Employee Health Plan & Employer Wellness Contracts & Employer and Community Engagement
- Shared Savings Program
- Population Health Analytics With Utilization Management
- Cultural Transformation & Physician Engagement/ Documentation Improvements

Other Related Work:

- Bundled Payment Initiative
- NewWest Medicare Advantage

Above Promotes/ Aligns Organizational Strategies In:

Regional Network Development
Payor Relations
New Business Opportunities
Patient Steerage Opportunities
Community Health Improvement Strategies

Match the Patient Population to the Resource

Managing Three Different Types of Patients Across the Health Care System

Patient Type	Characteristics	Resource Needs
High Risk Patients	~5% of patients Complex diseases High Utilizers of Care (Inpatient, ER, & Ambulatory)	• Ambulatory ICU • Intensive Coordinated Case Management
Rising Risk Patients	~15 % of patients Chronic Disease Management Medium Utilizers of Care	• Patient Centered Medical Home • Disease Management Registries • Keep patients from moving into high risk category
Low Risk Patients	~80% of patients Generally Healthy, Conditions easily managed Low Utilizers of Care	• Wellness Initiatives • Patient Portal • E Visits • Keep patients healthy and loyal

Source: Advisory Board Health Care IT Suite research and analysis.

Population Health Analytics

Physician Group Agreed on the ACO Metrics as the Common Data Set For Measurement:

- Addressed Challenges in Standardization
- Provided benchmark comparisons
- Provided reliable evidence based performance measures
- Focused on high impact diseases
- Highlight gaps in care (opportunities) for improvement

- ACO Metrics aligned with Meaningful Use Clinical Quality Metrics, HEDIS Measures, NQF Metrics, PQRS Metrics

Care Coordination & Patient Safety Domain

- ACO 8 (NQF 1789): Risk Standardized All Condition Readmission
- ACO 9 (NQF 0275): Ambulatory Sensitive Conditions Admissions: COPD/ or Asthma, age 40 and up
- ACO 10 (NQF 0277): Ambulatory Sensitive Conditions Admissions: Heart Failure (HF), age 18 and up
- ACO 11: Primary Care Physicians who successfully qualify for an EHR Program Incentive Payment
- ACO 12 (NQF 0097): Medication Reconciliation following transition in care
- ACO 13 (NQF 0101): Screening for future fall risk, age 65 and up

Preventative Care Domain

- ACO 14 (NQF 0041): Influenza Immunization, age 6 mo and up
- ACO 15 (NQF 0043): Pneumococcal vaccination for patients 65 years and older
- ACO 16a/b (NQF 0421): Body Mass index Screening, age 18 and up, calculated every 6 months, with follow up plan documented
- ACO 17 a/b (NQF 0028): Tobacco Use: Screening, age 18 & Up, with Cessation Intervention Documented
- ACO 18 a/b (NQF 0418): Screening for Clinical Depression, age 12 & up, with Follow Up Plan Documented
- ACO 19 (NQF 0034): Colorectal Cancer Screening, age 50-75, iFOBT 1 year, colonoscopy 10 year
- ACO 20 (NQF 0031): Breast Cancer Screening, age 40-69, with mammogram in 24 months
- ACO 21 a/b: Screening for high blood pressure, age 18 & up, with follow up plan documented

At Risk Population Domain: Disease Management

- ACO 22 (NQF 0729): Diabetes Mellitus: HgA1c Control (<8%), age 18-75
- ACO 23 (NQF 0729): Diabetes Mellitus: LDL Control < 100, age 18-75
- ACO 24 (NQF 0729): Diabetes Mellitus: BP Control < 140/90, age 18-75
- ACO 25 (NQF 0729): Diabetes Mellitus: Tobacco Non- Use, age 18-75
- ACO 26 (NQF 0729): Diabetes Mellitus: Aspirin or Antiplatelet Rx for DM & IVD, age 18-75
- ACO 27 (NQF 0059): Diabetes Mellitus: HgA1c Poor Control (>9%), age 18-75
- ACO 28 (NQF 0018): Hypertension (HTN): Controlling BP < 140/90, age 18-85
- ACO 29 a/b (NQF 0075): Ischemic Vascular Disease, Lipid Profile Performed, age 18 & up, LDL Control < 100
- ACO 30 (NQF 0068): Ischemic Vascular Disease, Use of aspirin/ alternate Rx, age 18 & up.
- ACO 31 (NQF 0083): Heart Failure, EF < 40%, use of beta blocker
- ACO 32 (NQF 0074): CAD, drug therapy for lowering LDL
- ACO 33 (NQF 0066): CAD, ACE/ ARB use if also DM or LVEF < 40%

Key Strategies for Operations and Analytics

- Apply to all patients, not just at risk care patients
- “Proven performance” needed for new business strategies and steerage
- Strengthening of regional network to promote the health of patients across our state and region.
- Using Registry Analytics for patient attribution by:
  - Financial Class
  - Disease Registry
  - PCP
  - Demographics

ACO Dashboards & Data:

1. Un-blinded Monthly Dissemination of Data
   - Physician, Pod (Medical Home), Department, Location
   - Text, Email, Intranet
2. Process:
   1. Standing Agenda Item at Department Meetings (including compensation model)
   2. Analytics for physicians to drill down on data

ACO Report Card

Billings Clinic

Physician Report Card

re		Cumulative			May-13			Apr-13			Mar-13			Feb-13			Jan-13		
	Panel size:																		
nation/ Patient Safety Domain	Measure	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Pe
lized All Condition Readmission	ACO 8---------- NQF 1789									# per month			# per month			# per month			
ensitive Conditions Admissions: COPD/ or Asthma, age 40	ACO 9----------NQF 0275									# per month			# per month			# per month			
ensitive Conditions Admissions: Heart Failure (HF), age 18	ACO 10---------- NQF 0277									# per month			# per month			# per month			
Physicians who Successfully Qualify for an EHR Program	ACO 11									Yes/ No			Yes/ No			Yes/ No			
econciliation following transition in care	ACO 12----------NQF 0097									% of eligible visits			% of eligible visits			% of eligible visits			
Future Fall Risk, age 65 and up	ACO 13---------- NQF 0101									N/A			% of eligible visits			% of eligible visits			
e Care Domain	Measure	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Pe
munization, age 6 mo and up	ACO 14----------NQF 0041	20647	24120	86%	3845	4846	79%	3488	4341	80%	4322	4835	89%	4409	4780	92%	4583	5318	
al Vaccination for Patients 65 Years and Older	ACO 15---------- NQF 0043	8291	9454	88%	1766	2021	87%	1562	1760	89%	1663	1918	87%	1607	1821	88%	1693	1934	
dex (BMI) Screening, age 18 and up, calculated Q 6 mo	ACO 16a----------NQF 0421	20353	22872	89%	4293	4604	93%	3797	4098	93%	4249	4605	92%	4189	4532	92%	3825	5033	
dex (BMI) Follow-Up Plan Documented	ACO 16b---------- NQF 0421	707	15807	4%	184	3406	5%	175	2960	6%	129	3330	4%	131	3295	4%	88	2816	
Screening, age 18 & up	ACO 17a----------NQF 0028	21503	22872	94%	4426	4604	96%	3918	4098	96%	4394	4605	95%	4264	4532	94%	4501	5033	
Cessation Intervention, age 18 & up	ACO 17b---------- NQF 0028	545	2980	18%	112	564	20%	88	521	17%	100	587	17%	122	616	20%	123	692	
Clinical Depression, age 12 & up	ACO 18a----------NQF 0418			N/A			N/A			N/A			N/A			N/A			N/A
Clinical Depression Follow-Up Plan, age 12 & up	ACO 18b----------NQF 0418			N/A			N/A			N/A			N/A			N/A			N/A
ncer Screening, age 50-75, iFOBT 1 yr, colonoscopy 10 yr	ACO 19----------NQF 0034	7947	11995	66%	1598	2508	64%	1415	2134	66%	1633	2445	67%	1652	2468	67%	1649	2440	
Screening, age 40-69, with mammogram in 24 months	ACO 20----------NQF 0031	5391	7202	75%	1142	1489	77%	942	1265	74%	1134	1522	75%	1158	1530	76%	1015	1396	
high blood pressure (age 18 and up)	ACO 21a	22246	22872	97%	4571	4604	99%	4061	4098	99%	4570	4605	99%	4491	4532	99%	4553	5033	
n for high blood pressure documented (age 18 and up)	ACO 21b			N/A			N/A			N/A			N/A			N/A			N/A
ulation Domain: Disease Management	Measure	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Pe
litus: HgA1c Control (< 8%), age 18-75	ACO 22----------NQF 0729	2773	3795	73%	589	784	75%	598	799	75%	534	726	74%	548	755	73%	504	731	
litus: LDL Control < 100, age 18-75	ACO 23----------NQF 0729	1898	3795	50%	419	784	53%	403	799	50%	338	726	47%	376	755	50%	362	731	
litus: BP Control < 140/90, age 18-75	ACO 24---------- NQF 0729	2855	3795	75%	617	784	79%	608	799	76%	539	726	74%	560	755	74%	531	731	
litus: Tobacco Non-Use, age 18-75	ACO 25----------NQF 0729	3501	3795	92%	729	784	93%	749	799	94%	666	726	92%	685	755	91%	672	731	
litus: Aspirin or Antiplatelet Rx for DM & IVD, age 18-75	ACO 26----------NQF 0729	600	1059	57%	151	281	54%	254	393	65%	67	133	50%	61	121	50%	67	131	
litus: HgA1c Poor Control, A1c > 9%, age 18-75	ACO 27----------NQF 0059	350	3795	9%	69	784	9%	71	799	9%	64	726	9%	65	755	9%	81	731	
(HTN): Controlling BP < 140/90, age 18-85	ACO 28---------- NQF 0018	8339	11548	72%	1763	2332	54%	1734	2404	65%	1698	2329	73%	1569	2244	70%	1575	2239	
cular Disease (IVD): Lipid Profile performed, age 18 & up	ACO 29a---------- NQF 0075	2602	3025	86%	558	649	86%	547	635	86%	511	592	86%	491	572	86%	495	577	
cular Disease (IVD): LDL Control < 100, age 18 & up	ACO 29b----------NQF 0075	1753	3025	58%	377	649	58%	362	635	57%	336	592	57%	342	572	60%	336	577	
cular Disease (IVD), Use of aspirin/ alt Rx, age 18 & up	ACO 30---------- NQF 0068	1614	3025	53%	349	649	54%	348	635	55%	331	592	56%	287	572	50%	299	577	
EF < 40%, use of beta blocker (age 18 and up)	ACO 31---------- NQF 0083	97	276	35%	16	52	31%	26	60	43%	18	57	32%	17	58	29%	20	49	
rapy for lowering LDL (age 18 and up)	ACO 32----------NQF 0074	2055	2698	76%	450	585	77%	417	553	75%	404	527	77%	388	514	75%	396	519	
B use if also DM or LVEF < 40% (age 18 and up)	ACO 33----------NQF 0066	867	1201	72%	178	256	70%	193	257	75%	177	236	75%	162	230	70%	157	222	

Year to Date Performance

Physician Repor

Monthly Performance: Num/ Dem & %

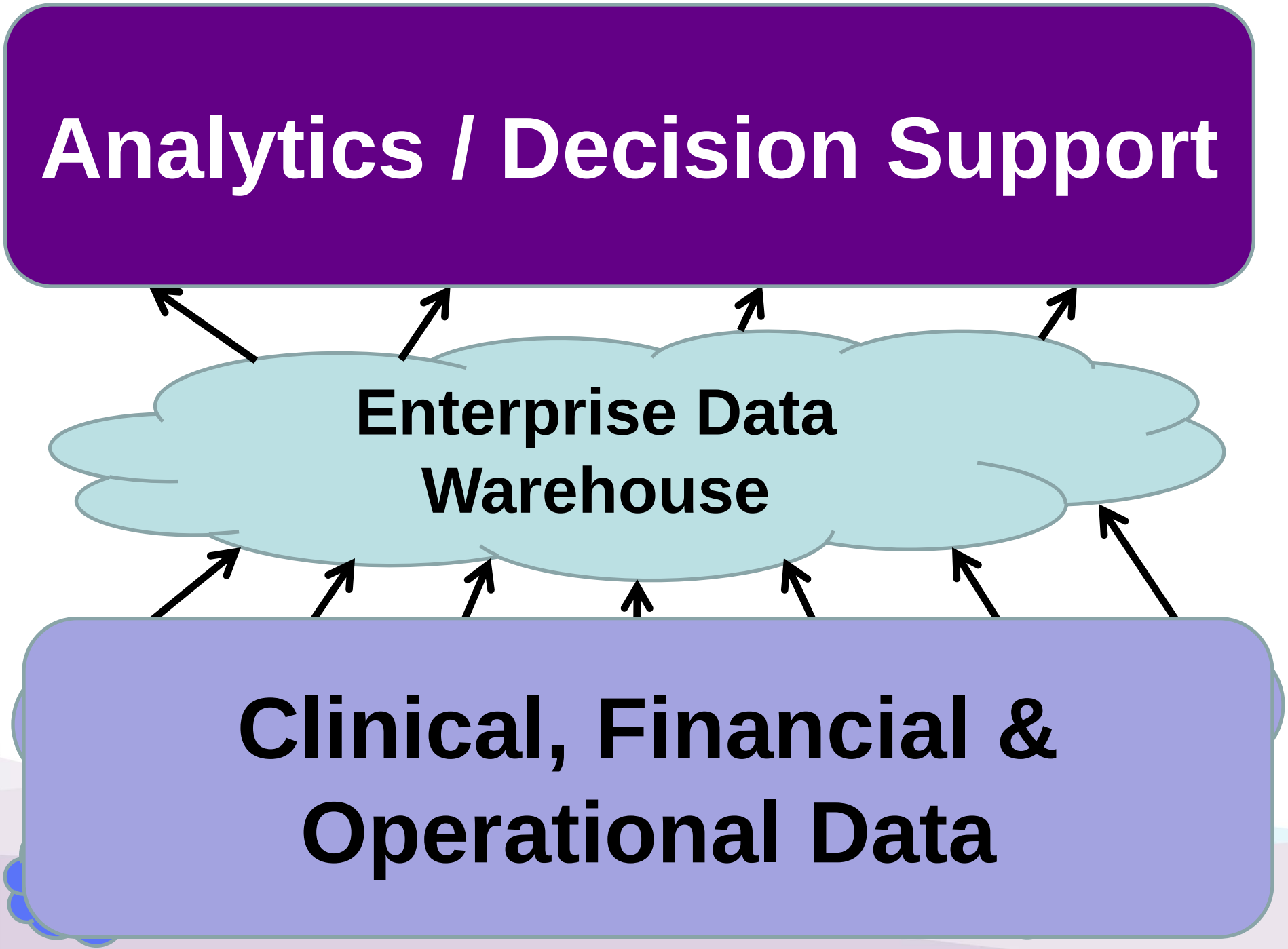
Hyperlink to CMS Specifications Sheet

Color Symbols for Benchmarks

re		Cumulative			May-13			Apr-13			Mar-13			Feb-13			Jan-13		
	Panel size:																		
nation/ Patient Safety Domain	Measure	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Performance*	Num	Den	Pe
ized All Condition Readmission	ACO 8---------- NQF 1789									# per month			# per month			# per month			
ensitive Conditions Admissions: COPD/ or Asthma, age 40	ACO 9----------NQF 0275									# per month			# per month			# per month			
ensitive Conditions Admissions: Heart Failure (HF), age 18	ACO 10---------- NQF 0277																		
Physicians who Successfully Qualify for an EHR Program	ACO 11																		
econciliation following transition in care	ACO 12----------NQF 0097																		
Future Fall Risk, age 65 and up	ACO 13---------- NQF 0101																		
e Care Domain	Measure	Num	Den																
munization, age 6 mo and up	ACO 14----------NQF 0041	20647	24120																
l Vaccination for Patients 65 Years and Older	ACO 15---------- NQF 0043	8291	9454																
dex (BMI) Screening, age 18 and up, calculated Q 6 mo	ACO 16a----------NQF 0421	20353	22872																
dex (BMI) Follow-Up Plan Documented	ACO 16b---------- NQF 0421	707	15807																
Screening, age 18 & up	ACO 17a----------NQF 0028	21503	22872	94%	4426	4604	96%	3918	4098	96%	4394	4605	95%	4264	4532	94%	4501	5033	
Cessation Intervention, age 18 & up	ACO 17b---------- NQF 0028	545	2980	18%	112	564	20%	88	521	17%	100	587	17%	122	616	20%	123	692	
Clinical Depression, age 12 & up	ACO 18a----------NQF 0418			N/A			N/A			N/A			N/A			N/A			N/A
Clinical Depression Follow-Up Plan, age 12 & up	ACO 18b----------NQF 0418			N/A			N/A			N/A			N/A			N/A			N/A
ncer Screening, age 50-7										66%	1633	2445	67%	1652	2468	67%	1649	2440	
Screening, age 40-69,										74%	1134	1522	75%	1158	1530	76%	1015	1396	
high blood pressure (a										99%	4570	4605	99%	4491	4532	99%	4553	5033	
n for high blood press													N/A			N/A			N/A
ulation Domain: Dise										ance*	Num	Den	rmance*	Num	Den	formance*	Num	Den	Pe
litus: HgA1c Control (<										75%	534	72	74%	548		73%	504	731	
litus: LDL Control < 100										50%	338	72	47%	376		50%	362	731	
litus: BP Control < 140/										76%	539	72	74%						
litus: Tobacco Non-Use, age 18-75		3501	3795	92%	729	784	93%	749	799	94%	666	7	92%						
litus: Aspirin or Antiplatelet Rx for DM & IVD, age 18-	29	600	1059	57%	151	281	54%	254	393	65%	67	1							
litus: HgA1c Poor Control, A1c > 9%, age 18-75	NQF 0059	350	3795	9%	69	784	9%	71	799	9%	64	7							
(HTN): Controlling BP < 140/90, age 18-85	NQF 0018	8339	11548	72%	1763	2332	54%	1734	2404	65%	1698	2							
cular Disease (IVD): Lipid Profile performed, age 18 & up	NQF 0075	2602	3025	86%	558	649	86%	547	635	86%	511	5							
cular Disease (IVD): LDL Control < 100, age 18 & up	ACO 29b----------NQF 0075	1753	3025	58%	377	649	58%	362	635	57%	336	5							
cular Disease (IVD), Use of aspirin/ alt Rx, age 18 & up	ACO 30---------- NQF 0068	1614	3025	53%	349	649	54%	348	635	55%	331	5							
EF < 40%, use of beta blocker (age 18 and up)	ACO 31---------- NQF 0083	97	276	35%	16	52	31%	26	60	43%	18	5	32%						
rapy for lowering LDL (age 18 and up)	ACO 32----------NQF 0074	2055	2698	76%	450	585	77%	417	553	75%	404	52	77%						
B use if also DM or LVEF < 40% (age 18 and up)	ACO 33----------NQF 0066	867	1201	72%	178	256	70%	193	257	75%	177	23	75%	162		70%	157	222	

Timely Frontline Information

- As or more important than compensation strategies
- Real promise in this arena over the next 2-5 years


Analytics / Decision Support
Enterprise Data Warehouse
Clinical, Financial & Operational Data




Business Intelligence Vendor Reporting

Bolt On Analytics

Billings Clinic Employees Using BI Analytics

Other Benchmarking / Collaborative Analytics

Enterprise Data Warehouse

EMR

Rev Cycle

ERP

Patient Satisfaction

Claims Data

Premier/ NSQIP/ STS/ NHSN

Other

Analytics

Analytics

Analytics

Billings Clinic

Billings Clinic MD Compensation Goals

- Desired Features of Compensation System
  - Supports organization's mission, vision & values
  - Considers constraints & maximizes flexibility of current systems
  - Competitive based on comparable “market” analysis
  - Perceived as equitable by physicians
  - Represents sound business principles
- Philosophy
  - Achieves alignment & consistency within Billings Clinic
    - Facilitates group concept within Billings Clinic
    - Incentivizes individual productivity & enhances individual satisfaction
    - Provides incentives for achievement of Clinic goals
  - Avoid inappropriate incentives
    - For ex booking credit for ancillaries ordered
    - Ownership incenting unnecessary volume
- Architecture
  - Is understandable & uniform in administration
  - Provides fair & accurate measurement across all revenue lines
  - Enhances the ability to recruit & retain physicians in the market
  - Aligns with organizational objectives and is affordable
  - Regulatory Requirements
  - Improves the competitive strength of the system

MD Compensation Evolution

- “Eat what you kill”
- % Net Bookings
- RVUs and conversion factors
- % individual production vs =share in group practices
- How to benchmark MD nonRVU work
- Increasing MD diversity
- Approaches to market total compensation

Billings Clinic MD Compensation

- 100 % RVU/conversion factor productivity
- 100 % RVU cf productivity plus QSL (5-10%)
- Straight salary
- Straight salary plus QSL (5-10%)
- Equal weight productivity/value metrics

Primary Care Compensation Strategy

- Value Based Movement
  - Focus from production to value based care
  - Primary Care compensation model is a blended model
    - Salary model based on median salary adjust for four components of performance
    - 10% Based on Team Production (Location based)
    - 40% Based on Individual Production (MD only)
    - 25% Based on Individual Quality Measures
    - 25% Based on Team and Individual Access Measures
  - Four components are based on three tiers
    - Minimum (25% lower than AMGA median compensation)
    - Median
    - Maximum (25% higher than AMGA median compensation)
  - Model design in 2012 ; transition year was 2013 when the blended method was modeled for Primary Care with the first impact to their salaries happening in 2014

Internal Medicine Compensation

Primary Care Example		Survey median	Minus 25% (Minimum)	Plus 25% (Maximum)
1.0 FTE		$ 250,000	$ 187,500	$ 312,500
Component	**Weight**	**Median**	**Minimum**	**Maximum**
Quality	**25%**	$ 62,500	$ 46,875	$ 78,125
Access	**25%**	$ 62,500	$ 46,875	$ 78,125
Team Production	**10%**	$ 25,000	$ 18,750	$ 31,250
Individual Production	**40%**	$ 100,000	$ 75,000	$ 125,000

Production Scorecard – Produced Monthly (AMGA 2012)

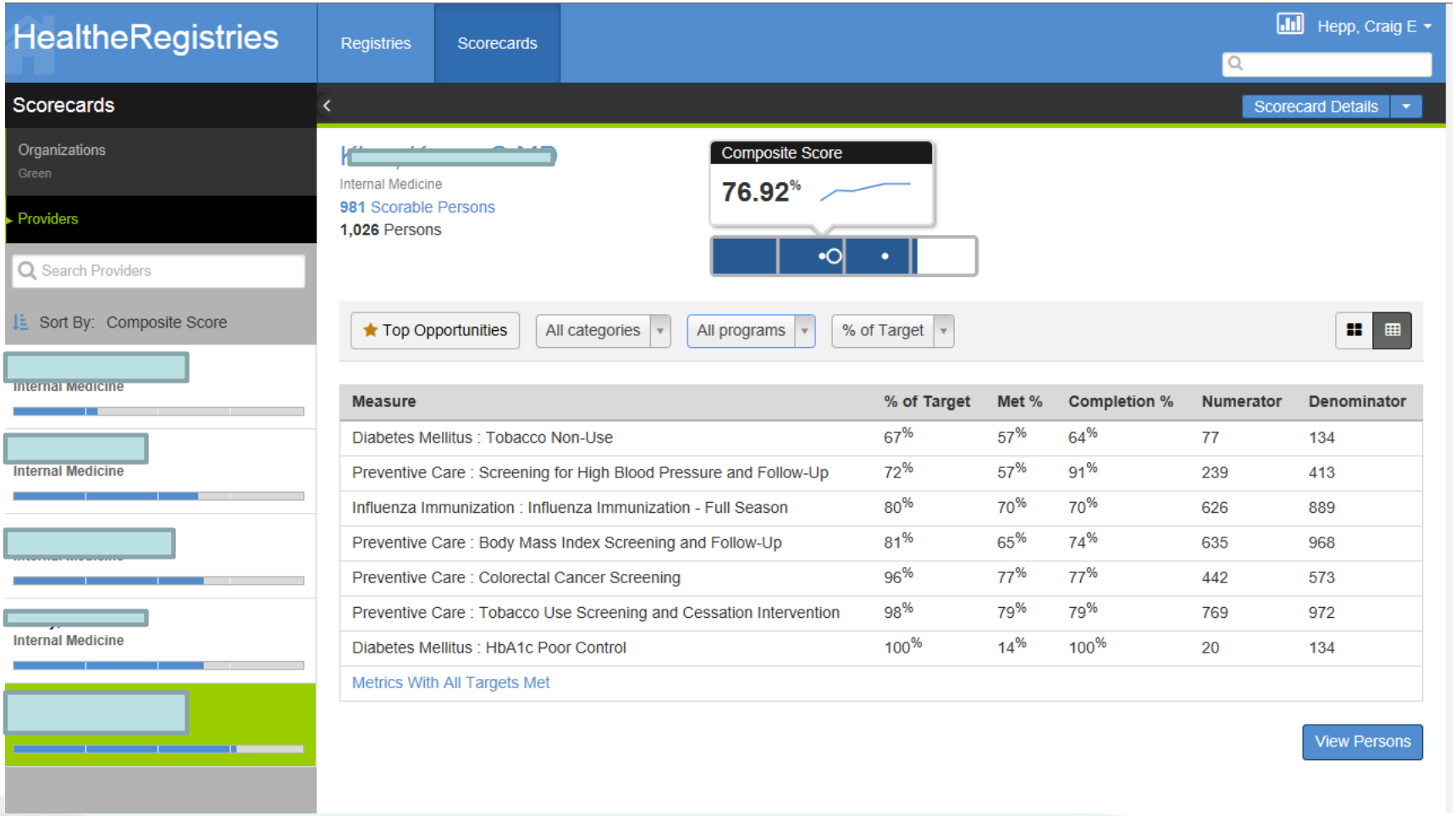
Access	Frequency		Meas Target	Target Source	Min	Med	Max
Team Production*	Monthly		% of AMGA Median	AMGA	0-84%	85-114%	115%+
Individual Production*	Monthly		% of AMGA Median	AMGA	0-84%	85-114%	115%+
* FTE Adjusted Measure							

Provider	Team	Clinical FTE	Actual OP RVU's	FTE Adj RVU's	AMGA Median	% Median
IM Phys 1	Delta	0.8	4,600	5,750	4,717	122%
FM Phys 1	Delta	1.0	4,700	4,700	4,890	96%
Primay PA	Delta	0.9	3,500	3,889	3,665	106%
Primary NP	Delta	1.0	3,400	3,400	3,315	103%
Team Total		**3.7**	**16,200**	**17,739**	**16,587**	**107%**

Access Score Card

	Spec Code	1210	Team FTE	6.41				
(	Team	IMR Faculty		Amb FTE	1.00	Pay FTE	1.00	
Scoring Measures								
Quarter / Calendar Year / Month	Q4 2014 Oct	Q4 2014 Nov	Q4 2014 Dec	Calendar 2014 YTD	Calendar 2014 YTD FTE Adj	Calendar 2014 Target	% of Target	Comp Score
Billed ambulatory visits - AMGA Definition	73	195	184	2,134	2,134	3,356	63.6%	1
HCC Score 2014 Standards (Age > 18 Only)	0.755	0.755	0.755	0.755	N/A	0.669	112.9%	2
Team Panel AMGA weighted (Quarterly)	10,309	10,309	10,309	10,309	11,275	12,192	92.5%	2
% Same Day Appointments Physician	11.6%	11.7%	12.2%	8.5%	N/A	6.5%	130.4%	3
% Same day appts team	19.8%	17.4%	17.8%	18.3%	N/A	10.0%	183.4%	3
								11
Provider is part of Team Roll Up	Y							
Scoring								
< 85% of Target =	1							
>= 85% of Target - < 115% of Target =	2							
>= 115% of Target =	3							

Panel Reporting 2015 (Healthy Registry)



Measure	% of Target	Met %	Completion %	Numerator	Denominator
Diabetes Mellitus : Tobacco Non-Use	67%	57%	64%	77	134
Preventive Care : Screening for High Blood Pressure and Follow-Up	72%	57%	91%	239	413
Influenza Immunization : Influenza Immunization - Full Season	80%	70%	70%	626	889
Preventive Care : Body Mass Index Screening and Follow-Up	81%	65%	74%	635	968
Preventive Care : Colorectal Cancer Screening	96%	77%	77%	442	573
Preventive Care : Tobacco Use Screening and Cessation Intervention	98%	79%	79%	769	972
Diabetes Mellitus : HbA1c Poor Control	100%	14%	100%	20	134

Process

- The Physician Compensation Committee (PCC) is integral in the compensation plan for the organization
  - The PCC oversight of physician compensation in the organization. Membership is a combination of senior leadership, physicians and compensation analysts
  - Committee role
    - Review staff physician compensation and production and compare to annual market data. The Committee makes recommendation to Leadership Council (LC)
    - Identify issues and alternatives for pay plan design, standard pay practices and policies
    - Discuss all special requests and make recommendation to LC

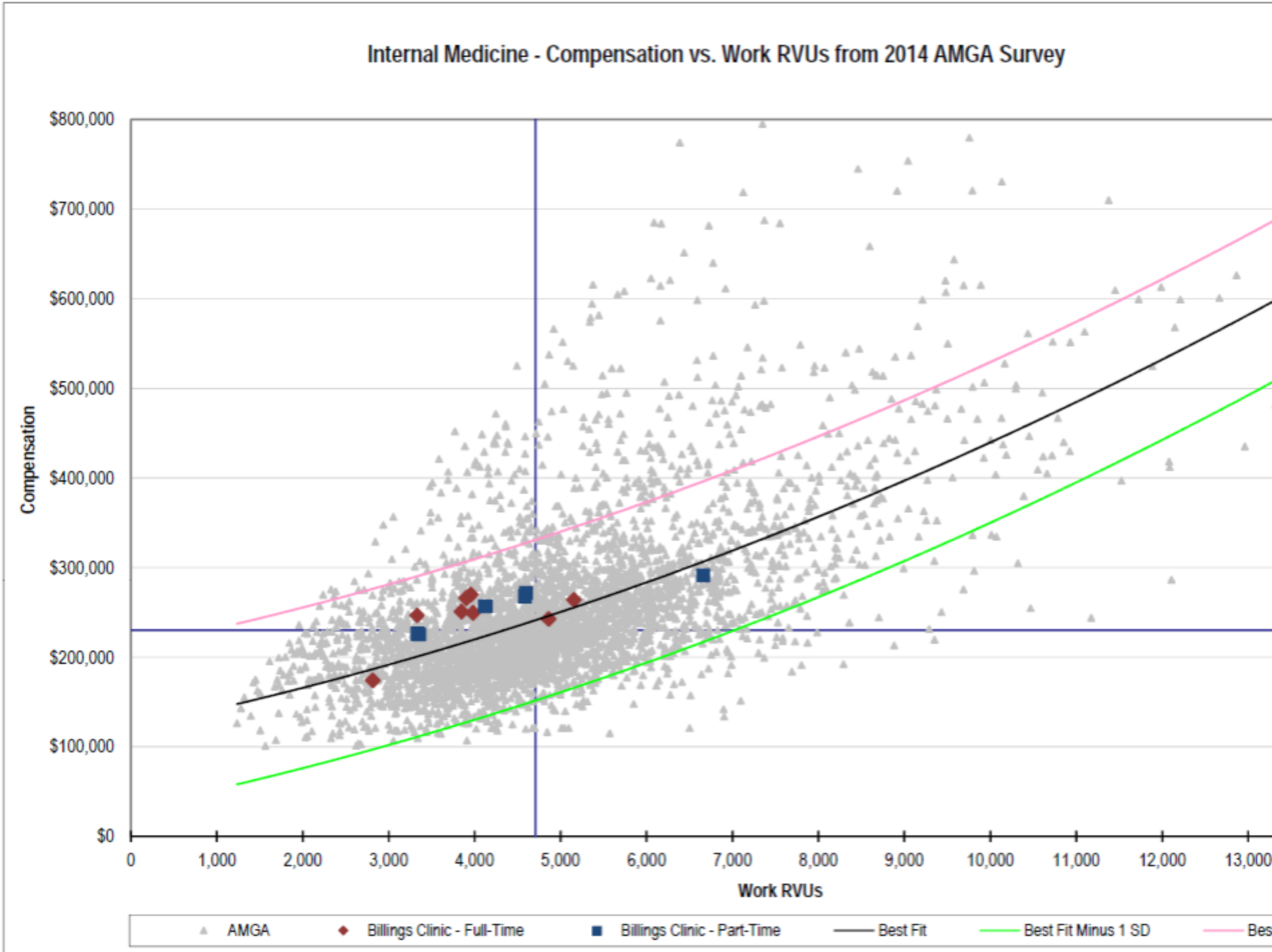
AND

Department recommendations

- Department Chair and Leadership may bring recommended department compensation model for review by the PCC
  - Intensivist compensation model
  - Primary Care

Lessons Learned

- Core principles for all compensation plans important
- One compensation model does not meet the needs for variability between departments
- When incorporating quality metrics the EHR should be robust to provide electronic collection of data for providers


Internal Medicine - Compensation vs. Work RVUs from 2014 AMGA Survey
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
Compensation
0
1,000
2,000
3,000
4,000
5,000
6,000
7,000
8,000
9,000
10,000
11,000
12,000
13,000
Work RVUs
AMGA
Billings Clinic - Full-Time
Billings Clinic - Part-Time
Best Fit
Best Fit Minus 1 SD
Bes

MARKET EVALUATION MATRIX 2014

	FY14 Billings Clinic Data	AMGA 2014	Comparison
1	Wrvu %tile	50th %tile (median)	At or above
2	Effective CF: Total compensation / wrvu (survey definition)	Comp to work ratio	Within 10%?
3	Wrvu FY14 Wrvu X CY14 CF +other comp	Wrvu %tile Comp %tile	Alignment & "Gap" within 10%tile points
4	Wrvu, total compensation	Scatter gram	(if producing > median) at or above best fit & within 1 std deviation
5	Other items for discussion:	Recruitment Retention	Other Department specific issues

MD Compensation and Value

- “Market” competiveness remains critical
- Underlying RVU and CF process determinations critical and controversial
- Uneven FFS payment issues (including hospital) at play as well and influential
- Recognizing work outside of patient visits
- Retail, Televisits, Outreach, Remote Consultation

Value Based Payment: Thoughts

- Current MSSP and Bundling designs complex and imperfect
- Data and real time information issues
- Beneficiary attribution and engagement
- Risk/benefit balance
- Low volume and low cost markets
- Socioeconomic and demographic variation
- Immature Electronic Health Information Systems
- Cost

MD Compensation and Health Reform

- Culture and values remain important
- Value can be delivered in most payment systems- importance of collegiality and investment in teams, timely information, patient centered focus, partnerships across the continuum
- Non-financial incentives critical

Non Financial Incentives

- Resources: Team including NP, PA, LPN, MA, RN navigators, Pharmacists, Social Workers
- EHR w real time feed back and analytics (this remains a mixed bag for MDs but is slowly improving}
- Sense of better results for patients than historical time-limited intermittent patient visit

Questions

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