UNC FP Clinical Faculty Meeting

Integrate & Excel Clinically
UNC FP Senior Leadership Panel

Matthew Mauro, MD
President, UNC Faculty Physicians

David Zvara, MD
COO, UNC Faculty Physicians

Jeanne Dellicarri, MBA, MPH
Vice President, Operations

Michael Sledge, CPA
CFO, UNC Faculty Physicians & SOM

Matthew Nielsen, MD, MS
Chair Liaison, Medical Center Improvement Council
1. FP Organization Overview

2. Excel Clinically
   a) Ambulatory Initiatives
   b) Quality & Safety Initiatives

3. Integration Initiatives

4. Q&A
UNC Faculty Physicians is the Faculty Practice of UNC Health

UNC Faculty Physicians Practice Plan

UNC Faculty Physicians (UNC FP) is the clinical component of the UNC School of Medicine (SOM). It was organized to provide the clinical faculty of the School of Medicine a vehicle for providing and billing for patient care services.

In 1998, the state created the UNC Health Care System which includes UNC Hospitals AND the patient care services of the SOM—UNC FP

- Part of the Health Care System  AND
- Physicians are School of Medicine Employees
**UNC FP Governing Body**

**UNC FP is directed by:**

1. The President of UNC FP

2. The UNC FP Executive Committee

<table>
<thead>
<tr>
<th>UNC FP Executive Committee</th>
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</thead>
<tbody>
<tr>
<td>President, UNC FP (chair)*</td>
</tr>
<tr>
<td>3 elected large department chairs*</td>
</tr>
<tr>
<td>3 elected small department chairs*</td>
</tr>
<tr>
<td>Vice President, UNC FP Operations</td>
</tr>
<tr>
<td>Chief Clinical Officer, UNC Health</td>
</tr>
<tr>
<td>*voting member</td>
</tr>
</tbody>
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3. The UNC FP Board of Directors

<table>
<thead>
<tr>
<th>UNC FP Board of Directors</th>
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</thead>
<tbody>
<tr>
<td>President, UNC FP (chair)*</td>
</tr>
<tr>
<td>Clinical Department Chairs*</td>
</tr>
<tr>
<td>6 at-large elected physicians*</td>
</tr>
<tr>
<td>President, UNC Hospitals*</td>
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<tr>
<td>Executive Dean, UNC SOM*</td>
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<tr>
<td>Associate Dean of Administration, UNC SOM</td>
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<tr>
<td>CFO, UNC FP</td>
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<td>*voting member</td>
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UNC Medical Center

• The UNC Medical Center (UNCMC) includes all UNC Hospitals' staff and UNC FP providers and staff.

• All members of the Active Staff must hold a faculty appointment in the School of Medicine or the School of Dentistry of the University of North Carolina at Chapel Hill.
UNC FP Composition

UNC FP Providers and Staff
Total FTEs

- Faculty Physicians: 1,174
- APPs: 600
- Clinic Staff: 595
- Admin Staff: 108
UNC FP is 64% outpatient revenue and 36% inpatient revenue when including for outpatient revenue generated from outside contracts, UPL, pharmacy and other sources.
UNC Medical Center Outpatient Services
Hospital-Based Clinics vs. Faculty Physicians Clinics

Hospital-Based Clinics
- Refers to hospital outpatient clinics and departments that are legally, financially, and clinically integrated into the hospital and comply with all CMS provider-based rules.
  - Operate under the hospital’s license
  - Are accredited by the Joint Commission and charge a “facility fee”
  - Report to one of the following leaders:
    - Meghan McCann (Brendan Fitzpatrick, Tracey Rankin, Melanie Dawes)
    - Steve Finch
    - Lauren Kearns

Faculty Physicians Clinics
- Classified as Provider-Based clinics (type of CMS billing; clinics are clinically integrated with UNC Hospital)
- May not require Joint Commission accreditation and do not charge a facility fee
- Report to Clinical Department School of Medicine Chairs and/or to Jeanne Dellicarri
- Are referred to as “FP Clinics”
UNCMC Outpatient Services – FY21 Annualized Volumes

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Visits</th>
<th>Calls</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>HB 64</td>
<td>HB 570,122</td>
<td>HB 643,344</td>
<td>HB 755</td>
</tr>
<tr>
<td>FP 80</td>
<td>FP 596,993</td>
<td>FP 818,180</td>
<td>FP 595</td>
</tr>
<tr>
<td>Total HB + FP 144*</td>
<td>Total HB + FP 1,167,114‡</td>
<td>Total HB + FP 1,461,524</td>
<td>Total HB + FP 1,350</td>
</tr>
</tbody>
</table>

*Excluding 10 Hospital-owned clinics
‡Excludes visits from Imaging, Lab & Diagnostics, SOM Center and UNCH owned. Visits are annualized.
Clinic counts from most recent Master Clinic List (June 2021)

- UNCMC Outpatient Services includes HB and FP clinics, centered around the Triangle.
- Our enterprise is large and growing
- From 3/15/2020 to 6/21/2021 Outpatients Services Clinics conducted 386,349 Virtual Visits averaging ~20% of all visit volume.
## UNC Medical Center Annual Outpatient Revenue
### Pre-COVID period 3/1/19-2/29/20

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Revenue from E &amp;M Visits</td>
<td>$81,734,708</td>
</tr>
<tr>
<td>Professional Revenue from Ambulatory Procedures</td>
<td>$72,428,338</td>
</tr>
<tr>
<td>Professional Revenue from Ancillary Services (Lab and Radiology)</td>
<td>$51,401,439</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$205,564,485</strong></td>
</tr>
<tr>
<td>HB Clinic Net Revenue</td>
<td>$142,500,000</td>
</tr>
<tr>
<td>Hospital Owned Net Revenue</td>
<td>$7,100,000</td>
</tr>
<tr>
<td>Hospital Revenue from Ancillary Services (Lab and Radiology)</td>
<td>$319,600,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$469,200,000</strong></td>
</tr>
<tr>
<td><strong>UNC MC Outpatient Revenue</strong></td>
<td><strong>$674,764,485</strong></td>
</tr>
</tbody>
</table>

*Professional revenue in Hospital Owned Clinics is UNCH revenue  
*E&M and procedural revenue breakdowns are broad Categorizations by CPT Code  
*Professional revenue is based on postdate between 3/1/2019-2/29/2020  
*Hospital net revenue estimated based on charges between 3/1/2019-2/29/2020 with a standard gross collection rate applied
Excel Clinically
Ambulatory Initiatives

David Zvara, MD
COO, UNC Faculty Physicians
Expanding Access Will Increase:

- Exceptional patient experiences
- Equitable access to quality care
- Specialty care for all North Carolinians
- Treatment for specialized diagnoses
- Medical Center’s value to UNC Health

UNMC Outpatient Services Aspire to:

Serve every patient seeking care, regardless of geography, payor, or care requested, ensuring quality care that is timely, relevant, and patient centered.

We Must Solve For The Following:

The complex and siloed nature of finance, operations, and leadership across UNC Health System, UNC Medical Center, and UNC School of Medicine creates unique challenges, and opposition to change that must be overcome. Some areas of focus include:

- Simplicity and clarity around goals, initiatives, and measures of success.
- Providing the resources needed to support efforts to improve access including staffing, space, and technology.
- Cultural shift towards a more open, and less exclusive mindset to providing specialized care.
- How to leverage stronger collaboration with system level Virtual Care and Population Health departments.
- Accountability amongst School of Medicine providers to meet specific standards of productivity, scheduling, and patient panel.
Insight:
For many specialties there is a substantial wait for available appointments.

Potential Causes:
- Providers only seeing patients that meet certain criteria
- Provider schedules and templates are overly restricted
- Provider productivity is not meeting planned/budgeted levels
- Shortage of Providers in specialty
- Support staffing shortage
- Accountability not enforced

Patient Impact:
Care is delayed, anxiety regarding untreated or undiagnosed health issue.

Med Center Impact:
Patients seek care at competing health providers, added burden on admin staff.

Potential Solutions:
- Create a “No Outstanding Referrals” policy
- Chairs enforce accountability
- Assess clinics holistically across all resources to identify true needs
- Accurately assess provider productivity, and report in transparent way to recoup availability
- Clear work queues prior to set date as stale and lost.
- Identify actual staffing (providers and support) needs, and recruit where appropriate
- Expand clinic hours
- Open templates / scheduling
- Virtual visits
Insight:
Patients can be overwhelmed trying to navigate care access pathways.

Potential Causes:
- Not clear to patients or referring providers who to see (provider or specialty).
- Multiple contact phone numbers are found and not all are valid.
- Technical issues or technology access can be a barrier to accurately navigating to the correct provider.
- Burden is placed on patients to produce or fill out extensive documentation in some specialty clinics.
- Some clinics do not allow patients to self schedule or refer.
- Some clinics default to voicemail with extended response times.

Patient Impact:
Poor experience, frustration waiting to talk to the right person, uncertainty about receiving the right care.

Med Center Impact:
Patients arrive already frustrated, may schedule to wrong clinic, poor staff and provider experience.

Potential Solutions:
- Increase PAC utilization (addresses many of the solutions below)
- Centralize – single number to call, one call to schedule with any specialty.
- Ensure each call is answered by a human
- Expand hours to call and speak to a human
- Make the patient feel known when they call in, not just a number
- Create RN navigator role
- Solid hand-offs
- Expand functionality and adoption of MyChart and Well platforms
- Allow patients to self schedule on-line
- Co-Space / Multi-Provider Appointments
Quality & Safety Initiatives

Matthew Nielsen, MD, MS
Chair Liaison, Medical Center Improvement Council
VISION
To be the nation’s leading public school of medicine

MISSION
To improve the health and well-being of North Carolinians and others whom we serve. We accomplish this by providing leadership and excellence in the interrelated areas of patient care, education and research.

We strive to promote faculty, staff and learner development in a diverse, respectful environment where our colleagues demonstrate professionalism, enhance learning, and create a personal and professional sustainability. We optimize our partnership with the UNC Health Care System through close collaboration and a commitment to service.
Success is measured externally across several programs with patient safety and patient experience having the most impact

<table>
<thead>
<tr>
<th>Program</th>
<th>US News</th>
<th>Leapfrog</th>
<th>CMS 5-Star</th>
<th>CMS Readmission</th>
<th>CMS HAC</th>
<th>CMS VBP</th>
<th>Vizient Q&amp;A</th>
<th>Blue Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doximity Survey</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Process/Structural Measures</td>
<td>✓ ✓</td>
<td></td>
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</tr>
<tr>
<td>Patient safety - infections</td>
<td>✓ ✓ ✓ ✓ ✓</td>
<td>✓</td>
<td>✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓ ✓</td>
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<tr>
<td>Patient safety – complications (PSIs)</td>
<td>✓ ✓ ✓ ✓ ✓</td>
<td>✓</td>
<td>✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓ ✓</td>
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<tr>
<td>Readmissions</td>
<td>✓ ✓</td>
<td></td>
<td></td>
<td></td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>✓ ✓</td>
<td></td>
<td></td>
<td></td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience</td>
<td>✓ ✓ ✓ ✓ ✓</td>
<td>✓</td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td>✓ ✓ ✓ ✓</td>
<td></td>
<td></td>
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<tr>
<td>Efficiency/cost</td>
<td></td>
<td>✓ ✓</td>
<td></td>
<td></td>
<td>✓ ✓</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness &amp; effectiveness</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>✓ ✓</td>
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UNCMC is nationally ranked for 3 adult specialties and 7 pediatric specialties.

### Adult Specialties
- **Nationally-ranked (top 50):**
  - Gynecology #18
  - Ear, nose, and throat #36
  - Nephrology #39
- **High-performing:**
  - Diabetes and endocrinology*
  - Gastroenterology and GI surgery*
  - Oncology*
  - Urology*
  - Psychiatry*
- **Not ranked:**
  - Cardiology and heart surgery
  - Geriatrics
  - Neurology and neurosurgery
  - Orthopedics
  - Pulmonology
  - Ophthalmology
  - Rehabilitation
  - Rheumatology

### Pediatric Specialties
- **Nationally-ranked (top 50):**
  - Pediatric diabetes & endocrinology #13
  - Pediatric pulmonology & lung surgery #22
  - Pediatric nephrology #31
- **Nationally-ranked (top 50):**
  - Pediatric orthopedics #32
  - Pediatric urology #35
  - Pediatric gastroenterology & GI surgery #45
  - Pediatric oncology #46
- **Not ranked:**
  - Pediatric cardiology and heart surgery
  - Neonatology
  - Pediatric neurology and neurosurgery

### Procedure or Condition
- **High-performing:**
  - Aortic valve surgery*
  - Chronic obstructive pulmonary disease*
  - Colon cancer surgery*
- **High-performing (cont.):**
  - Congestive heart failure*
  - Heart bypass surgery*
  - Lung cancer surgery*
- **Not ranked:**
  - Abdominal aortic aneurysm repair
  - Hip replacement
  - Knee replacement
  - Transcatheter aortic valve replacement

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**UNCMC Public Rankings**

**Leapfrog – Safety Grade**

<table>
<thead>
<tr>
<th>Spring 2021</th>
<th>Fall 2020</th>
<th>Spring 2019</th>
<th>Fall 2018</th>
<th>Spring 2018</th>
<th>Fall 2017</th>
<th>Spring 2017</th>
<th>Fall 2016</th>
<th>Spring 2016</th>
<th>Fall 2015</th>
<th>Spring 2015</th>
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<tbody>
<tr>
<td>A</td>
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**US News & World Report – Best Hospitals Ranking**

**UNCMC**

**CMS – Star Rating**

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<tbody>
<tr>
<td>Overall rank</td>
<td>34</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Overall score</td>
<td>56.04%</td>
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**Vizient – Quality & Accountability Scorecard**

- 2020 Scorecard for UNCMC
- UNCMC overall rank, 2005-2020
True North: High Reliability Organization

Our **True North** aim is to be in the **top 10% nationwide** in the areas of Health and Well-being, Patient Centeredness, Safety, Timeliness and Efficiency, Provider and Staff Engagement, and Cost Effectiveness.

**Multi-faceted Transformation Strategy**

- Engage and develop leaders at all levels
- Align FP/SOM incentive plans with quality goals
- Contract with IHI for high reliability consultation / coaching
- Complete evaluation of immediate coding & documentation opportunities
- Workgroups to address quality gaps (CMS Star, Leapfrog, US News)
- AHRQ Patient Safety Culture Survey & action planning
- Quality Leadership Training
- Align with Population Health and Value Strategy
Transformation in Peer Academic Health Systems

Created belief in stretch vision

• Translated into tangible improvements for each area
• Leadership believed it could happen → Chairs believed → Faculty followed
• Departments = critical performance units

Data / transparency

• Powerful source of focus & motivation
• Knowing where doing well (& where to focus improvement) >> Believing
• Developed leaders across the organization
# FY22 UNC Medical Center Organizational Goals—Clinical Quality

<table>
<thead>
<tr>
<th>Category</th>
<th>MEASURE</th>
<th>Baseline</th>
<th>Threshold</th>
<th>Target</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Adult Mortality Index, Vizient academic model (Triangle)</td>
<td>0.92</td>
<td>3%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>Adult, all payer, 30-day readmission rate</td>
<td>10.03%</td>
<td>0%</td>
<td>1.5%</td>
<td>3%</td>
</tr>
<tr>
<td>Patient Harm</td>
<td>PSI90 Composite (AHRQ rate)</td>
<td>1.50</td>
<td>5%</td>
<td>7.5%</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Harm (entity-specific)</td>
<td>CLABSI house-wide (count)</td>
<td>113</td>
<td>5%</td>
<td>7.5%</td>
<td>10%</td>
</tr>
<tr>
<td>Patient Harm (entity-specific)</td>
<td>Hospital-Acquired Pressure Injuries (count)</td>
<td>1218</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Additional goals and priorities for quality council and SLT consideration

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Colorectal Ca Screening</td>
<td>Inclusive of primary care clinics</td>
</tr>
<tr>
<td>Diabetes A1C</td>
<td>Inclusive of primary care clinics</td>
</tr>
<tr>
<td>Hypertension BP Control</td>
<td>Patients identified through hypertension registry</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Urgent care only</td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>Exclude Dermatology, Ophthalmology, Urgent Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve cost &amp; quality of care</td>
<td>Length of Stay index (Vizient, academic model)</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Enhanced Recovery After Surgery (ERAS) – Medical Center specific</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Blood management (increase % of 1 unit orders)</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Bariatric pathway (structure)</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Sepsis mortality (adult, Vizient mortality index)</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Joint surgery pathway (increase # of patients)</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Diabetes pathway (structure)</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Heart failure pathway (increase # of patients)</td>
</tr>
<tr>
<td>Patient Harm</td>
<td>Antimicrobial Stewardship (increase antibiotic timeouts)</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>SAFE reporting &amp; learning (structure)</td>
</tr>
</tbody>
</table>
Dual Transformation / Ready for next

Process

Process Outcomes Experience

Process Outcomes Experience Efficiency

Pay for Reporting

Pay for Performance

Pay for Performance Risk based contracting

Transparency

UNC Health Alliance

UNC Health Care
“Doctors and nurses are stewards of something precious. Ultimately, the secret to Quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, then you can work backward to monitor and improve the system.”

Avedis Donabedian
One Great Team

HEROES WORK HERE
Integration Initiatives

Matt Mauro, MD
President, UNC Faculty Physicians
Wake County Activities

Panther Creek
Cardiology
Pulmonary
Internal Medicine
Nephrology
Orthopaedics
Neurology
Surgery
OB/GYN
MFM

Children’s Raleigh
Urologic Oncology
GYN Oncology
Uro-Gynecology
Neuro Intensivists
Pediatric ENT
Physician Organization: High-Level Overview

UNC Physicians

- Faculty Physicians
- Physicians Network
- Rex Physicians
- Caldwell Physicians
- Health Alliance
- Key Partners
Implications of “integrate clinically"

What we ARE doing...

Maintaining our existing physician entities
Enabling physicians to speak with one voice
Creating mechanisms to drive collaboration in order to:
  • Drive overall growth for the system
  • Enhance our ability to share learnings and continually improve quality and safety
  • Improve the consumer experience
  • Expand footprint of research and teaching

What we ARE NOT doing...

• Requiring all physicians to work side by side in every location
• Combining all practices into one employer
• Mandating one-size-fits-all approaches
• Materially changing current compensation
• Encouraging and rewarding facility- or practice-based thinking
Specialty Programs are designed to drive clinical integration
For FY22, UNC Health has invested $2.6 million in Specialty Programs efforts

**Primary Care:** In process of developing a multi-year strategic plan to expand footprint, unified quality collaborative (PCIC)

**Hematology/Oncology:** Building quality improvement collaborative (CCQI), expanding clinical trials to Wake County (5 set to open by August), developing new care navigation model

**GI:** Introducing IBD and Liver services into Wake County, expansion of clinical trials

**Behavioral Health:** Standing up a system-wide patient coordination team, developing a collaborative care model with Primary Care

**Hospital Medicine:** Establishing key hospital medicine specific metrics, exploring virtual cross-Entity coverage model
Can we get a 10 minute, "funds flow for dummies", primer?
What data do we have to demonstrate that this Funds Flow model is working better than the prior model?
What affect will changes in E&M coding have on reimbursement, compensation, and funds flow?
How are physicians who receive high amounts of funding (federal, other) accounted for in the "clinical FTE"?
How are high performing divisions within departments rewarded?
How does individual productivity get tracked? Do they take into account institutional impact such as seeing Charity Care patients and the overall service and/or revenue generation for the hospital system?
Decentralization creates duplicate overhead - how does the hospital hope to manage the growth in administrative costs, to ensure fiscally responsible support for its mission of delivering care?
UNC Health leadership has repeatedly noted a vision for “innovation” in rural health, including in recent press releases announcing partnerships with new hospitals. How does the UNC FP support this mission?
What is the vision for UNC as a tertiary and quaternary care hospital, and how does this support our healthcare system?
What steps are being taken to ensure consistent quality across the health system?
Do we have CON for the new hospital in Holly Springs and Rehab in Hillsborough? If not, how will this impact current capacity?
Besides moving PMR to Hillsborough what is the 3-5 year vision for that campus? What services are going to be added as the hospital expands to 150 beds and which service line/physician leader is in charge of that expansion of services?
How are you supporting faculty who are primarily clinical but trying to break into research? How does Funds Flow provide opportunities for protected time without grants?
What feedback have you received about how well Eastowne is functioning?
How are you supporting faculty physicians who are exhausted from the past year of Covid?