South Carolina Hospital Association

A Tale of Three Cities
It was the best of times...
...it was the worst of times.

- South Carolina ranked 45th among all US states in health status in 2011.
- In 2012 we fell to 46th.
- We have to do better.
Our nation’s health and health care are badly in need of an overhaul.
When it comes to health care, Americans want three things...

1. Give me the best health care possible
2. Send the bill to someone else
3. Don’t bother me about my behaviors
America ranks dead last in health status

America ranks dead last, continued

Obesity Trends* Among U.S. Adults
BRFSS, 1985

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data           <10%          10%–14%

Map showing obesity trends among U.S. adults in 1985, with states color-coded to represent obesity rates. Map includes states with no data, <10%, and 10%–14%.
Obesity Trends* Among U.S. Adults
BRFSS, 1986

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1987

(*BMI ≥30, or ~ 30 lbs. overweight for 5’4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1988

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1989

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1990

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1991

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1992

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1993

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data           <10%          10%–14%          15%–19%
Obesity Trends* Among U.S. Adults
BRFSS, 1994

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1995

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1996

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1997

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1998

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1999

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2000

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2001

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2002

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2003

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2004

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2005

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2006

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2007

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2008

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2009

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 2010

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)
What’s driving SC’s low health status?

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>49</td>
</tr>
<tr>
<td>Children in Poverty</td>
<td>48</td>
</tr>
<tr>
<td>Low Birth weight</td>
<td>47</td>
</tr>
<tr>
<td>High School Graduation Rate</td>
<td>47</td>
</tr>
<tr>
<td>Crime</td>
<td>46</td>
</tr>
<tr>
<td>Lack of Health Insurance</td>
<td>45</td>
</tr>
<tr>
<td>Obesity</td>
<td>42</td>
</tr>
<tr>
<td>Premature Death</td>
<td>42</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>40</td>
</tr>
<tr>
<td>Smoking</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: America’s Health Rankings, published by the United Health Foundation
In order to lower health care costs, SC needs better health and better health care.
Is our system broken? Absolutely not.

WARNING:
Every system is perfectly designed to get the results it gets.
– Paul Batalden, Dartmouth Institute for Health Policy and Clinical Practice

The US health care system was designed to fix acute illness at any cost.

It does exactly what it was built to do.
What was the US health care system built to do?

- Recruit workers in the era of wage controls during WWII (employer-sponsored health insurance)
- Provide health insurance to retirees from age 65 until end of life (Medicare)
- Cover the uninsured in America (Medicaid)
- Treat everyone in emergency conditions even if they are unable to pay (EMTALA)
What was the US healthcare system NOT built to do?

- Promote good health
- Manage chronic disease
- Contain costs
- Encourage collaboration among competing hospitals and physicians
The changing nature of advocacy
key strategic objectives

- Coverage
- Insurance Reforms
- Delivery System Reforms
- Payment Reforms
- Transparency
- Health IT
implications for hospitals

- Achieve solid clinical alignment between hospital and physicians
- Deliver superior outcomes
- Reduce costs
- Develop integrated information systems
- Form strategic alliances
- Prepare for new payment models
do you know the difference?
implications for hospitals

- Achieve solid clinical alignment between hospital and physicians
- Deliver superior outcomes
- Reduce costs
- Develop integrated information systems
- Form strategic alliances
- Prepare for new payment models

Change your business model.
Which one can you control?
Among the best heart care in country

Cut response time for heart attack in half

Average door to balloon time in SC is 45 minutes

Consistently rated one of best states
Hospital infection rate below national average

“We won’t stop until we eliminate the threat of health acquired conditions in all hospitals across our state.”

Dr. Rick Foster
Lead state for safe surgery initiative

“SC has a tremendous history of successfully introducing other quality initiatives such as improving the care of heart attack patients and reducing infection. We would like to collaborate with SC hospitals in developing a model to improve surgical safety at a state level that other states can follow.”

Dr. Atul Gawande
Ranked one of the top five states in health improvements by feds

“SC hospitals have been stars from the start of the 5 million lives campaign. I’m deeply indebted to you SC leaders as you set the stage for others.”

Dr. Don Berwick
SC hospitals aren’t working alone
Collaboration Pays Dividends

- In early 2012, The Health Research and Educational Trust (HRET) ranked South Carolina in the top quartile of all states on established core quality measures.

- In July 2012, SCHA received the National American Hospital Association’s Dick Davidson Quality Milestone Award for Allied Association Leadership.

- SC hospitals reduced documented elective inductions as a subset of the >=37 to <39 weeks delivery by 50%.
State performance — overall score

Process Quality + Readmissions + Mortality + HCAHPS
**SC is #5 in the nation for getting the highest bonuses on average in the VBP program**

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Percent of Hospitals Getting a Bonus</th>
<th>Percent of Hospitals Getting a Penalty</th>
<th>Total Number of Hospitals Per State</th>
<th>Average Change In Payment From Value-Based Purchasing Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Maine</td>
<td>79%</td>
<td>21%</td>
<td>19</td>
<td>0.23%</td>
</tr>
<tr>
<td>2</td>
<td>South Dakota</td>
<td>73%</td>
<td>27%</td>
<td>15</td>
<td>0.17%</td>
</tr>
<tr>
<td>3</td>
<td>Nebraska</td>
<td>59%</td>
<td>41%</td>
<td>22</td>
<td>0.17%</td>
</tr>
<tr>
<td>4</td>
<td>Utah</td>
<td>75%</td>
<td>25%</td>
<td>28</td>
<td>0.16%</td>
</tr>
<tr>
<td>5</td>
<td>South Carolina</td>
<td>69%</td>
<td>31%</td>
<td>51</td>
<td>0.15%</td>
</tr>
<tr>
<td>6</td>
<td>Kansas</td>
<td>74%</td>
<td>26%</td>
<td>46</td>
<td>0.13%</td>
</tr>
<tr>
<td>7</td>
<td>Montana</td>
<td>67%</td>
<td>33%</td>
<td>12</td>
<td>0.13%</td>
</tr>
<tr>
<td>8</td>
<td>Idaho</td>
<td>77%</td>
<td>23%</td>
<td>13</td>
<td>0.11%</td>
</tr>
<tr>
<td>9</td>
<td>North Carolina</td>
<td>69%</td>
<td>31%</td>
<td>83</td>
<td>0.11%</td>
</tr>
<tr>
<td></td>
<td><strong>U.S. AVERAGE</strong></td>
<td>52%</td>
<td>48%</td>
<td>2984</td>
<td><strong>0.02%</strong></td>
</tr>
</tbody>
</table>
South Carolina Hospital Association

A Tale of Three Cities
The regions that fared best under CMS's hospital VBP program

Cities in Indiana, South Carolina are among those faring best

Topics: Reimbursement, Finance

January 10, 2013

*Kaiser Health News* this week identified the U.S. regions where hospitals are most—and least—likely to receive bonuses under Medicare's value-based purchasing (VBP) program.

Under the VBP program, Medicare will withhold up to 1% of its regular reimbursement based on their performance on certain quality measures and on patient experience surveys. In an analysis of the program, *KHN*'s Jordan Rau examined 304 hospital markets across the United States, excluding Maryland. For the purposes of *KHN*'s analysis, the 212 markets with at least five hospitals were deemed to be “major markets.”

According to Rau, hospitals in these 10 major markets fared best under the VBP program:

- Fort Wayne, Ind.;
- Greenville, S.C.;
- Newport News, Va.;
- Boise, Idaho;
- Florence, S.C.;
- Bangor, Maine;
- Grand Rapids, Mich.;
- Jackson, Tenn.,
- Portland, Maine; and
- Charleston, S.C.
The surprise ending

South Carolina emerges as a leader in health care improvement, thanks to partnerships with great people and great organizations

We aspire to be a learning laboratory for the Triple Aim
Lessons learned

- Collaboration accelerates performance improvement
- Public scrutiny and positive peer pressure ensure leadership engagement
- We can’t make a population healthy by giving them high quality health care
- The Triple Aim is an essential strategy
- Fatigue among QI professionals is a problem, but we will never get off the project treadmill until we build a culture of safety
South Carolina

Safe Care

creating highly reliable healthcare — every patient, every time!
Our objectives

- Build universal awareness of high reliability science among SC hospitals
- Demonstrate that it is possible to achieve high reliability at scale
- Move all SC hospitals closer to high reliability for the benefit of every patient in our state
- Change the national perception of SC
Our aspiration

- It is a far, far better thing that we do, than we have ever done...