Jack Beal: So, we'll start with a brief overview that I think at a high level identifies the areas that we'll plan to address during today's webinar. The key learning objectives ... So, we want to do several things. We want to discuss a little bit about the ways in which data can be used to engage, and not just engage, but to create alignment with physicians in leading improvement work. And so, I think, as well, we'll discuss a little bit about some of our past practices or historic practices that maybe created problems, or lack of engagement by our physicians. And I think one of the things that we know, and I'm sure most have experienced is that there's very little moderation as to whether physicians are either engaged or disengaged.

Jack Beal: And so, I think that there's this a pendulum swings, significantly, if you have physicians who are disengaged and so, as opposed to being participants in the improvement process, they can be dissenting that can provide opposition, distressed, et cetera. So, I think from our perspective, we see as a first step, really that level of engagement is being very, very key. We'll also identify the levels of physician leadership that can be engaged and discuss a little bit about how to develop leadership, ways in which we're actually actively working to develop leadership skills amongst our physicians.

Jack Beal: We'll talk a little bit about the types of data and information that most interest physician leaders, and probably equally as important we'll discuss how to start and to really develop trust from physicians, with respect to data. And then lastly, we'll discuss some of the ways in which some of the mechanisms that we have rolled out and implemented that we think have been effective in terms of being able to actually engage physicians in improvement work.

Brooke MacCourtney: All right, so we're going to go ahead and ask our first poll question. So, Jack and David would like to know, on a scale of one to four, how would you rate your organization's effectiveness in engaging physicians in improvement work? Okay. So, your answers are number one, not at all. Number two, somewhat effective. Number three, moderately effective. Number four, extremely effective, or you can answer unsure or not applicable. So, we'll go ahead and launch that poll for you. So, go ahead and take a minute to answer that for us.

Brooke MacCourt...: Looks like our answers are coming in, we're getting some good responses. We'll give you another couple seconds to answer. Looks like we're leveling off. And we'll go ahead and close that poll now, and we'll share the results. So, it looks like we had 10% say not effective at all. 34% said somewhat effective, 31% said moderately effective, only one percent said extremely effective, and 23% said unsure or not applicable. What do you think about those results, Jack?

Jack Beal: Yeah, so I think the results aren't surprising. Again, historically I think they're likely reflective that area between somewhat and moderately effective is probably where we've lived. I think hopefully, and some of the anecdotes and

the objectives that we'll discuss today are the things that we're doing to inch that upwards to really have the level of engagement be a much more effective. And so, one of the things that we'll touch on quite a bit throughout the course of the webinar is the notion of alignment. So, how are we creating alignment in terms of the objectives, and the priorities between the organization's leadership, and physicians?

Jack Beal: And we think that's one of the better ways or one of the key ways in which we will improve upon our effectiveness in terms of actually engaging physicians to do improvement work. So, I'm going to jump through. Okay. So, a little bit of background on us. We were technically created in 1906, though our organization, the existing organizational structure that we work under now was created actually in 1998. And so, prior to that, the University of Kansas Hospital was operated by the University of Kansas.

Jack Beal: So, under the board of regions in 1998, the state of Kansas essentially spun out the hospital, and created a new corporate instrumentality, like an agency of the state, but is distinct from the university. It did that because of some of the problems that existed, at that point, in terms of the type of care, the success or lack thereof in terms of how the hospital had been operated. So, span forward then it's 2020, and so in the course of about 21 years, we've grown very rapidly.

Jack Beal: And some of this data actually is a bit dated. So, fiscal year '19 actually had about 45,000 discharges, just under 36,000 surgeries, just under 62,000 UV visits. And approximately, a million and a half in ambulatory encounters. The other key seminal I think moment for us occurred I guess about four years ago now. So, we operated historically under what I've considered to be more of a federated model where we have the ... And this is pre January 1, 2016. Prior to that time, there was the University of Kansas, there was us University of Kansas Hospital that's what we were known by at that point.

Jack Beal: And then there were 18 distinct faculty practice plans, each living within its own nonprofit corporation that then rolled up to what was an MSO type structure. And so, there was very little integration, particularly clinically, much less throughout the whole of the academic medical center. And so, January 1st of 2016, we effectuated what we call as clinical integration. And so, in essence, we created the university of Kansas physicians, which is the largest multi-specialty group practice in the state. We have about over 1,000 physicians, some of whom are our scientists, all of whom are educators. And so, we've really over the last four years, worked on a more of a basic level of integration.

Jack Beal: Meaning that we consolidated those 18 distinct entities, essentially, merged them into one single multi specialty group practice. And so, as noted, some of our challenges really existed that were intrinsic to our model in the sense that it was very decentralized now that we have, and one of the main reasons that we

elected to become more integrated was to do some of the things that we'll go over here today.

Brooke MacCourtney: (silence). Double clicking. And then this advance this slide.

Jack Beal: Sorry, I'm having some technical difficulties here.

Brooke MacCourtney: Now we can switch to my screen. Does it seem to be working? All right. We'll go ahead and switch to my screen so everyone can just wait just one minute. We'll go ahead and switch screens. (silence). Put my screen up. Thanks for being patient everyone while we just deal with this little technical issue. So, are you able to see my screen? Sorry. Yup. Okay. So, let's just advance. All right.

David Wild: All right. So, together Jack and I lead a department, a group of teams that we refer to as performance improvement. And under that performance improvement umbrella, there really are three distinct groups that we'll spend some time talking about today that are actively involved in this work. Our applied analytics team does the heavy lifting, analytics lifting, for the organization in all areas, really from finance to mergers and acquisitions to clinical quality.

David Wild: And they primarily focus on predictive and prescriptive analytics and monitoring. Although, they do focus some of their efforts on a more epidemiological and statistical analysis as well. Business intelligence solutions are experts in ad hoc reporting, and BI tool development, and support of those tools. And also help the organization with benchmarking. And finally, Arlene promotion office is our group that teaches and supports our performance improvement methodology, both the improvement system and the management system across the organization.

David Wild: These three teams together work to address this problem. Dale Sanders, from HealthCatalyst actually shared a version of this slide with me several years ago and it has caused me much heartache ever since. And the premise here is that the curve needs to be compressed up into the left to improve or increase the value of the data that we have as it becomes information that teams can use to create actionable knowledge. All three of those teams that I just mentioned work on compressing different parts of this curve.

Jack Beal: Well, I just would say David, that just in terms of the context of this discussion, right? Where we think that there needs to be alignment or there should be alignment along this curve. If you think about, right, there occurs an event, or some scenario. I think we feel like at that point we all have to recognize, there has to be a level of awareness that that is an important enough event or scenario to either dig further or to consider some intervention. And thus, so I

think we want to ensure that it meets directionally, our physicians have a level of awareness in terms of really what's important, so that that can be escalated.

Jack Beal: And then I think as well, and David I'd like your thoughts once then we collect the data, I think there needs to be alignment in terms of how we're looking, how we're analyzing that data. But again, it really gets to the level of trust I think that the decision makers have in the data that's collected. So, alignment there, right? Trust in the data, which will be one of the focal points. And then finally, I think, after the analysis complete, then there has to be some decision, and oftentimes those decisions are made by consensus. And so, I think there also we would be looking to be able to align ourselves with physicians to ensure that we're moving in the same direction.

David Wild: Yeah. I think I agree with all of that. There's no doubt that the events being important are big enough to spend the time and effort, that the process of making that determination is key, and then likely would with any group of consumers of information, we have the conversation of well, exactly how was this analyzed, what part of the story might it miss telling, and how should we use this to improve?

David Wild: So, I hear from different groups each of these comments probably daily. And I think that all can be true, in different circumstances. We have all experienced, I am sure, or at least read or heard about the challenges that our highly educated positions face on a daily basis. Significant educational debt, ever increasing administrative burden, operational and EMR workflows that are designed to do everything but make it easier to take care of patients. Asking a group, in that situation to take on any other thing. Even one more project or initiative could be that proverbial straw that breaks the camel's back.

David Wild: These things and many more have pushed a profession that once led many aspects of decision making in their industry, to record levels of disengagement, frustration, the burnout term that we all hear so much about, and moral injury. We thought long and hard in our planning process of this work about how we would use the programs we were envisioning as tools to engage our physicians, frontline and leaders in improving care and how we deliver it. So, there are many Heifetz quotes that I love and perhaps my favorite, and I'm paraphrasing here, is the largest or worst type of leadership failure is treating an adaptive problem as if it were a technical one.

David Wild: If you are at all familiar with the concept of adaptive leadership, that's probably hits home. I've been involved with many initiatives, initiatives in air quotes, of course. Even led some where the entire plan was just go tell the doctors to do this thing called X. I'm proud to say in this scenario, with all of these programs that we work so hard to develop, that we spent years investing in understanding root causes of poor physician engagement in our improvement work. And then

learned as an organization how to address those root causes, recognizing the entire time that there was no simple technical fix.

Jack Beal: So when we started this journey, which was back in 2017, this is really the current state of the organization, at least in terms of key or identifiable areas which we were trying to work with physicians towards improvement. And so, a lot of these should look familiar. So, we had the legacy medical director, directorship programs. and really we had those is probably the, if not the primary, then the substantial mechanism for having I guess a forum or establishing a relationship in which to engage our physicians. I think the reality was, at that time ... And again, this is probably not uncommon is that those were relationships where we had defined probably a pretty standard set of services that required the physicians to do something.

Jack Beal: We had them fill out time records, time reports. Those time reports again, generically described what they were doing, but there was really no clear objectives attached to any of those medical directorship relationships other than of course those that were specifically related to some licensure or accreditation. We had, again, numerous clinical departments that had essentially grown up, were born in this environment of lots of independence. And so, again, prior to January 1st of 2016, each of our departments was a separate entity, with their own separate compensation plans, very little reliance on one another in terms of success, success in terms of compensation, recruitment, their ability to recruit physicians, et cetera.

Jack Beal: And so, there was really no forum quite frankly to provide information and to solicit really meaningful feedback from our physicians essentially to enable them to actually lead. There was an us versus them mentality. Again, not uncommon. I think, it's that common battle of a physician's desire to retain autonomy, and the hospital, their health systems desire for control given some of the business factors like we got to replace such as paying or being at risk for the physician's salary, et cetera. And then I think as we stepped into this both before and after what I've referred to as clinical integration, before the physicians really paid what they produced essentially.

Jack Beal: And it was predominantly based on their collections. Once we did integration, we had to step into it with something and we wanted to step into it with something that accounted for or promoted work by our physicians. And so, initially we started with really just a purely productivity oriented model, with no real defined parameters around quality or efficiency or the other now really important objectives that we have as a health system. And I think just generally, Brooke, we recognize too that this was probably ... At this point, again in May, 2017 we recognize that this was probably as much our problem.

Jack Beal: I think the factors that David had referenced in terms of some of the stereotypes associated with physicians, I think finally we probably recognize that we were perpetuated on those, right? And so, we viewed some of our physicians maybe as being melodramatic. I think the counter to that that we've considered and that we're now realizing is that they really didn't have an outlet to be able to express their views, and to take an active leadership role. And so, you having a lot of pent up frustration because they really didn't have an opportunity to be engaged, quite frankly.

Jack Beal: Probably a little scared that some of them would go too far. Again, that gets back to ensuring that level of alignment, but we really didn't provide them any direction, prior to this period. And then finally, I think, there was probably a presumption that some of them were just naturally disengaged. But again, we didn't provide them real opportunities to test that. And so, I think as we have gone through this journey, a lot of what we associated with disengagement, with the typical problems, or maybe some of the older stereotypes that maybe we associated with physicians, was as much our inability to effectively engage them I guess in terms of each of you able to provide them the resources, to have meaningful input, to provide them a forum in which to provide that input, and frankly to provide them some direction, because it's that last aspect of direction that's really critical to achieve alignment.

Brooke MacCourtney: All right. So, we're going to launch our next poll question. So, on this one-

Jack Beal: So, is there a way you can skip back one? I apologize.

Brooke MacCourtney: Yeah, we can go back, absolutely. Yeah, you're fine. Let's go with it.

Jack Beal: Okay. So, then with all of that as a backdrop, what does future state for us? So, I think we have three objectives here. And the first probably is our improvement work must align in all aspects. I think what we realize is that that really is this linchpin here. I mean, you need a level of engagement. And we want our physicians to feel empowered to vocalize what they see as problems or if they have improvement ideas. But the magic I think, and there's no bright line road or test for this, but it really is to achieve a sufficient level of alignment to ensure that we're marching forward, and to ensure that the work that we're doing with them ends up being more effective.

Jack Beal: And so again, we don't necessarily know right now and I don't think that there is necessarily an exact structure, right? For what utopia looks like with respect to physicians. I think we know that physicians will play an essential and a necessary role. There has to likely be a transition to first engagement, and then I think from our perspective it's ultimately been pushing that to then how do you develop responsibility, a sense of responsibility, and then a sense of

accountability? And core to all of that is creating a level of trust and transparency in terms of that relationship.

Brooke MacCourtney: All right. Now, we'll go ahead with the poll question. So, this question we would like to know how frequently does your organization share departmental performance information with clinical departments? So, we'll go ahead and launch that poll for you to respond to. So your options are, you can respond annually, quarterly, monthly, weekly, or more frequently, or unsure, or not applicable. We'll give you a few seconds to get those answers in. Looks like we've got a lot of people voting, which is great. I appreciate your answers. Looks like you need another couple seconds. We'll go ahead and close the poll and share the results.

Brooke MacCourtney: So, it looks like we had three percent respond that they share their performance information with their clinical departments annually. 27% do it quarterly, 22% monthly, nine percent weekly or more frequently, and 39% said unsure or not applicable. What are your thoughts on those responses?

David Wild: Yeah, I find that interesting. I think that, it makes sense that quarterly and monthly combined are probably popular choices. I'm really interested to know, and maybe we'll get some type of comments about this, but in the unsure or not applicable being the largest single group, is that you don't know as an audience if you share information or that you are not sharing information? This is a little bit different than when we asked this question of groups. Normally that's a small percentage, and so I'm not sure if that's reflective of the audience or the way we ask the question today.

David Wild: But in general, I think we know that that performance information tends to be shared with physician groups on some periodic basis, usually quarterly or monthly and related to financials. And I'm not always sure that that's the best or most right way.

Jack Beal: Well, I think too, I think what we've learned it's not enough just to share the departmental performance information. That really doesn't resonate as well with particularly our physician. I think a necessary part of that is then to have a forum with the physician leaders, whomever that may be, to be able to discuss it, to test if they have questions about the data, and frankly to get their feedback in terms of how they could potentially perform with their problem areas.

David Wild: So, with all of that backdrop, moved into what we designed and implemented, and now how widely deployed across our organization. This slide shows at a high level what these improvement programs look like. Our care connection program identifies and supports informal leaders, physician leaders to address

problems that are identified at a local level, really creating point improvements on a unit or in a clinic, or in a very specific clinical program.

David Wild: Our value based performance program engages an entire division or a department in improving the quality or cost of care, connecting multiple point improvements to create line improvements. And our department of planning program engages our physician leaders in strategically connecting the improvements, and the planning for growth and improvement, to create plan improvements either inside their department, or in conjunction with others. So, our care connections program, is the result of a three year redesign of our traditional medical director program that Jack mentioned as the starting point.

David Wild: And the four key features you see identified here were really grounded in our target condition of creating a tool that encouraged leadership improvement work and engagement. So, pay for trying instead of pay for time, generating lots of ideas and testing your own solutions. Really working on things that we are all clear are important to our patients and our organization. And then a final foundational feature here that said you should share this work with others who might benefit and ideally build your CV at the same time.

David Wild: Inside this program are two general buckets or types of work. And we were very thoughtful and intentional about designing these two separate buckets of work. We knew that there would be problems that we as the system wanted physicians to work on, to lead improvement around. And this became our care advancement bucket. It's a group, or a list of items that we actually put out a broadcast saying, "We're requesting your proposals if you're interested in working on things." And then we review the ideas and choose the leaders that we will fund time for based on that, the ideas that are submitted, our executive steering committee reviews, all those projects submissions, and then approves funding to support the physician for their time.

David Wild: But separately and more importantly, we recognize that there would be ideas or there would be problems that were important to our physicians that we weren't even aware of. They would be great ideas. They would be things that were well worth supporting and working on. And those type of ideas, you come to us with something we don't even know yet as important became our care transformation bucket. So, we have parallel tracks designed to address both of those issues.

Jack Beal: And that's really intended to push down even to the lowest levels of what we consider our physician organizational structure. The expectation that you'd get with the problem solve and engage and identify performance improvement activities. So, the other thing that we're doing has been noted, and we're actually, as we get to some of the subsequent slides that have some examples of the visuals that we use as part of these departmental finance, and planning

sessions, just to know we're actually in the midst of going through this right now. So, this will be our second year, I guess, to go through these planning sessions.

Jack Beal: And so, the templates that we'll show here are from the previous year. But we'll be sure to note what we've done to try to improve, both visual, and the scope of what we're covering through these sessions. So, this slide really just depicts the sequence in terms of how we've tried to build this. So, I think as noted, right? The data is essential. And so, one of the, I guess, foundational tactics that we're still working on frankly within our department is the spread of, I guess, knowledge management and data literacy.

Jack Beal: And so, we've sequenced this such that we first produce what has now become a standard template of information, produce those, give them to the departments. And then the next step is to schedule office hours with just our analytics leadership. So, that excludes our senior vice president level and that groups who are senior team. And this really is an opportunity for the department to ensure that it understands the data and understands the information that's been presented.

Jack Beal: We think this is a crucial step in terms of developing the trust within the data. And then, the next step then is just schedule a planning meeting with our senior leadership. And this group encompasses really both senior leadership and really any other leadership areas that may be relevant to a particular department. And so, the idea is a forum, and a means for our department chair, our highest level of physician leaders to be able to express, I guess their input, their thoughts in terms of either problem areas, potential areas of improvement, potential strategies, et cetera. And then we come together and at the very end of it, this gets back to the notion of alignment is we have an aligned plan then that we will have agreed on with our department chairs as to prioritizing next steps.

Jack Beal: Both in terms, again of any performance improvement activities, any strategic initiatives, any other planning type activities, we will have alignment at the conclusion of this process. At the same time, again, the objective at least is that what we will have also done is ... And I should know at the start of this process, there is a level of direction that's provided by the health system, right? So, we know the areas in terms of departments performance that are very important to us. And so, we align our information packets to be consistent with our strategic or operational priorities, right?

Jack Beal: So, we are still setting the direction, we set the parameters, and then that then leads and ensures that as we go through the rest of the process, as we promote feedback by our physician leaders, that ideally it's all aligned with the organizations priorities, excuse me.

David Wild: So, the final improvement program is what we call a value based performance. And this is a concept aimed at engaging departments or divisions in adding forms of compensation that are not primarily related to volume, or productivity and move more towards compensation based on value really without it being forced upon them. So, the process is depicted here. First we find improvements that both the health system, and the department sees as valuable. Then we move to support department or division in their measurements, in idea generation, in establishing a baseline, and in providing any analytics support that's necessary.

David Wild: Then we really just get out of the way, remove any barriers, and let that group run. And I'm excited. We'll share with you here the impact of the first six months of measurement, and four of these projects in a little bit.

Jack Beal: Just say the, I think one of the items that was noted that would be identified through this webinar was how do you, I guess, identify, develop physician leaders, and how do you develop tactics, I guess, that are adaptable or applicable to particular levels of physician leaders? I think just to know that, right, we are going over three of our tactics or strategies here. The care connections, the departmental finance, and planning sessions, and then value based performance. The departmental planning sessions really are ... That's the only one of the three is really directed at the highest level of physician leadership. In part it's because it's an annual planning session.

Jack Beal: And quite frankly, it's time intensive if you consider we have 21 or 22. 22 clinical departments that all align with an associate of academic department on the university side. Right? So 22 departments, meaning 22 clinical service to choose our chairs. And then in all of these meetings, we have at least two to three representatives of our senior leadership team present. And so, it's very time intensive, the time it takes not only to produce the data but to present it to schedule office hours with our clinical service chiefs, and then ultimately schedule the core departmental planning meetings, it's very time intensive.

Jack Beal: And so that tends to be higher level, but more focused on the real key organizational priorities, the value based performance and the care connections really is ... I think they're really designed to identify lower physicians who aren't at that high of a level of leadership, but who can serve as physician champions for particular initiatives that will benefit the system. Right? So, and I think in each of these particularly value-based performance, one of the thing that is to know we have project specific tasks, right? So, as David noted, these tasks really are ... Our core expectation is that, in order to qualify this has to be something that generates additional efficiency or cost suits.

Jack Beal: And we have to be able to calculate it, so if we can't calculate it, at least at this point it's really not eligible. We've explored the concept potentially go into like

an outside valuation company, but we really at least initially have really tried to ensure that any potential incentive payment was correlated to actual cost savings in another area. Right? So, what we have is then you generate savings ... And David noted, we'll talk a little bit more about the performance within the first six months of this program. You generate the savings, but then there are gating measures that we've included, again, that tie back to organizational priorities such as quality service, access, the documentation.

Jack Beal: And so, we've imputed those gating metrics A, to continue to expose our departments and our physicians to the things that are really important to the organization. B, to continue to be able to produce data so that they develop continued familiarity with that data and trust, and C, ultimately, I think, from the department's perspective, I think the fact that this all relates back to a project that someone else's identified, really creates a natural physician champion, right? But with the inclusion of those gating metrics, it requires departmental achievement of key organizational priorities. So, it aligns the entire department. That's really the point. It's not just to isolate necessarily one physician, but through the value based performance. So, they have a physician champion that can promote an activity that's beneficial to your organization, and on behalf of an entire department or subspecialty.

Jack Beal: So we'll just jump through here again, these are some of the templates or the visualizations that we used during our initial round of departmental financial planning sessions. And so, you can see that as part of developing I think trust and thus tried to improve engagement and alignment, we're very careful in terms of how we characterize performance. Right? And so, while there is where a red indication or red bar, we wanted to at least frame that as being as positive, I guess as positive as we could. And so, you'll note there, right? That we have annotated that as a potential improvement opportunity.

Jack Beal: This isn't intended to be pejorative or to serve as punishment for the departments. It's really intended to be very constructive, and that's articulated to each of our department chairs in advance of when we initiated these planning sessions. If you'll jump, Brooke. So, these again are just some of the additional slides that were within the information deck that these are pretty rudimentary measures, and metrics around provider productivity, and patient satisfaction. Again, both of those aligned with our key organizational priorities.

Jack Beal: And I think this is the final one. Again, just another example of how we've depicted performance on a few of the areas within these, planning sessions. And then I think the final slide, Brooke, is a market analysis. So, it's really bringing our physicians in, whereas this historically had been really purely in the realm of our strategic teams, really be able to pull our physicians to hopefully make them feel like they're involved in that process because that is actually very important to us.

Jack Beal: As we look to expand, we're primarily located in Kansas City. Right now, we do have affiliate hospitals throughout the state of Kansas, but we are the University of Kansas health system, and the state of Kansas is a big state. And so, to be able to have physician input, in terms of particularly highly sub specialized areas that maybe more difficult to recruit in particular areas of the state, I think having them involved up front has been very beneficial to us.

David Wild: And so, all of these domains, the examples that those last few slides just represented, the information that provided context started a conversation with each department. Keeping all of this in mind, and it's probably pretty clear here that I have wholeheartedly drank the adaptive leadership Kool-Aid, but mainly because it conceptually makes sense to me. But this was really important as well. This concept of understanding the productive range of tension, knowing if the temperature or the tension is too high or too low in your conversation to actually result in advancement or improvement was actually part of our consideration here.

David Wild: So, the reason that we put all three of these programs in place was really to begin to move a conversation, and allow different physicians, different physician groups or departments to really meet us where we wanted to be at their own pace rather than forcing it on them when it came time for some renegotiation of professional services contracts, for example. And now we'll move again to a little bit of a high level view at least to start out with. But an example of how we show that all this work has been beneficial. So, high level results for our care connections program in its first year, 37 projects were approved.

David Wild: And those 37 projects span 17 of 21 different clinical departments that existed at the time, at the beginning of this fiscal year. Their first quarter results were reported in November, for each of those 37 projects, only one had concern from the executive sponsor that it wouldn't end up achieving its intended outcome. And so, as those projects for this fiscal year, our fiscal year is July 1 to June 30th. As those begin to wind down, over the course of the next several months, we'll really have a better picture of the total impacts.

David Wild: But at least first quarter results, and mid year reviews showed that everyone felt their projects would end up with the intended benefit. For the value based performance projects, so, our first good sign was there was measurable improvement, and savings in 80% of the projects in the first month. And so, to explain this a little, all of these projects kicked off July 1st with the beginning of our fiscal year. So, we had a baseline period where we measure performance in the prior fiscal year. Jack mentioned gating measures. We determined our baseline performance on those gating measures, and we helped the team understand exactly or the department understand exactly what information we would be providing them monthly to show movement.

David Wild: And then we kicked those projects off July 1st. And as of December 31st, savings from the first six months of the measurement period for the first four projects were just under $400,000. And we expect that as we move from four projects to at least one for every one of 22 clinical departments, we will see that same benefit per measurement period of six months. And then finally, as it relates to the department, finance and planning meetings, a lot of interventions or process outcomes related to growth, and improvement plans that are now in place, and agreed upon as Jack mentioned with aligned work for all 21 clinical departments.

David Wild: And that results in more than 100 different projects or ideas that are many now complete as we work on planning for the next fiscal year or somewhere in the vetting process, or scoping. And to provide you a little bit of an example of what some of the value based performance projects actually look like, our division of pulmonary and critical care medicine came and said, "We think that we can impact the CLPD readmission rate across the year for patients that we actually take care of in the hospital." And so, you'll note here the red line, at about 18.8%, that was the baseline for the prior fiscal year. And you'll notice that July, August, October, November, and December were all significantly below that baseline.

David Wild: And that has resulted in actual measurable savings related to readmission, and the direct cost of providing that care for this patient population. Our anesthesia department recognized that we were using a significant amount of IV acetaminophen, IV Tylenol at a direct cost that is somewhere near 100 times the cost of the same oral dose, which is equally effective. The baseline here shows in the peri-operative environment around a two percent utilization rate of the oral acetaminophen dose, the oral Tylenol dose, in the baseline period, and then an increase to eight percent in July. And increasing every month since then.

David Wild: Our critical care teams realized that the choice and duration of antibiotics had a pretty significant impact on the total direct drug cost for their patient population. And to put in place a project aimed at reducing the average direct costs per patient of antibiotics month over month. And short of a single patient outlier driving up the average cost for a long course of antibiotics in October. I've been successful there as well. And finally, some results of our department finance and planning sessions. So, Jack shared the information that we provided to the departments to start that conversation, those domains.

David Wild: And the results of that was this form, the departmental leadership, the senior physician leadership and their business leadership inside the department providing us by division in this case orthopedics. What they hoped to do, what the priority was, what challenges they anticipated in each of those, and where they had market opportunities, and how we would improve and grow. And

these are the plans that we got for all 21 of our clinical departments last fiscal year. So, wrapping this all up, there are a number of things that we've learned in this process, and that we would recommend to you as you think about how you might begin to change the way you engage your physicians in improvement work.

David Wild: First of all, we've talked about this throughout the entire webinar. This must be done at multiple levels. We hit early career informal leaders with the care connections program. We hit divisional and department, mid-level leaders with the value based performance program, and we engage the senior leaders, senior physician leaders in the department, the department chairs, and the vice chairs in the department of finance and planning process.

Jack Beal: Yeah, I mean, I think too, there's a lot of ways ... It's not like we weren't trying to engage or improve performance in partnership with our physicians prior to May of 2017, we actually spent a lot of time, we spent years. Again, when we did clinical integration., that was January 1st of 2016, actually, prior to that period as we were in the process of negotiating with our physicians, we recognize that we couldn't have a compensation model that was premised solely on productivity. We knew, we could foresee enough changes within the industry that the health system at least was adamant that we include components for compensation that were unrelated to productivity. And so, even prior to January 1st, 2016, and then after up until May of 2017, we tried a number of different paths to try and actually get that implemented.

Jack Beal: And I think the more we fail, the more we realize that A, anything we told our physician leadership at that point, they distrusted because they thought that in the context of how we were raising it, we had an agenda. B, they didn't have the experience really to take what we were saying, and be able to apply it in terms of their practice. And so, we knew that it would have to be more iterative, I guess. And then, I think the last thing is, we, I think figured out ultimately that we were never going to effectuate broad scale change with our physicians if it was dictated by the health system. We were never going to get to the point of having the level of integration, of having the types of relationships that we knew were ultimately critical for us to have longterm success with our key physician leaders if we were merely pushing something onto them that they didn't believe it.

Jack Beal: And so, again, a lot of what we've discussed here today gives our physicians throughout the organization the opportunity to become leaders. To provide input, voice their opinion. And I think what we're doing and then is taking that, try to provide as enough direction and as much influence as we possibly can to align it with the organization's goals. But then to really let establish the standards, right? A lot of these in the VBP and the care connections we're

establishing standards, and then of course expectation that's been articulated is that those standards will be continuously applied, right?

Jack Beal: So, we'll have continuous stretched goals here, and once we accomplish something from the BBP perspective for example, that will become the standard, and there and there won't be any level of sharing from a cost savings standpoint. And so, we're really, again, elevating our physicians in a way that allows them in line with parameters that are set by the organization to really create their own practice and operational standards. And it's turned out, very well we think thus far.

Brooke MacCourtney: All right. So, we want to thank Jack and David for their presentation and we're going to move into our Q&A session. So, if you have any questions now it'd be a great time to submit those on your GoToWebinar panel, and we'll get through as many as we can. We are getting close to the top of the hour, but Jack and David have agreed to stay on for a few extra minutes to answer your questions. So, if you have any, please go ahead and ask those now. And we have one more poll question for you before we dive into our Q&A. So we'll go ahead and launch that.

Brooke MacCourtney: So, while today's webinar was focused on how to engage physicians in leading a continuum of improvement across an organization, some of you may want to learn about the work that HealthCatalyst is doing in this space, or maybe you'd like to learn about our other products and professional services. So, if you'd like to learn more, please answer this poll question. And we'll go ahead and leave that open for a few minutes while we go ahead and jump into these questions. So, we've got quite a few. So, our first question is from Jill, and she asks on slide 16 is there a team developed and by whom? And is this team typically interdisciplinary or just physicians?

David Wild: So, I think this is referring to the departmental finance and planning session. I believe that's slides 16. And the team related to information.

Brooke MacCourtney: We can jump back to the last slide.

David Wild: Let's just confirm.

Brooke MacCourtney: It was this slide.

David Wild: 16. Okay. And so, yes, without a doubt there is a team involved here. The core group I guess I would describe it is comprised of our analytics team leadership, some of our strategy and planning team. And then some representation of-

Jack Beal: Clinical affairs-

David Wild: ... Clinical affairs and finance.

Jack Beal: Finance, that's the group that's represented at the office hours. And then, all of the feedback, right? So, we have representatives from the analytics team just because again, we're trying to develop familiarity and trust in the data. So, that's essential. Strategy, and finance historically has had close relationships with our particular ... Again, this is a forum for the highest level of physician leaders that we have. So, strategy and planning that team has historically had some level of relationship with them. And then because there are financial components, and because quite frankly, this is newer, and we're still developing level of education, we do have someone's who's more strategic finance.

Jack Beal: And then as noted, our clinical affairs team is really ... Ben lives under our chief medical officer and it's both, he's our executive vice president of clinical affairs and our chief medical officer. And so, that is the group that is on a more the designated liaison to our multi-specialty faculty practice plan. And it's really a more focused level of leadership, I guess, as well a liaison between our other departments and our physician group. And so, we felt like that was a good core team. But then what they'll do is they'll extract feedback through the office hours, and they'll share it with all of the participants then in the more formal planning meeting.

Jack Beal: And in that planning meeting we'll have, so if it's a surgical specialty, we'll have our vice president of Peri-op, if it's a more of a clinic oriented, nonsurgical, non hospital-based specialty we'll have our VPs of ambulatory. So, we ensure that that group within those planning meetings is the right group to address really any issue based on the feedback that was presented during the office hours and then up to the actual planning needed to be able to address any issue that our department chairs or clinical service chiefs raised through that process.

Brooke MacCourtney: Great. Let's go back to our Q&A slide. All right. Okay. So, our next question comes from James and he says, with good success in engaging and aligning physicians, we find ourselves struggling to provide the resources, information and our manpower needed to empower quality and cost effectiveness. How should a healthcare system plan ahead for that and address that potential barrier when it arises?

David Wild: So, obviously I think that is not a problem that is unique to you, James. I think, the more information that we provide and the more helpful that information is, the more demand there is for the same sort of support and work. And the same is true on the improvement side, the more we start supporting teams to make clinical or operational improvements, the more poll, and demand there is for that work. I think that there are ways we can prepare for that. I think we have been planning on and understanding how to continue to improve the impact, and efficiency of our teams to be able to support more in the sense of volume, I

guess. We also know that as the organization grows, it's likely we'll need to add resources to support that. That's new for us, understanding how those two things are parallel to each other. Jack you have more to add?

Jack Beal: Well, yeah, I guess, fundamentally, this happened ... Because your point just won't take it. There's a lot to do. There's been a lot done, I think recognize as we gain traction here that the bundle of work isn't willing to dissipate. And so, it really just I think fundamentally has to be a really key, serious, important organizational priority. And I think we have gotten ... I mean that has been decided by our senior leadership team. And so, then that then translates into how are we prioritizing. And this is ... Particularly the three initiatives that we've discussed, those are three very, very important initiatives for our teams, and thus we prioritize them accordingly.

Jack Beal: But I think as David said, the hope, right, is that as we progress with this work, that we're going to develop more standardization. The more familiarity we develop with the data, the hope is that we'll have people using better and more our self-service tools. And that hopefully will alleviate reliance on our teams and allow us to deploy them elsewhere. I think right now, because they were laying the foundation, it's hard to get away from that. And so, I do think we'll probably have to potentially add some additional resource at least in terms of staffing to be able to really support, and spread this work at the pace that we think is necessary.

David Wild: Yeah, I'll chime in one more little piece to really highlight the concept of the importance of self-service tools in your question or in the answer to your question, James. If you're able to have an army of 1,000 or 2,000 or 5,000 people who understand the data, the information, and can use it on their own without having resources in the sense of people to do that for them, by truly pushing that information to the bleeding edges of the organization, I think that's another way that you can be prepared for that need for more resources.

Brooke MacCourtney: Great. So, we're about five minutes past the hour. We're still going to go ahead and answer. We got a couple more questions still. So, we have another one from Jill and she asks, have you worked on PI initiatives that reduce ed and hospital admissions when they're not determined to be medically necessary? How do you show the financial gain with this when ed visit and hospital volumes are often still rewarded versus value?

David Wild: So, the short answer to that question is yes. Although, most of that work has not been tied to any of these three programs that we talked about here today. One of the other areas that falls under our performance improvement umbrella that we didn't talk about today is our team of physician advisors. And that physician advisory team is very heavily involved in point of status entry management. So, historically that role probably was more focused on is this

patient in observation or outpatient or is this patient an inpatient? Are we in the correct status? And how do we manage those things?

David Wild: We've actually pivoted that team to be much more involved and is there medical necessity to be in the hospital, and how can we manage that? And for us, the financial impact is really a moot point because we are full to the gills. If we don't admit a patient who doesn't need to be admitted from the ed, there are three other patients that are waiting for that bed one way or another through the transfer center, being held in a recovery room or in the ed in another way.

Jack Beal: Yeah, I think we've got the point of ... Certainly good point, Joe that at least in today's environment, and I think we'd done in our last presentation on this topic that we're in Kansas and Missouri, essentially, we're right on state line. And so, our region is still very much a fee for service approach from manage care, and third party care standpoint. And so, it is true, that we generally get paid for each admission, but I think as we've started to look at it, I think what we realize, that there's contribution margin and there's operating margin, right? So, it's true that we're getting paid for it, but there's a whole host of stuff, particularly things where there's questionable necessity I guess, or if there's a better way to treat that patient besides the hospital.

Jack Beal: Generally, treating them outside the hospital is a better decision for us. Right? Because we don't be well from an operative, we generally have probably a negative operating margin in a lot of those services. So, really behooves us to not only treat them in an alternative setting now, but really to also work ... Well, the other things we're working on is on a broader scale to say, right, what's the full scope of what we can do to ensure that people who don't need to be in the hospital stay out of the hospital? And then similar work around readmission.

Brooke MacCourtney: Great. All right. We're going to answer a couple more questions. If you have any last minute questions, go ahead and submit them now. We're going to probably wrap up pretty soon, but we'll go ahead and do a couple more. And so, Edward asks, did these efforts lead to any increases in your HCAP scores or entering into value added contracts with MCOs that increased reimbursement? Did you use your EMR to collect/capture data? If not, why not?

David Wild: So, I'll answer those in order. So, did these efforts lead to any increases in your HCAP scores? Again, the short answer there is yes. Although, in targeted areas. Historically as an organization we have been a very strong performer in the HCAP or patient experience realm. And regularly find ourselves in the top decile. That is in fact our goal. And so, in a few areas where we had opportunities, yes, we have absolutely.

Jack Beal: So, our focus right now is as much on CG caps, right? It's really the ambulatory setting where we see there's big potential for greatest level of improvement.

David Wild: Did these help us enter into any value added contracts with MCOs that increased reimbursement? To be completely honest, in our market, there's not a huge push for value components of contracts. Although, we do work in some ways for the commercial contracts in that space, primarily around delays with placement to post acute care facilities, some around readmissions, and avoidable delays, or unnecessary admissions. Although, that hasn't been a very large focus of work. And then-

Jack Beal: But I think they're just two, just to know that, right? I mean, we feel like we're already in the wall, right? I mean, because reality is we see probably like everyone increase downward pressure from a revenue standpoint, the hospital side. And so, it really becomes essential for us to control quality service efficiency cost. We probably would prefer that payers be able to be more transparent with us about what it is that they're looking for. Because right now, again, it's that just continued downward pressure. So, I think a lot of the same things that we're working on can actually be applied. Right? Once you have a little bit more formality to the value base components of managed care contracting.

David Wild: And finally the last question there about EMR. Do we use that to change or to collect data? Again, short answer there is yes. The EMR is one of about 130 different data sources, or systems that bring data into our enterprise data warehouse. So, it is one component of this work, but not the only.

Brooke MacCourtney: Okay. It looks like Edward had one more question. He said you appeared to have gone from multiple faculty plans to one organization. What steps did you take to change the culture besides structural change?

Jack Beal: Well, so it's been about four years since we changed structure. I think I've always said that initially what we did was only changed the structure, right? We changed the organizational structure, changed some of the governance structures. But the real work was going to be about actually implementing a tighter level of integration. There's still a lot of work to be done here. I'll just say that. I think a lot of the work that we're doing, we feel like is imperative to increasing the level of integration. One of the things we tried to do in terms of our multi-specialty, so again, we have this new multi-specialty robust, very robust faculty practice plan called UKP.

Jack Beal: And so, whereas historically, we have 18 different corporations, departments each with their own president, when you realize that the first thing we needed to do was not only merge that but create a single board. So, we have a single board of UKP that has representation from the health system, has

representation from university, and then it has position representation. But I think one of the keys from our perspective when we went into it was we wanted to, I guess, remove some of the historic power and control that our department chairs had.

Jack Beal: We really wanted to create a faculty practice plan where everybody was integrated, and you had a single board that was cohesive and that looked at UKP as really not just its parts but the true some of its parts. And so, we just thought that, I guess, decrease the debt dynamic, the role of our department chairs from a governance perspective would be helpful. Truthfully, that's probably had mixed results. Our department chairs continue to be very powerful in terms of ... And have lots of authority, and influence. And so, there's still a lot of work there I think.

Jack Beal: I think some of this though is to, again, to develop consistent standards across our physician enterprise where obviously each sub specialty, each department, there will be some adaptation that's necessary, at least in terms of the conceptual framework that it all looks as similar as possible. So, we're all starting to speak and look at performance through one lens. Again, early on in the process, there's a bunch of other stuff that we've done that we've created probably additional meetings. And we've noted our clinical affairs team, we're starting to grow that to help be able to support our faculty practice plan more. But the truth is we haven't done as much as we need to do. And so, I think a lot of those, the cultural changes really are still to come.

Brooke MacCourtney: Great. All right. I think we'll go ahead and wrap up. We want to thank David and Jack for taking the time to present to us today, and we also want to thank all of you for joining us.