Session 44AB
New Models for Efficient & Effective Healthcare Operations: Lessons Learned

Presented by:
Stephen Sibbitt, MD
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New Models for Efficient & Effective Healthcare Operations: Lessons Learned

Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

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- Robert Pryor, MD, MBA
Introduction of Speakers

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Baylor Scott & White Health,
Temple Region

Robert W. Pryor, MD, MBA
Senior Vice President
Kaufman Hall

Learning Objectives

• Discuss how to become an adaptive healthcare organization
• Learn an approach to systematic assessment and improvement of clinical and administrative processes
• Understand how Baylor Scott & White Health applied the Toyota Lean principles of complex adaptive systems, and the results achieved to date
Agenda

• Physician Integration in Health Systems: Two Different Models
• How the Clinic Model Promotes “Practice Efficiency”
  — The Scott & White Clinic model as example
• Ten Examples of Clinic Model Success
  — Factors Contributing to Success
• Introduction of Lean Leadership Management
  — Building a Culture of Continuous Improvement
  — Examples of Successful Projects
• Practice Efficiency and Other Considerations
• Adoption of Change: Focus on Advanced Practice Professionals
• Summary

Physician Integration in Health Systems: Two Different Models

Acquire Practices
• “Targets of opportunity”
  — Hospital based
  — Cardiology
  — Orthopedic
• Fit them into existing hospital structure
• Physician compensation: individual profit/loss
• Leakage vs. “keepage”
• Retain independent culture

Clinic Model
• Strategic growth
  — Rationalization of subspecialties
  — Advanced practice professionals
  — New sites
  — Access
• Have governance structure and administrative structure
• Low-margin specialties can be cross-subsidized within clinic
• Best care is clinic care
• Clinic culture
Issues Related to Growth/Scale

- Network Adequacy
  - Contracted lives
- Economies
  - Purchasing
  - Overhead
  - Management
  - Access to capital
- Diseconomies
  - Communication
  - Maintain and promote culture
  - Redundancies

MIPS Proposed Rule Estimated Impact on Total Allowed Charges by Practice Size

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Eligible Clinicians*</th>
<th>Eligible Clinicians with Negative Adjustment</th>
<th>Eligible Clinicians with Positive Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo</td>
<td>102,788</td>
<td>87.0%</td>
<td>12.9%</td>
</tr>
<tr>
<td>2-9 Eligible Clinicians</td>
<td>123,695</td>
<td>69.9%</td>
<td>29.8%</td>
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<tr>
<td>10-24 Eligible Clinicians</td>
<td>81,207</td>
<td>59.4%</td>
<td>40.3%</td>
</tr>
<tr>
<td>25-99 Eligible Clinicians</td>
<td>147,976</td>
<td>44.9%</td>
<td>54.5%</td>
</tr>
<tr>
<td>100+ Eligible Clinicians</td>
<td>305,676</td>
<td>18.3%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

*Note: For years 1 and 2, eligible clinicians are physicians (MD/DO and DMD/DDS), physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists; in years 3+, CMS may broaden the definition.
Sample Clinic Structure

How Does the Clinic Model Promote “Practice Efficiency?”

- Consider within context of:
  - Local environment
  - Market forces
  - Cultural norms of practices
- Broader than visits/RVUs and direct costs
- We will discuss from the perspective of a group model in CTX
  - Description of that to follow
Building Culture

- Long history is helpful, but not necessary
- Culture is passed by telling stories

The Early Years in Temple, Texas and the Scott & White Clinic
The Early Years in Temple, Texas and the Scott & White Clinic

History of the Scott & White Clinic

- Origin as a physician-led group practice from late 1890s
- Quality focus/one-stop shopping
- Research and education always part of mission...
  - Large GME program and affiliation with a medical school
  - Research department begun in the early 60s
- Embraced HMO concept in late 70s
  - Developed Primary Care Regional system of clinics
- Consolidated for-profit clinic with NFP hospital in early 2000s
- Regional clinic expansion into Waco, College Station, Round Rock, and Hill Country
Scott & White Clinic

[Image of historical portraits]

Scott & White Clinic

[Image of building exterior]

2017 CONGRESS ON HEALTHCARE LEADERSHIP
Scott & White Clinic

October 2013 Merger Created Baylor Scott & White Health

Largest Not-for-Profit System in Texas

- **53** Hospitals
- **28** Freestanding Imaging Centers
- **28** Ambulatory Surgery Centers
- **980+** Access Points
- **120+** Satellite Outpatient Clinics
- **ACO**
- **Certified HMO**
October 2013 Merger (continued)

Largest Not-for-Profit System in Texas

- **43,500+** Employees
- **#1** Largest Employer in Temple
- **#5** Largest Employer in Dallas/Ft. Worth
- **6,600** Physicians
- **5*M** Annual Patient Encounters
- **3*M** Outpatient Registrations
- **5,250+** Licensed Beds
- **$7.5B** Total Oper. Rev.
- **$9.7B** Total Assets
- **$1.3B** Adjusted EBITDA

Ability to Assume Risk

Working together as an integrated delivery system, Scott & White Memorial Hospital, the Scott & White Clinic, and the Scott & White Health Plan were ranked in the *Dartmouth Atlas* of Health Care as among the lowest cost and highest quality healthcare systems in the mid-2000s.
Health Plan Market Reach

- Contracts with more than 8,500 physicians and 90 hospitals
- Approximately 300,000 members
- #1 plan in Texas for commercial and Medicare for 3rd year in a row, as ranked by NCQA
- Rated 4 stars by Centers for Medicare and Medicaid Services

Management

- Coordinated and integrated clinic management
Operating Structure/Principles at Legacy S&W

Keys to efficiency and effectiveness

• Physician/Admin dyad evolved
  – Triad ...and eventually a team of 4
    • CMO/CNO/Admin/CFO
• Regional budgetary control over inpatient and outpatient services
  – Coordination of ISFP across regions
• MORs
  – Performance goals for Finance, People, Quality/Safety, Service, Growth, and Academics

Operating Principles

• Promotion (early adoption) of Lean
  – Lean management training
• Promotion of APPs
  – Role in governance and ex-officio member with Board of Directors
• Adoption of PCMH with team-based care
  – Mental health services within primary care settings
• Clinical Pathway development
  – QA work
• Access improvement efforts
  – Same-Day Access
Ten Examples of Clinic Model Success

- Speed and efficiency of implementation
- Positive outcomes (administrative and/or clinical)

1. Same-Day Clinic Appointments – Background

- Access was a problem: S&W = Sit and Wait
- Service metrics and revenue challenges prompted action
- Leadership decision
- SDA = same-day appointment offered with any provider in any site if call received before noon, or next day if received after noon
- Few excluded: Dermatology, Mental Health, and Pain clinics
1. Same-Day Clinic Appointments – Plan

- Immediate implementation of same-day appointments—all regions, all clinics (few exceptions)
  - CEO mandate... MAKE IT HAPPEN
  - Endorsed by Senior Executive Committee and Board of Directors
  - SDA Task Force working since August 13
    - Comprised of 70 individuals, including regional leadership, regional Contact Center managers, Chairman, IT, marketing
  - Rapid training of Contact Centers and clinic staff commencing
- Rapid implementation related to clinic management structure and shared values with common mission

1. Same-Day Clinic Appointments – Success

From 2/01/2014 to 7/28/2016

<table>
<thead>
<tr>
<th>SDA Requests</th>
<th>SDA Accommodated</th>
<th>Percent Accommodated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,324,351</td>
<td>1,259,142</td>
<td>95.08%</td>
</tr>
</tbody>
</table>
2. EPIC Roll Out

- Large single day “go-live” for large region that included 3 hospitals and 30+ clinic sites
  - Often one of the main barriers to CPOE adoption
  - Concern that CPOE systems will create more work; cling to their traditional paper-based ordering methods

2. EPIC Roll-Out: CPOE Compliance

Project Phoenix – Go-Live KPI Report

![CPOE Compliance Graph]

What is the overview of the metric? The graph is measuring CPOE usage based on the HIMSS requirement of 90% for inpatient hospitals and 95% for clinics
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2. EPIC Roll-Out: CPOE Compliance
Project Phoenix – Go-Live KPI Report

What is the overview of the metric?
The graph is measuring CPOE usage based on the HIMSS requirement of 90% for inpatient hospitals and 95% for clinics.

3. Generic Prescription Usage

- Favorable pricing on generic prescriptions
- Cost savings for patients and Health Plan with increased utilization
- Requires providers to be engaged in prescribing
3. Generic Fill Rate: BSWH Employee

![Bar chart showing generic fill rates for BSWH Employee from 2013 to 2016 (YTD) with CTX and NTX categories.]

4. Coronary Stents

- A new contract for coronary stents began 3/25/16
  - One vendor removed and replaced with a 90% dual vendor contract
- Benefit to system costs if usage of two vendors > 90%
### 4. Coronary Stents: Drug Eluding Stent Market Share

**July 1 – Sept 30**

<table>
<thead>
<tr>
<th>Facility</th>
<th>NON-ABSORB</th>
<th>ABSORB</th>
<th>SYNERGY</th>
<th>NON-SYN</th>
<th>QTY</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMORIAL</td>
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<td>0%</td>
<td>102</td>
<td>161</td>
<td>61%</td>
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<td>COLLEGE STATION</td>
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<td>0%</td>
<td>127</td>
<td>11</td>
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<td>0%</td>
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<tr>
<td>ROUNDO ROCK</td>
<td>51</td>
<td>0%</td>
<td>22</td>
<td>22</td>
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<td>HILLCREST</td>
<td>43</td>
<td>23%</td>
<td>125</td>
<td>18</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>MCKINNEY</td>
<td>8</td>
<td>10%</td>
<td>8</td>
<td>60</td>
<td>77%</td>
<td>2%</td>
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<tr>
<td>GARLAND</td>
<td>143</td>
<td>74%</td>
<td>28</td>
<td>15</td>
<td>8%</td>
<td>6%</td>
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<tr>
<td>THHBP</td>
<td>532</td>
<td>90%</td>
<td>0%</td>
<td>2</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>CARROLLTON</td>
<td>27</td>
<td>63%</td>
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<td>0%</td>
<td>0%</td>
<td>2%</td>
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<tr>
<td>BHVH</td>
<td>290</td>
<td>29%</td>
<td>329</td>
<td>27%</td>
<td>28%</td>
<td>69%</td>
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<tr>
<td>IRVING</td>
<td>47</td>
<td>87%</td>
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<td>0%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>THHBD</td>
<td>16</td>
<td>21%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>60%</td>
</tr>
<tr>
<td>BSW Total</td>
<td>1187</td>
<td>43%</td>
<td>795</td>
<td>574</td>
<td>21%</td>
<td>180</td>
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</table>

System Compliance = 94%
Target Compliance = 90%
*Facilities in RED are below the SharedClarity compliance level

### 4. Coronary Stents: Bare Metal Stent Market Share

**July 1 – Sept 30**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Vendor 1</th>
<th>QTY</th>
<th>%</th>
<th>Vendor 2</th>
<th>QTY</th>
<th>%</th>
<th>Vendor 3</th>
<th>QTY</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMORIAL</td>
<td>23</td>
<td>96%</td>
<td>1</td>
<td>4%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRAPEVINE</td>
<td>3</td>
<td>21%</td>
<td>11</td>
<td>7%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRVING</td>
<td>10</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARROLLTON</td>
<td>7</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HILLCREST</td>
<td>3</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROUNDO ROCK</td>
<td>1</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GARLAND</td>
<td>10</td>
<td>71%</td>
<td>3</td>
<td>21%</td>
<td>1</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHVH</td>
<td>12</td>
<td>55%</td>
<td>0%</td>
<td>0%</td>
<td>10</td>
<td>45%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>THHBP</td>
<td>6</td>
<td>50%</td>
<td>0%</td>
<td>6</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KMGU</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>1</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THHBD</td>
<td>0%</td>
<td>0%</td>
<td>1</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSW Total</td>
<td>75</td>
<td>68%</td>
<td>15</td>
<td>14%</td>
<td>19</td>
<td>17%</td>
<td></td>
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</table>

System Compliance = 83%
Target Compliance = 90%
*Facilities in RED are below the SharedClarity compliance level
5. Blood Product Utilization

- Overuse of blood products in healthcare settings has several negative impacts
  - Higher mortality in specific populations
  - Higher costs without proven benefits
- Effort to reduce inappropriate blood utilization

5. Blood Product Utilization: Total Units Transfused

8/1/11 – 10/31/16 Entire Program History

- 40% reduction in units consumed over a 5-year period
  - Not related to a decrease in patient volume
  - Significant cost savings (conservative: direct savings of $1M/year)
6. Provider ICD 10 Education

7. Medicare Spending per Beneficiary
8. CMS Star Ratings

Hospital Compare

- Provides information about hospital quality to help patients make informed decisions and encourage quality care improvement at the hospital level
- More than 100 quality measures, and 4000 hospitals

Aim is to summarize information in a way that is useful and interpretable for patients

<table>
<thead>
<tr>
<th>Domain</th>
<th>Rating per National Average</th>
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</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Above</td>
</tr>
<tr>
<td>Safety</td>
<td>Above</td>
</tr>
<tr>
<td>Readmissions</td>
<td>Below</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Above</td>
</tr>
<tr>
<td>Effectiveness Care</td>
<td>Same</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Same</td>
</tr>
<tr>
<td>Efficiency Imaging</td>
<td>Same</td>
</tr>
</tbody>
</table>

9. Leapfrog Rankings

Hospital Safety Score

Outcomes + Process

Leapfrog Survey + CMS Data

% Risk of Avoidable Death

<table>
<thead>
<tr>
<th>Score</th>
<th>Spring 2015</th>
<th>Fall 2015</th>
<th>Spring 2016</th>
<th>Fall 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>2.9164</td>
<td>3.254</td>
<td>3.4384</td>
<td>3.4885</td>
</tr>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. NCQA Patient-Centered Medical Home Recognition

- BSWH mandate: all 52 CTX primary care clinics achieve PCMH recognition
- All 52 primary care sites submitted applications
  - All sites received recognition within 9 months (September 2014 – June 2015)
  - All sites achieved “Level 3”— highest-possible level

Factors Contributing to Success

- Integrated and aligned Clinic Group Practice Model
- Proven process to reduce waste
  - Lean Leadership Management
  - Applying Toyota Production System
Introduction of Lean Leadership Management

- Links strategy to operations
- Uses a “bottom up” operating system
- Management sets goals, some weekly, some monthly, and some yearly
- Cascades of huddles create communication up and down the organization daily
- Frees management time
- Combines management by metrics with management by walking around
- Quality, safety, cost, delivery, and morale

Building a Culture of Continuous Improvement

A culture of improving every important measure—every day by every employee

Objectives:
1. Rapidly increase the agility, flexibility, and speed with which we lead change and improvement, focused on the consumer/patient
2. Refine and deepen our operational excellence
3. Align leaders, practices, policies, and decisions with the belief that people are BSWH’s most valuable resource
4. Increase employee satisfaction, engagement, and meaning
Building a Culture of Continuous Improvement: Training

Trained: through Dec 2016

- Orientation – All new staff
- FUNdamentals (#101) – All new staff
- Practitioner (#201) – 4,650 staff
- Practitioner Project (#301) – tracking great gains
- LMS (#401) – 2,350, plus 1,800 LMS Quickstart
- ~1,200+ A3s – tracking great gains, and self-sufficient Supervisors

Building a Culture of Continuous Improvement: Idea Huddles

*Jul thru Nov 2016

<table>
<thead>
<tr>
<th>Region</th>
<th>Boards</th>
<th>Cumulative Ideas Implemented FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round Rock</td>
<td>101</td>
<td>967</td>
</tr>
<tr>
<td>Waco</td>
<td>103</td>
<td>1131</td>
</tr>
<tr>
<td>College Station</td>
<td>96</td>
<td>901</td>
</tr>
<tr>
<td>Hill Country</td>
<td>63</td>
<td>376</td>
</tr>
<tr>
<td>Temple</td>
<td>279</td>
<td>3180</td>
</tr>
<tr>
<td>Children’s</td>
<td>41</td>
<td>196</td>
</tr>
<tr>
<td>CCH (PACS)</td>
<td>21</td>
<td>147</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>704</strong></td>
<td><strong>6898</strong></td>
</tr>
</tbody>
</table>

1,283 huddles x 20/ea = **25,660 staff engaged daily/weekly!**
Building a Wider and Deeper Culture of Continuous Improvement

Efforts

Major Projects (DMAIC, Workshops, etc.)

Minor Projects (local A3s)

Idea Huddles

Faster PDCA Cycles by More Staff Toward Better Care

Examples of Successful Projects

Increase UTI/Strep Same-Day Appointments for Copperas Cove Family Med

- Number patients seen same day for UTIs or Strep up from 41.4% to consistently > 90%
- Recovered revenue of UTI: $1423.95, Strep: $991.44 per month; 294 additional patients FY16
- CGCAHPS “right-away appointment as soon as needed” score increased from 46.7 to consistently > 95

Austin/Round Rock Recruiting

- Decreased clinic open positions from 75 to 38 and total region openings from 180 to 87 while adding ~250 new growth positions
- Spreading new standard work practices throughout system
Examples of Successful Projects (continued)

CBRE Maintenance Room Renovation Time
– Reduced room renovation time by 83% from 5.9 to 2.0 days
– Reduced average monthly number of rooms blocked for maintenance issues by 39%
– Increased annual patient bed availability to additional 2,138 days
– Estimated $2.02M in recovered room billing potential,* per year

Austin/Round Rock Prescription Refill Center
– Refill turnaround time: Same-day refill closure 86%
– MyChart refill message TAT is 6-7 hours vs >12
– Patient satisfaction from 37% to 91%

BUMC Interv. Radiology: Improved On-Time Starts and Increased Cases
– On-Time Starts – Improved to 100%
– Increased IR Cases Completed – 80 additional per month = $480,000 (approx.)

Practice Efficiency and Other Considerations

• Staff turnover rates
• Provider turnover rates
• Overall provider satisfaction
• Patient satisfaction
• Quality
• Cost and delivery (budget)
Operating Principles (continued)

• Practice redesign work
  – Putting joy back into practice became a focus
  – CMA expanded roles
  – Pharm techs and Rx refill centers
  – Decentralization of Call Centers
  – Optimization of EHR
  – Pilots with scribes
  – Salary models with team goals for access/quality/service metrics

Pilots

CMA (Shepherd Model)
• Started pilot with four locations
• CMA stays with patient from start to finish and assists provider in the room with documentation
• Strong early returns; interest in expansion

Scribes
• Vendor provided scribes to 11 selected doctors
• Strong early returns; program expanding

Expansion of Centralized Refill for Primary Care
• Divert appropriate refills from provider’s in-basket to central pool
• Staffed by LVNs and pharmacy tech trained staff working from approved protocols

Killeen Contact Center
• Removed Killeen market (4 clinics) from larger Divisional Call Center
• Will focus on continuity of care for clinic teams (important to doctor and patient)

Value Comp Pilot
• Moved doctor compensation in two clinics from RVU-based pay to salary
• Incentives around team-based care, quality, access, patient satisfaction, etc.
Pilot Progress: Trending Upward in Meaningful Metrics

Provider Satisfaction (survey sample size of 33)
- Ability to deliver effective quality care: pilot group 27 percentage points higher than the field
- Satisfied with current environment: pilot group 31 percentage points higher than field

Scribes
- Time in Epic after hours: 40% decrease
- RVUs: 8% increase

Shepherd Model (Enhanced Care Team)
- Time in Epic after hours: 5% decrease (data from total pool – some providers realizing significantly more reduction in time); lessons learned continue
- RVUs: 8% increase

Patient Satisfaction
- Survey data not yet compiled for group; on-site (informal) surveying results show improved patient satisfaction; they like additional time/attention from provider
- One FM Clinic with Shepherd Model hit 100% previous month

People Provision
- Supporting the needs and development of our providers
- Overcoming burnout, enhancing resilience, and increasing quality for providers, care teams, and patients within our Clinics
  - Provider Retreat (Internal BSWH Program)
    - Find attendees by way of open invite and recommendations from others
    - Mix of different specialties and varied levels of “burnout” – seek balance in each session
    - 98%+ satisfaction
  - Lunch and Learns
    - Meet providers where they are
    - Facilitate time of community and team building
  - Medical Director Equipping
    - Leader development for front-line medical directors
    - Initial program is one year (demonstrated gains already in first quarter)
    - Percentage indicating confidence in their role as a Medical Director doubled
    - Percentage indicating being better equipped to lead as Medical Director also doubled
Adoption of Change

- Advanced practice professionals (APPs)

Focus on Advanced Practice Professionals

- Town Hall meetings held to hear “concerns” from APPs
  - Variable reporting structures
    - Clinic admin vs. RNs vs. physicians
  - Variable expectations from providers
    - Acute vs. chronic care
    - Autonomy vs. micro-management
  - Professional respect
  - Compensation issues
    - Market competitiveness
    - CME
APP Professional Environment Improvement Efforts

- Education for leaders and providers
- Engagement with HR
  - Management structure created
    - APP Council established
    - Leaders elected
    - Development and validation of standardized tools for selecting APP leaders
    - Standardization of reporting/evaluating
  - Wage/market corrections
  - CME enhancement
- Future projects
  - APP fellowships (Internal Medicine)
- Recognition with Board of Director attendance
- Expanded roles and numbers
  - Primary care
  - Hospitalist teams

Growth of Provider Workforce

![Graph showing the growth of PHYSICIANS and APPs from 2011 to 2015 with a 24% and 36% increase respectively.](image)
Growth in Visits (in 000s): 16 Percent

Summary

“Group Practice” vs. “Confederation” of Clinic Practices?

- **Group**
  - Shared MVV and goals
  - Shared management structure
  - Physician management
  - Common quality standards
  - Cross subsidies
  - Common EHR
  - Coordinated care
  - Governed by physician BOM
  - Care management

- **Confederation**
  - Disparate MVV and goals
  - Independent practices
  - Non-physician managers
  - +/- Quality standards
  - Little/no cross subsidies
  - +/- Shared EHR
  - Fragmented care
  - +/- Governed by physicians
  - +/- Care management
Biography—Stephen Sibbitt, MD, MBA, FACP

Dr. Sibbitt is the Chief Medical Officer, Temple Region, and Associate Chief Medical Officer, Central Division, for Baylor Scott & White Health. Dr. Sibbitt served on the Scott & White Clinic Board of Directors, and is a current member of the Metroplex-Adventist Hospital Board of Directors, and the Baylor Scott & White Health-Continuing Care Hospital Board of Directors. Dr. Sibbitt also currently serves on the Texas Hospital Association Board of Trustees, and the Texas Care Alliance Board of Directors.

Dr. Sibbitt completed his Medical Degree at the American University of the Caribbean and his Internal Medicine training at the University of Texas Medical Branch. He joined Baylor Scott & White Health in 2003, was inducted into the Alpha Omega Alpha Medical Honor Society in 2011, and earned a Masters of Business Administration degree with Baylor University in May 2016, graduating Beta Sigma Gamma.

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Biography—Robert Pryor, M.D.

Robert Pryor, M.D., is a Senior Vice President of Kaufman Hall with more than 40 years of healthcare experience as a physician, educator, and administrator. Dr. Pryor is a member of the Strategic and Financial Planning practice, and focuses on assisting hospitals, health systems, and other healthcare organizations nationwide with population health management, physician leadership and alignment, and organizational transformation for value-based healthcare.

Prior to joining Kaufman Hall, Dr. Pryor was President and Chief Medical Officer (CMO) of Baylor Scott & White Health, the largest not-for-profit health system in Texas with 49 hospitals and more than 850 outpatient clinics, pharmacies, and senior health, ambulatory surgery, and emergency medical centers. At the time of the 2013 merger of Baylor Health Care System and Scott & White Healthcare, Dr. Pryor was President and Chief Executive Officer of Scott & White Healthcare and Chairman of the Scott & White Health Plan.

Dr. Pryor has held numerous academic, hospital, and medical staff appointments, and served on industry boards at the local, regional, and national levels. He has delivered more than 100 presentations in the U.S. and abroad, coauthored a book, and authored book chapters and articles in more than two dozen publications.

Dr. Pryor received an M.D. from the University of Texas Medical Branch at Galveston, Texas, and an M.B.A. from Arizona State University. He is a board-certified pediatrician and a Fellow of the American College of Chest Physicians and the American College of Critical Care Medicine.