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STRIVING BEYOND REFORM

Inspiring case examples from Fairview Health Services, St. Luke's Hospital, Bellin Health, and other forward-thinking providers:

- Creating alliances that profit the community
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- Cutting costs as payments decline
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To navigate the healthcare maze, savvy organizations rely on Navigant's healthcare consulting professionals to embrace payment reform and implement effective business models such as accountable care organizations. Using the ACO compass, new payment reform guardrails and a commitment to greater engagement, early adopters can begin redesigning their current systems to better position themselves for inevitable change.



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AWE-INSPIRING PROVIDERS

his is not a report about what's wrong with the U.S. healthcare system. This is not a report that advocates specific tasks that need to be completed in response to healthcare reform legislation.

This is a report about possibility and perspective. It is a report about courage and fortitude. It is a report, ultimately, about inspiration.

A 2009 study found that readers are more likely to pass along an optimistic article than a negative one. Researchers tracked more than 7,500 *New York Times* articles over a six-month period. One attribute, in particular, skyrocketed articles to the top of most e-mailed list: a sense of awe. Awe-inspiring material requires people to broaden their minds and view the world in a different way, explain researchers Jonah Berger and Katherine A. Milkman.

You need only stop by the NICU or accompany a physician on rounds to be overcome by the sheer possibilities of modern medicine. Yet, today, some of the most awe-inspiring healthcare stories are unfolding, not in the surgical suite or research lab, but in conference rooms and during team meetings.

As illustrated by the case studies in this report, there are profound and important changes occurring in health-care management. Hospital administrators, physicians, nurses, and other key players are working together to redefine and redesign how health care is delivered and reimbursed. They are driven by a singular goal: enhance the *value* of care. By improving quality and reducing costs, providers will improve the health of their communities and ensure their own long-term viability.

Take the story of Fairview Health Services, which intends to become one of America's first accountable care organizations (see page 11). The seven-hospital system is already in a good position to succeed under a two-year, risk-based contract. Four pilot primary care clinics have already reduced their total cost of care growth rate by 5 percent, with corresponding improvements in quality.

Or consider the home-grown process improvement model developed at Magee-Womens Hospital at the University of Pittsburgh Medical Center (see page 33). Staff used the six-step process—which focuses on

improving the patient and family experience—to design a joint-replacement program that consistently scores in the 99th percentile on patient satisfaction surveys and above national averages for clinical outcomes.

"If you want to build a ship, don't drum up people together to collect wood and don't assign them tasks and work, but rather teach them to long for the sea."

—ANTOINE DE SAINT-EXUPÉRY

The leading-edge providers in this report believe that their approaches will help them thrive in the post-reform era. However, most of these providers began their efforts years before the healthcare reform debate began anew.

By sharing their stories, these providers are helping to shift paradigms and open minds to new possible approaches to healthcare delivery—advances that benefit patients and the bottom line. For instance, more than 30 percent of primary care physician visits at Group Health Cooperative are now conducted via e-mail and other secure electronic exchanges (see page 45). In addition to pleasing patients, the technology-enabled medical homes are reducing costly emergency and urgent care visits.

Yes, there are many challenges ahead for healthcare providers. There are many tasks that need to be delegated under healthcare reform. But, first, consider the power of possibility. Step up. Teach your staff, your patients, your communities to long for a better healthcare system.

Debora Kuchka-Craig, FHFMA

Chair, HFMA

Corporate Vice President, Managed Care

MedStar Health

Richard L. Clarke, DHA, FHFMA

President and CEO

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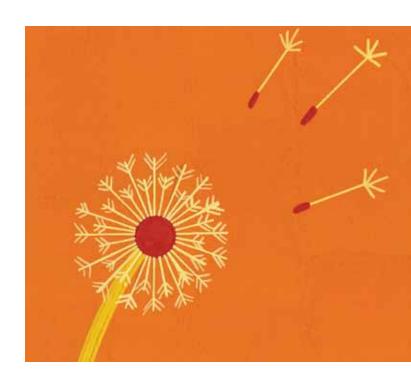
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CREATING ALLIANCES THAT PROFIT THE POPULATION

Hospitals and health systems are partnering with other local players—from physicians to schools—to improve the health of their communities and rein in unnecessary costs.

erving the community" has always been a central mission of hospitals and health systems, and providing emergency and acute care services will always be a core part of that mission. However, in hopes of reducing overall costs of care, leading-edge hospitals and health systems are expanding their focus to include prevention and wellness. It is no longer just about serving the community, it's about improving the health of that community.

The two hospital systems profiled in this section have formed business savvy partnerships to help keep patients healthy and out of acute care facilities. By encouraging healthy lifestyles, cancer screenings, and chronic disease management, providers stand to benefit financially under risk-based payment arrangements. They are also building loyalty, reinforcing their positions as providers of choice among patients, payers, and employers.

PROMOTING WELLNESS IN SCHOOLS

This past August, children enrolled at Kennedy and Chappell Elementary Schools in Green Bay, Wisc., were invited to drop by the school to pick up free school supplies—and receive a free dental checkup. The parents or guardians who brought them were encouraged to complete a health risk assessment.

As the school year progresses, students will take confidential online health assessments. They will see their teachers rushing to onsite Zumba® classes after

school. The children can invite their grandparents for free blood pressure screenings on Grandparents Day. And they will grow microgardens and get a chance to sample the "veggie of the week" during lunch.

Improving health, decreasing costs. Front and center through all these healthy changes: Bellin Health System in Green Bay. The one-hospital system came to appreciate the power of population health initiatives after seeing the positive effects on its own workforce. Bellin experienced a 33 percent decrease in employee healthcare costs after introducing a comprehensive wellness program for employees, hiring a health coach, and offering free preventive services. The cost of employee health coverage has not increased since 2002—and Bellin estimates it has saved \$10 million on employee health costs over a five-year period.

Convinced that improving population health is the key to solving America's healthcare cost crisis, Bellin Health is now launching special programs throughout Green Bay targeting three specific groups: employers, seniors, and children/families.

The overall goal of the school program—called ThriveTM to Be the Best You—is to encourage healthier habits at school and to help parents, students, and staff learn how to make healthier lifestyle choices. The program was developed by Bellin Health.

"We're hoping to track these children and their families all the way into, and possibly through, high school," says Amy St. Laurent, Bellin's vice president of family programs and services. Bellin has similar programs for employers and seniors.

Building on a pilot project. Bellin piloted the Thrive™ program during the 2009–10 school year at Kennedy and Chappell Elementary Schools, both of which serve a high percentage of low-income families.

Children, families, and staff at the pilot schools were encouraged to complete confidential life health questionnaires and participate in biometric screenings, which include body mass index calculations and blood pressure/cholesterol readings. The data collected so far has provided insights into where Thrive programming needs to be targeted. "Weight and nutrition are the

Thrive™ Measures

Bellin Health and the Green Bay Public Schools identified performance measures to track the success of the Thrive™ to Be the Best You school program. Guided by the principles of IHI's Triple Aim Initiative, the program is measuring three key areas: health improvement, cost control, and enhanced experience/engagement.

	Health Improvement	Cost Containment	Experience/Engagement
Staff	Body mass indexHealth risk assessmentLife health assessment	Sick daysHealth risk assessment converted scores into cost	Green Bay Public School staff satisfaction survey
Children	Body mass indexLife health assessmentFitness baselines	 Cost based on achievement/ academic level on Wisconsin Knowledge Concepts Examination scores 10 or more full day absences Reading and math proficiency 	 Absences/tardies Attitude survey—elementary social networking tool
Families	Body mass indexHealth risk assessmentLife health assessment	 Health risk assessment converted scores into long-term healthcare cost 	 Thrive events at the schools attended by parents (i.e., parent/teacher conferences, school social events, dances) Activity of parents/families before and after health risk assessments and life health assessments

Source: Bellin Health System and Green Bay Public Schools. Reprinted with permission.

biggest problems for all groups in the two pilot schools, says Ann Barszcz, Kennedy Elementary's principal. "I was also surprised at the number of families that we have that smoke."

The pilot was also successful at engaging school staff and students.

Kennedy Elementary staff members are highly motivated, says Barszcz. "One of our staff members lost 77 pounds as a direct result of her learning her biometrics and her body mass index," she says. "She said, 'I am done with this,' and she totally changed her lifestyle."

Based on the success of its two-school pilot, the Thrive program is now available to all 26 elementary schools in the district this school year. Bellin staff are working with school leaders to develop health improvement goals and tactics for the school community—teachers, students, and their families—based on data gathered during the pilots.

For example, last year's health risk assessments revealed that many children do not have regular dental care, so Bellin Health arranged for free dental checkups to be offered before the school year started. The health system also arranged for school supplies to be given away during these free checkups—after learning that parents and guardians are more likely to attend events when free items are provided.

Improving grades, too. Bellin and Kennedy officials are excited to advance their work together this year. Bellin nurses and other staff will be on hand for open houses, healthy Halloween parties, parent-teacher conferences,

Encouraging Wellness at a Young Age

Now in its second year, Bellin Health's Thrive program is encouraging students, families, and school staff to adopt healthy habits.

Bellin Health estimates it saved \$10 million on employee health costs over a five-year period after introducing a comprehensive wellness program for employees.

and other events in which they have an opportunity to connect with parents.

"It is the future for our school. That is how I look at it," says principal Barszcz. "There's so much research about how health and wellness and physical activity affect student learning. I look at this as an opportunity that really has no bounds."

Indeed, the connection between healthy lifestyles and student achievement is why the Green Bay school system jumped at the opportunity to have the Thrive program in its schools.

"We are hoping that over time our data will show that it increases student attendance at school and parent involvement. Research shows that any time you have more parental involvement in your schools, students are more successful," says Kim Pahlow, the district's executive director of learning. For that reason, the program is tracking not just body mass index and fitness scores, but also reading and math proficiency scores and data about absenteeism and bullying.

A two-way investment. Bellin Health is the program's primary funder, while the principals at individual schools are bringing in business partners to provide incentives, such as free school supplies, that engage parents.

Both Bellin Health and the school district are also making significant time and energy investments. "It takes a commitment by each school's staff because they have to be willing to work with the kids, and they have to be willing to attend the family nights and be there when the parents come to school," says Pahlow. "Bellin's people are here in our district office and they're attending events as well. If there's a family night at Kennedy, at least two or three people from Bellin attend. It's definitely a collaborative activity, and if both sides weren't working hard, it would not work."

In addition to its commitment to improving population health, Bellin Health also has a business goal. The health system hopes to expand the Thrive program throughout the Green Bay area and, eventually, offer it to other districts in the state for a fee.

IHI's Triple Aim Initiative

The Triple Aim process shifts the focus away from individual institutions and providers—and their outcomes—to population health. The Institute for Healthcare Improvement (IHI), based in Cambridge, Mass., encourages participants to adapt five principles when designing a new model of care.

- Involve individuals and families when designing care models
- Redesign primary care services and structures
- Improve disease prevention and health promotion
- Build a cost-control platform
- Support system integration and execution

Two Triple Aim Case Studies

	CareOregon	Genesys Health System
Key organizer	Oregon-based, not-for-profit managed healthcare plan serving Medicaid enrollees	A not-for-profit integrated healthcare delivery system based in Flint, Mich.
Other key players	Safety-net medical clinics, a local hospital system, and federally qualified health centers and similar community organizations	Primary care providers affiliated with the Genesys physician-hospital organization (PHO), not-for-profit Genesee Health Plan, and other community organizations
Targeted populations	Low-income patients, including those with complex chronic conditions, who are served by safety net clinics	Patients who receive all or most of their health care through Genesys and its affiliated physicians Low-income, uninsured county residents who receive basic health care through Genesee Health Plan
Care model	 Fostered the development of patient- centered medical homes in safety-net clinics 	 Engaged community-based primary care providers in a PHO who emphasizes care coordination, preventive health, and efficient use of specialty care
	 Developed a multidisciplinary case management program to help high-risk members find community-based resources, resolve difficult behavioral issues, and improve self-management 	 Promotes health through the use of health navigators, who support patients in adopting healthy lifestyles Partnered with a county health plan to extend access to primary care and other basic services to low-income, uninsured county residents
Early results	 Savings of \$5,000 per-member, per-year for high-risk patients through better coordination of care, while maintaining or slightly improving quality of life Implementation of patient-centered medical homes in safety-net clinics was associated with improved continuity of care, health screenings, and chronic care management (e.g., 7 percent increases in the proportion of patients with controlled blood pressure and of patients with controlled diabetes during one year) Median monthly costs were 9 percent lower for dually eligible patients who received care in medical home pilot sites versus traditional care sites 	 General Motors spent 26 percent less on health care for enrollees who received services from Genesys-affiliated physicians versus local competitors Use of the hospital, ED, and high-tech imaging services was lower than state averages for similar physician groups participating in an insurer's pay-for-performance program
		■ Use of health navigators among low-income, uninsured patients enrolled in a county health plan improved health behaviors of at-risk patients (e.g., 53 percent increase in physical activity among those who were inactive, 17 percent quit rate among smokers, 80 to 90 percent increase in disease self-management by formerly unengaged diabetic patients) and has contributed to a 50 percent reduction in hospital admissions and ED visits

Source: McCarthy, D. and Klein S., The Triple Aim Journey: Improving Population Health and Patients' Experience of Care, While Reducing Costs, The Commonwealth Fund, July 2010. Reprinted with permission. For the full report, visit www.commonwealthfund.org.

PARTNERING WITH PAYERS



As it rolls out its school wellness program, Bellin Health is guided by the principles of

the Triple Aim initiative, launched by the Institute of Healthcare Improvement in 2007 (see sidebar on page 10). Bellin is one of 60 sites across the world participating in the Triple Aim initiative, which has three goals:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Reduce, or at least control, the per capita cost of care

Fairview Health Services, a seven-hospital system in Minnesota, has goals that mirror Triple Aim. But it is using a different approach to achieve these ends.

Fairview intends to become one of America's first accountable care organizations (ACOs). Its self-imposed deadline is 2012, and its transformation—which involves changing the delivery model, payment system, and patients' experience with the health system—is well under way.

ACOs use legal partnerships between hospitals and physicians to improve the coordination, efficiency, and quality of patient care. Because the concept is still new, there is no established norm for how these partnerships are formed or exactly how they should work. The basic idea is that ACOs will accept accountability to improve

> the quality and reduce the cost of care for a defined population of patients goals that promise to benefit the communities ACOs serve.

> Becoming accountable goes hand in hand with taking on more financial risk. Fee-for-service arrangements with payers are typically replaced with capitated and/or pay-for-performance type arrangements. As discussed in detail in this case study, Fairview is in middle of a two-year, risk-based contract with Medica—one of the largest payers in the Minneapolis

market. Fairview also intends to participate in the Medicare Shared Savings Program, which is scheduled to commence by Jan. 1, 2012. Under the Medicare program, qualified ACOs that meet specified quality performance standards will be eligible to receive a share of any savings achieved.

Fairview is well positioned to adopt the ACO model because it already offers a broad continuum of services and has put a number of structural components in place that help align the interests of physicians and hospitals. Fairview's integrated medical practice includes 450 employed physicians, including those who work

The New Value Chain

Fairview Health believes that healthcare reform must create a new value chain that improves quality, improves the patient experience, and reduces cost.

"Fairview is doing

a very nice job of

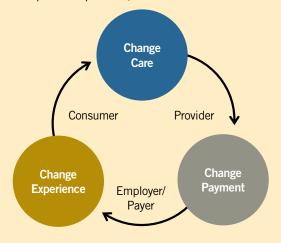
bending the cost curve

compared to what it

would have been in

a fee-for-service

environment."



Source: Fairview Health Services, 2010. Reprinted with permission.

Change care to focus on the health of a population and deliver improved outcomes at a reduced cost.

Change payment to models that are aligned to enable new care models and reward providers for the value they produce (move from fee-for-service that rewards volume to global payment systems that reward value).

Change the experience of the individuals accessing the healthcare system and ensure the engagement of the patient/ consumer to drive dramatically improved outcomes.

at its 49 primary care clinics, and 550 affiliated academic physicians. Through a physician hospital organization, Fairview also works closely with Fairview Physician Associates, a network of 630 independent, closely aligned physicians. In addition, Fairview provides home care and senior services.

Reassigning duties has improved patient access to care and overall efficiency. In one clinic, primary care physicians saw their end-of-day duties—patient messages, lab result review, and charting—decrease from an average of 90 minutes to zero.

Starting with one payer. Two years ago, during routine contract negotiations, the top executives at Fairview and Medica decided there had to be a better approach to provider-payer relations than the standard adversarial dynamics.

An analysis of 2008 claims found that Medica members served by Fairview primary care clinics already had a total cost of care below the market average. Fairview leaders believed that they could drive costs even lower and improve the health of Medica members by redesigning the way care is delivered, says James M.

Fox, Fairview's senior vice president and CFO.

In 2009, the two parties entered into a two-year contract that pays Fairview based on the achievement of defined outcomes for quality and total risk-adjusted cost of care—for all Medica members served by Fairview-employed primary care physicians.

The contract includes pay-for-performance incentives based on Fairview's performance on certain diabetes and vascular care measures, as well as the health system's success in controlling the total cost of care for Medica members, as compared with communitywide data.

Fairview's ACO Journey By 2012, Fairview plans to be an integrated accountable care organization. The path to this goal includes significant work under way as well as changes that still need to be made—including new Medicare payment models. 2012 **Population** Population/ lighly Enga Global Payment Package **Payment** Methodologies Virtual Care Technology Fragmented Individual/ Discount FFS Encounter Episode/Lifetime Care Delivery Work under way ■ ■ Work yet to begin Source: Fairview Health Services, 2010. Reprinted with permission.

It is too early to share results from the new contract. But neither Medica nor Fairview shies away from expressing their optimism about this new way of doing business. "It's safe to say that Fairview is doing a very nice job of bending the cost curve compared to what it would have been in a traditional fee-for-service environment," says Charles Fazio, MD, Medica's chief medical officer.

The relationship has increased transparency between the two partners, giving Fairview access to information that is vital to improving the health status of Medicainsured patients. "The biggest value Medica is bringing to Fairview in the current phase of our relationship is

information about Medica members who are in the Fairview system," says Fazio. "Who would we predict, based on our analytics, is about to get sicker and benefit from some kind of outreach? Which members with chronic diseases do we predict could be healthier and, therefore, have a lesser need for services?"

Fairview's experience to date suggests that the ACO model can be good news for health systems, says Fox. "In the long term, I expect we will be more profitable than under fee-for-service medicine."

Redesigning care. Reorganizing to become an ACO requires a total cultural transformation, says Fox. Toward that end, Fairview has assigned four primary care clinics to take the lead in designing new care processes for the system. These beta-site clinics are focused on four goals:

- Reduce the total cost-of-care growth rate by 20 percent
- Improve patient satisfaction
- Increase the number of patients cared for by clinic physicians by 50 percent
- Improve quality of care measures

Each of the four beta sites has reorganized its workforce into teams, which include a physician, a nurse practitioner, nurses, medical assistants, and schedulers. Team members "huddle" at least once each day to discuss issues about individual patients, as well as ways to improve patient flow and care processes. Patients choose their own physician-led team, assuming the team has capacity, and each team is responsible for a panel of patients.

Reassigning duties within the teams has improved patient access to care and overall efficiency. In one clinic, primary care physicians saw their end-of-day duties—patient messages, lab result review, and charting—decrease from an average of 90 minutes to zero because other team members are now handling that work. In

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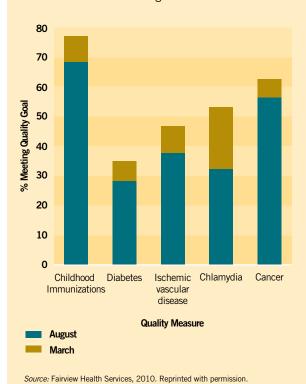
another clinic, the percentage of patient messages that required a physician's response fell from 30 percent to 3 percent, as other team members were empowered to address patient needs themselves.

Meanwhile, the beta sites are also developing new ways to serve patients, including nurse-only visits, group appointments, and virtual care visits via e-mail and phone conversations. In the traditional model, a patient being monitored for high blood pressure was routinely scheduled to see a physician; now hypertension patients can be seen by a registered nurse if clinically appropriate.

Preliminary data indicates that these clinics have, on average, reduced their total cost of care growth rate by more than 5 percent, says Fox. In addition, clinical quality is improving. Fairview Eagan Clinic, which is one of the beta sites, documented improvements in the percentage of patients obtaining needed immunizations and screenings within five months of launching the new team-based approach (see the exhibit below).

Eagan Clinic Quality Data 2009

Four primary care clinics at Fairview are serving as beta sites for designing new care delivery processes. Just eight months into the initiative, one clinic had already increased the number of patients receiving needed immunizations and screenings.



Patient satisfaction is mixed, as is the increase in number of patients cared for, but the transformation is just getting under way so it is too early to evaluate.

There were some initial costs involved in the primary care transformation. The cost of hiring additional staff members for the physician-led teams in the clinics and the short-term drop in productivity increased the cost-per-patient in these clinics by more than 15 percent during the transition to the new care delivery model. Medica agreed to help pay for some of the changes in care delivery at two Fairview clinics.

"These costs are necessary funding requirements needed to create care model changes to better manage the outcomes represented in our four goals," says Fox.

Spreading the improvements. Meanwhile, Fairview is using a rapid-iteration innovation model to spread improvements across the health system—and speed clinical transformation. Using this approach, all of Fairview's 40 primary care clinics are expected to adopt the new processes piloted at the four innovation sites by the end of 2010.

Fairview is using several strategies to hasten the systemwide changes needed to succeed as an ACO. More than 100 physician leaders have been trained at the Fairview Leadership Academy, where they learn principles of adaptive leadership and skills needed to inspire culture change. Additionally, more than 1,200 physicians, nurses, and other staff members have participated in simulations designed to foster teamwork and behavior changes.

Changing physician compensation. Hand in hand with redesigning the primary care delivery model is a redesign of physician compensation. Fairview-employed physicians are being paid to manage the total healthcare costs of a panel of patients. By receiving a base salary with incentives for their performance on quality and cost measures, the physicians are aligned with the ACO model, says Fox.

Even as Fairview moves aggressively to become an ACO, Fox does not expect all payers to embrace the concept quickly. "I expect we will live with feefor-service, ACO, and bundled payments for the next few years," he says.

NEXT: BUNDLING RISK

Bundled payment, value-based purchasing, and other payment system reforms are creating more synergy between quality and financial goals. See Section 2, page 22, for more.

Hospital Strategies to Support Accountable Care

As healthcare reform nudges the nation's payment system toward prioritizing value over volume, hospitals' ability to manage patient outcomes and expenditures is increasingly important. Many hospital executives are exploring new ways to minimize fragmented care, avoid repetitive services, and improve clinical and service performance.

One strategy gaining particular momentum to this end: accountable care.

■ What Is Accountable Care?

Put simply, accountable care is about providing high-quality patient care at the best possible cost. Formal accountable care organizations involve payer-provider collaborations where incentives are established to manage the care of a specific patient population in order to improve care, keep the population healthy, and—if all goes as planned—create efficiencies that reduce the cost of care.

Accountable care models can be organized in a number of ways, ranging from a fully integrated system to payer-driven projects aligning independent physician practices. Incentive structures aren't one-size-fits-all either. A number of different options are being explored, from "one-sided" shared savings within a fee-for-service environment to substantial capitation arrangements with quality bonuses for meeting performance targets. Providers that, in effect, already provide accountable care include integrated organizations such as Kaiser Permanente and Geisinger Health System, whose models of in-house insurance plans and employed physicians have proved effective at improving quality and reducing costs.^a

Regardless of the particular care or business model employed, all hospitals have an ability to incorporate some elements of accountable care. Examples of what it can take to support accountable care include everything from creating patient-centered wellness education to sharing health information electronically with physicians to negotiating performance-based incentives with payers. Essentially, it is all about driving high-quality care through relationships with other stake-holders: patients, physicians, and payers.



■ Focusing on Care: The Patient

Accountable care demands a coordinated approach to delivering healthcare services that includes an emphasis on wellness and keeping communities healthy.

Coordinated care. A key challenge to providing care in today's acute care environment is the sheer number of specialists, nurses, therapists, and other clinicians that may be involved on cases with multiple diagnoses. Improving quality therefore often involves creating a better patient care experience throughout the care process, from the initial visit in the primary care physician's office to the hospital stay to after discharge.

Billings Clinic in Montana supports seamless care in several ways. To enhance communication along the care continuum, the organization has invested in an electronic health record (EHR). The central database makes patient information available instantaneously, so any of the physicians associated with a patient's care can be kept up to date with procedures and medications a patient has received. Even physicians that

^a Arnst, Catherine: "The Hospital, Your Care Coordinator," U.S. News and World Report, July 26, 2010.

are not employed with the clinic have access to the system. "After you have referred a patient, you are able to log on and follow the patient's progress," notes Mark Rumans, physician in chief at Billings. The EHR also is used to track and manage important screenings for patients. During an office visit, physicians can identify, for example, whether a patient is due for a mammogram, colonoscopy, or prostate exam.

Also key is the organization's use of hospitalists—physicians responsible for the care of hospitalized patients—to provide a central point of accountability and to support continuity of care. Hospitalists coordinate patient care among specialists and keep primary care physicians informed. They also coordinate care upon discharge, helping patients to understand the treatment process, coordinating medication use, and making sure the primary care physician receives a discharge summary.

Once a patient has been released, clinical navigators often provide a central point of contact. A clinical navigator works by providing one-on-one support for the patient, helping to ensure the individual receives a treatment plan that is both understandable and feasible and coordinating timely treatment. Navigators are particularly effective in areas that have a high rate of readmissions, such as cardiology.

TriHealth, Inc., a Cincinnati-based system with two hospitals, aligned physician practices, and various outpatient facilities, married its navigator program in senior services with a quality and operational initiative for patients with congestive heart failure (CHF). After discharge, a registered nurse or social worker calls patients to check on their status and review their medications. One call is made shortly after discharge; because readmission often occurs at about 21 days out, a second call is made two weeks later, explains George Feghali, MD, chief medical officer and senior vice president of quality at TriHealth.

Feghali says navigators have made important discoveries that have helped care providers to understand how to better meet patient needs. For example, a navigator learned that one CHF patient stopped taking his diuretic because he lived in a household where he shared the restroom with five individuals. With this insight, the navigator was able to identify the simple solution of a portable toilet—leading to full medication compliance. Such one-on-one support and interventions have led to considerable success. "We dropped our readmission rate by 23 percent within the first three months of implementing the program," notes Feghali.

At North Shore-Long Island Jewish Health System in Great Neck, N.Y., a multihospital system with more than 5,600 hospital and long-term beds, navigators actually make house calls. The health system began a pilot program for cardiac patients in conjunction with its home care services department. Nurse practitioners and physician assistants who are part of the inpatient care team visit the patient's home, helping to smooth the transition from the hospital. They also coordinate follow-up care with the cardiac surgery team, cardiologist, and primary care physician.

It is important that the same team members who oversee care during the hospital stay also provide the home care, notes Kenneth J. Abrams, MD, MBA, senior vice president of clinical operations and associate chief medical officer at North Shore-LIJ. "There is a level of trust and understanding in the relationship because you've got people who are very familiar with what's taking place and can intervene very quickly," he says.

Less than a year in, the program already is showing success. Patients often make positive comments about the home visits with surgeons, notes Abrams. "We also have seen a significant decrease in one- to two-day readmissions for patients following open heart surgery."

Keeping communities healthy. Also important for accountable care is incorporating preventive strategies to support wellness, including efforts that span beyond the hospital's four walls. Last May, North Shore-LIJ created a department of population health to examine the effects of various lifestyle and occupational factors on individual health and to develop targeted interventions. The department—which comprises such clinicians as occupational physicians, epidemiologists, and occupational nurse practitioners—is developing a health and wellness strategy for the system's workforce that will then be used as a model when expanding into the community.

Abrams says the innovative program supports the system's 10-year mission to expand from disease treatment to prevention. "Our intention is to become a true *health* system, where we will have clear, documented, and demonstrable evidence of having improved the health of the population," he says.

TriHealth also is taking steps to promote wellness. Through referrals from their primary care physicians, TriHealth patients can obtain a free fitness evaluation and then receive discounts on programs offered at the system's fitness pavilion, Feghali says. Internally, TriHealth offers a healthy living program. By practicing healthful habits such as eating right and getting health screenings, employees can earn points that translate into discounts on their health insurance premiums. "We have saved 20 percent on our employee health costs over the past five years by doing this," Feghali says.

The system also runs similar types of programs for some of the area's major employers. "It's through these types of initiatives within our corporate health program that we try to impact an even larger population of patients," notes Jerry Oliphant, chief operating officer and executive vice president.

Focusing on Caregivers: Physicians

One of the principal goals of healthcare reform is to restructure incentives in a way that minimizes payment for redundant services, provider mistakes, and subpar outcomes. This

refocusing quite naturally puts clinicians—physicians most prominently—at the forefront of accountable care initiatives. Hospitals can work with physicians to improve care delivery by supporting them in leadership roles, offering quality incentives, and seeking their input on IT initiatives.

Elevated physician engagement. Redesigning clinical care delivery for the healthcare environment that lies ahead requires not only strong physician relationships, but also physician leadership presence in decisions affecting strategy. In large part, success in obtaining strategic input comes from being inclusive.

Emergence of the Accountable Care Organization

Under the Affordable Care Act, Accountable Care Organization (ACO) pilots for Medicare are scheduled to begin by Jan. 1, 2012. The law gives the Department of Health and Human Services authority to expand successful ACO models, such that ACOs could have a large impact on how all providers approach cost reduction and quality improvement in the future. In the meantime, a number of pilot programs across the country and in different institutions are exploring ways to improve healthcare value through the accountable care foundations of a collaborative culture among care providers, continual process improvements, and aligned incentives.

The Premier Initiatives. The Premier healthcare alliance has launched two ACO Collaboratives.

The ACO Implementation Collaborative was launched in May and is geared toward healthcare systems that have already developed the foundational elements necessary to execute an ACO strategy. The Implementation Collaborative currently comprises 24 health systems with more than 80 hospitals and 6,000 physicians. Each organization has developed a collaborative, transparent relationship with at least one payer that will facilitate data sharing. The payers involved include provider-owned, for-profit, not-for-profit, employer, and union-sponsored plans. To facilitate the development of ACOs, the Implementation Collaborative is creating a transparent and standardized system of measures so that data generated by the 24 health systems can be shared

and analyzed. From these data, high performers will be identified and their best practices shared.

Premier's ACO Readiness Collaborative consists of health systems that are committed to executing an ACO strategy, but first need to build the capabilities that will be required to implement in local markets. To date, 45 health systems have joined the Readiness Collaborative. Participants will take part in an onsite capabilities assessment to identify and prioritize key efforts required to operate a successful ACO. They will also attend educational events highlighting execution strategies associated with key components needed to operate as an ACO. Particular focus will be placed on developing the infrastructure to collect population-based health metrics.

The Dartmouth/Brookings Institute Initiative. The Dartmouth Institute for Health Policy and The Brookings Institute are working with three providers to create organizations that are locally accountable for population health and share in the savings generated by shifting from an "intervention"-based healthcare system to a "prevention"-focused system. To facilitate this goal, the organizations will rely on advanced measures to track and improve performance.

Other notable ACO efforts in the works include Colorado's Medicaid reform effort, which will implement an Accountable Care Collaborative with 60,000 clients, and a pilot from The Robert Wood Johnson Medical School in New Jersey, which will link more than 100 physicians with half a dozen hospitals under a value-based incentive program.

Physician leaders generally are more willing to participate in finding a solution to quality issues when hospitals engage them in such discussions as determining outcome or performance criteria. At St. Louis-based SSM Health Care, a system of 15 acute care hospitals in four states, the health system and all of its physicians—employed and independent—collaborate on which metrics are used as quality performance measures. The discussions involve strategic goals of the health system and the reasonable level of performance that can be achieved with the physicians' help. Such collaboration gives physicians a clear voice and helps to foster success, notes CEO Bill Thompson. "There is a great deal of input."

Data-based incentive structures. Many hospitals are stepping up efforts with physicians around performance data monitoring and reporting and enlisting their guidance in steps needed for improvement. In some instances, accountability for meeting productivity and performance targets is being built into compensation or through bonuses or other incentives.

At TriHealth, physician contracts include quality incentives, which are based on the quality data physicians report on such initiatives as CMS's Physicians Quality Reporting Initiative and Aligning Forces for Quality, a privately run program, explains Feghali. Hospitalists are measured by additional data, particularly performance on meeting clinical standards, such as compliance with heart failure protocols. The physicians receive a quarterly report on their performance from the medical director of their practice. Those who fail to meet a certain standard are given a remediation plan; individual progress is reviewed again in three months.

"All of these incentive structures are set up in such a way that if you meet a certain percentage of the performance target, then you get your quality bonus; if you don't, you don't get your bonus," Feghali says. Contracts of physicians with continually subpar performance may not be renewed.



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Data reporting also plays a strong role at SSM. Performance expectations on measures of quality, safety, patient satisfaction, and meeting financial targets are set for the system's presidents, shaping their discussions with the system's 250 employed physicians, notes Thompson.

Over the past three years, SSM has implemented co-management companies—joint ventures between the hospital and a group of physicians that manage a service line. The health system has such arrangements in orthopedics, cardiology, and surgery. Physicians have part ownership in and manage the companies, which receive a small fee for developing standards, overseeing provision of care, and supervising the group. When physicians meet or exceed quality, safety, and satisfaction goals, the co-management company earns an incentive.

"None of the dollars involved are huge, but what we believe the co-management companies provide is a venue where physicians, who are not part of the same group, can come together and make decisions that are in their interests and the hospital's collectively, as opposed to everyone looking out for themselves," says Thompson, noting that for the most part, all but one of the companies have exceeded expectations in terms of improving quality, lowering cost, and improving satisfaction and safety.

Technology input. As the primary users of the technologies used to coordinate and monitor care, physicians should take part in IT decision making. Physicians also can serve on IT committees or assume executive-level IT positions.

"At our organization, physicians are intimately involved with everything that happens in information services," says Mark Rumans of the Billings Clinic, which has a 272-bed hospital and multiple outpatient clinic. A chief medical information officer leads inpatient IT initiatives, and another physician leads the outpatient side. Rumans says physicians also drive requests for IT enhancements. For example, physicians wanted more real-time patient data on such core measures as pneumonia, heart failure, and heart attacks. Previously, much of such quality data was being extracted manually from charts. A group of physicians visited the headquarters of the system's EHR vendor to review a product that automatically extracts such data.

At SSM, physicians as well as other clinicians helped choose the EHR system, which has been implemented in nine of the system's hospitals so far, notes Bill Thompson. The health system has a medical informatics group that is led by a physician, Richard Vaughn, MD, who is the corporate vice president for clinical decision support and chief for medical

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An ACO's IT Needs

Keith J. Figlioli, senior vice president for Healthcare Informatics, Premier healthcare alliance, describes the importance of comparative health data to support and improve ACO models of care.

What role does data management play in an ACO environment?

A key focus of an ACO is population health data management to facilitate the flow and analysis of clinical, financial, and patient-related data and information across all components of the ACO.

Within our ACO Implantation Collaborative, we developed a participant work group to ensure information and technology needs are met and data are standardized. This group is developing a set of tools and activities that enable collaborative participants to implement population health data management capabilities to improve the health of the population, enhance the patient experience of care, and improve trends for total per capita cost of care. It will act as a test-bed for long-term health IT efforts, such as electronic health records and achieving meaningful use.

Specifically, this group will identify key population health data management strategies and capabilities required to facilitate successful ACO models driven by priorities identified by other work groups. Also, the group will help

members leverage existing local IT investments while achieving required ACO population health data management capabilities; research successful prototypes and develop trusted sources of key capabilities for deployment within members' ACO IT solution architectures; and identify and/or develop creative IT-enabling business models that members may utilize to obtain and deliver IT solutions for successful ACO operations.

Are there general IT needs when working within a collaborative structure?

We've learned that any successful collaborative needs to stress data collection and normalization, allowing for standardized data to be meaningfully compared. Also, transparency of that data is essential. Participants have to commit to the open sharing of performance data across the collaborative. In doing so, they can easily identify top performers and learn from them to create similar quality gains in their own organization. Also, the collaborative can set performance targets, identify opportunities for improvement, and establish areas of focus.

Source: Premier, Inc.

informatics. In his role as a physician champion, Vaughn has been active in the system's EHR rollout, acting as a liaison between physicians and the product's vendor. "He has worked very closely with groups of physicians for the past four years, designing the EHR system to meet the needs of the physicians," Thompson says. "He is very active in the installations and offers support, whether by simply being on-site or by teaching other physicians in small groups and, when necessary, one-on-one."

■ Focusing on Cost: Payers

Hospital-payer relationships often are challenged by the inherent conflict over optimal levels of payment. However, when quality becomes a central focus, both parties often find working together is made easier because they hold similar goals. In particular, hospitals often find great benefit to pushing the quality agenda with payers by improving

performance data transparency and encouraging even at a small level—some form of performance-based payment. More ambitious efforts may include encouraging participation in formal local, regional, or national programs.

Pushing the quality agenda. Payers generally have access to claims data, which are generated for billing purposes—not clinical insight. One of the keys therefore to negotiating pay for performance is the hospital's willingness to share clinical performance data, which can be uniquely valuable.

TriHealth takes such an approach. For example, where billing data could include a 401.1 diagnosis code for hypertension, TriHealth's data might not only indicate that a patient has hypertension — but also that his hemoglobin A1c level is under 7 percent, which tells the payer the patient's blood sugar is being managed and therefore the likelihood is lessened for complications affecting the eyes, kidneys, and nerves.

"We're providing those data to payers and saying: 'This is how well controlled our patients' diabetes is," Feghali says. Payers can then marry such quality data with how often TriHealth diabetic patients visit the emergency department and their lengths of stay.

"At the end of the day, cost is the issue," Feghali says. "Most of our negotiations with payers are going to be based on what is the best quality, and then the payer translates that level of quality into what cost it will mean to them, and therefore what payment level to provide to us."

North Shore-LIJ has pay-for-performance programs with most of its major payers. When providers meet agreed upon goals, the resulting financial benefits can come in the form of payment bonuses shared by provider and payer. Some programs are initiated by the health system; others, by the payer. "We build the programs based on what we see as our critical areas for improvement within the health system," Abrams says. "We usually agree on a set of metrics and deliverables." When there is disagreement, the two sides negotiate on what to include.

Formal projects. At TriHealth, a number of formal quality programs are being pursued with payers. Just one example is the TriHealth Physician Practices/Humana Patient-Centered Medical Home pilot, which explores the impact of care coordination on outcomes, quality, and cost for commercial and Medicare Advantage members. Performance is evaluated on key clinical, financial, satisfaction, and patient-centeredness measures. Quarterly data are compared with baseline data for both a test group and control group.

Another initiative pursued is Aligning Forces for Quality, a joint program between the Health Improvement Collaborative of Greater Cincinnati and the Robert Wood Johnson Foundation. The initiative brings providers, insurers, employers, and the community together to harness local forces to improve care through consumer engagement, quality improvement, health IT, and performance measurement and reporting.



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Feghali notes that project successes with one payer often serve to encourage similar efforts with others. As an example, the organization's diabetes initiative has now garnered the support of three major health plans, after an earlier version was pursued with just one. Also, experiencing wins builds a foundation for setting the bar higher or expanding value-based payment to other areas the next time. Payers are invested in success as well, with hopes that long-term findings will lead to better ways of providing care, improving health, and lowering cost overall.

■ Value Proposition

Strategies that enhance accountable care are extensive but share an underlying premise. Hospitals must collaborate with other healthcare stakeholders in such a way that demonstrates improvement in outcomes and measurable cost containment, if not cost reduction. Like anyone else, patients and payers are looking for value. As Abrams notes:

"The overall question is: How do we make sure that we are getting the best result for the least dollars? If we're going to spend more, we want a better result. I don't think anybody objects to that," he says, noting that spending more should be an exception, not the rule. "We truly believe that the higher the quality, the better the outcome, and the lower the cost. High-quality medicine costs less."



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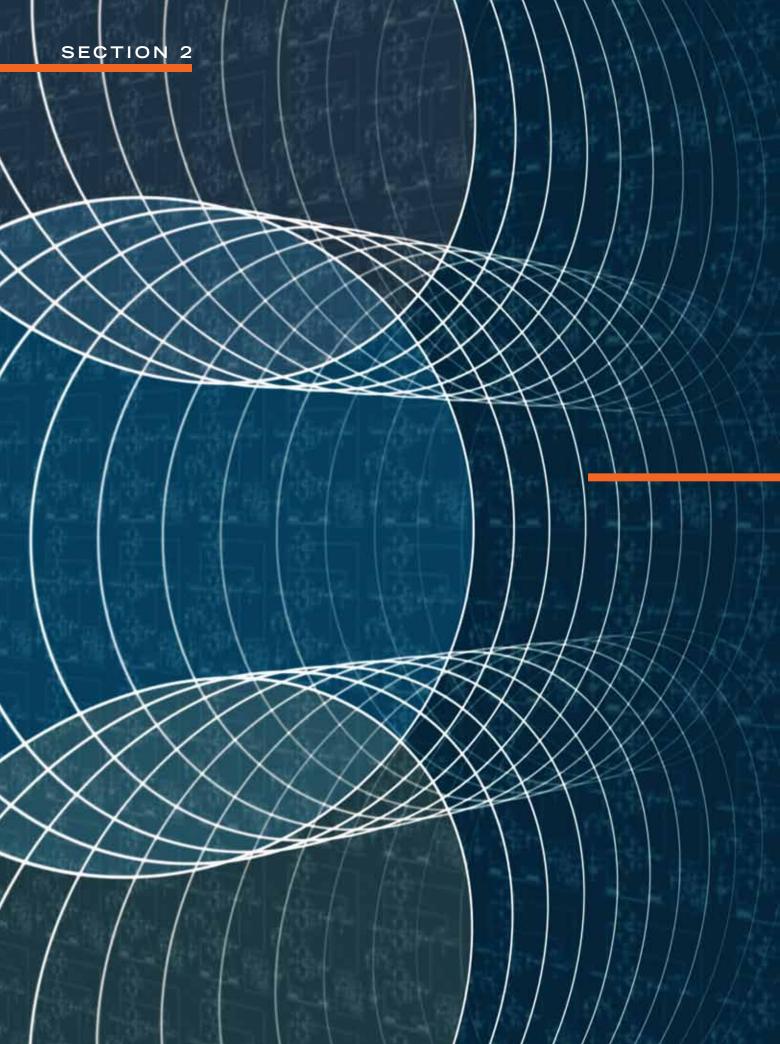
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BUNDLING CLINICAL QUALITY AND FINANCIAL RISK

Progressive providers are positioning themselves to do well under performance-based payment structures by reaching across the continuum to improve clinical quality.

he Centers for Medicare & Medicaid Services (CMS) is taking off the kid gloves. Hospitals have been required to provide quality and patient satisfaction scores to CMS—as reported via Hospital Compare—for years. But when CMS' value-based purchasing program launches in October 2012, hospitals' Medicare reimbursements will be directly tied to their performance on these measures. Lower-performing hospitals stand to lose up to 1 percent of their Medicare revenues—rising to 2 percent in 2017. In addition, facilities with high readmission and high hospital-acquired infection rates will be hit with further Medicare penalties.

Private payers are also pushing for performanceand risk-based payment structures, negotiating capitated contracts and pay-for-performance incentives. At the same time, bundled payment demonstration projects, which package hospital and physician payments for patient services into a single fee, are being closely watched by providers and payers alike.

All of this means that providers are bearing greater financial risk for the health of patient populations. There are now clear financial reasons—in addition to omnipresent mission-related motivations—to invest time and dollars in improving clinical quality and managing population health through collaborative,

cross-continuum efforts. As shown in these case studies, bundling clinical and financial goals can lead to an ROI that satisfies both clinical and finance leaders.

REDUCING READMISSIONS

CASE **Study** When Medicare begins reducing payments to hospitals with high readmission rates in

October 2012, St. Luke's Hospital in Cedar Rapids, Iowa, will be able to look back on a decade of work with pride.

Nationally, the 30-day readmission rate for congestive heart failure (CHF) patients is almost 27 percent. At St. Luke's, a 500-bed hospital with between 25 and 30 CHF inpatients each month, the 30-day readmission rate is 15 percent, down from 23 percent in previous years.

Experts estimate that 80 percent of readmissions are preventable. Given that, economist Kenneth E. Thorpe estimates that Medicare could save \$21.4 billion in 2013 by reducing payments to hospitals with high readmission rates. Heart failure, heart attack, and pneumonia are the likely targets for the readmission provision in the health reform law, says Thorpe. (Thorpe, K.E., Ogden, L.L., "The Foundation that Health Reform Lays for Improved Payment, Care Coordination, and Prevention," *Health Affairs*, 2010, vol. 29, no. 6, pp. 1183-1187).

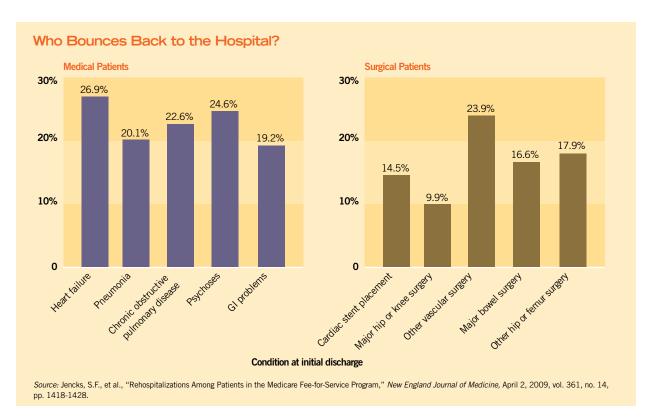
St. Luke's staff started working on heart failure readmissions in 2000, but their breakthrough came in

2006 when St. Luke's participated in the Transforming Care at the Bedside project, a national program aimed at improving care on medical and surgical units sponsored by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement.

"We had an eye-opening experience that this is not about a discharge—it is about a transition," says Peg Bradke, St. Luke's director of heart care. "We had been viewing heart failure readmissions as our problem; so we were looking only at our little portion of the issue. We soon found out that this is a continuum of care issue."

Standardizing care. St. Luke's Transition Home for Patients with Heart Failure program uses several strategies to improve patients' success after leaving the hospital:

- An assessment of the patient's postdischarge needs that begins when the patient is admitted to the hospital
- Patient and family education using the "teach back" method, in which patients and family caregivers are asked to explain in their own words what they understand about the patient's nutritional needs and medication regimen, and the symptoms that require immediate medical attention
- Effective handoffs, including medication reconciliation and transmitting critical information to the next caregivers



 A standardized process for posthospital follow-up care, including ensuring the patient sees a physician within five to seven days after discharge

The transition process includes a home care coordination visit within 24 to 48 hours of discharge. If the patients do not qualify for Medicare-paid home care, St. Luke's covers 60 percent of the cost of the visit and a home care agency subsidizes the rest.

"These home visits are really important in helping us identify specific ways to help patients manage their disease," says Bradke. For instance, she has come to believe that medication reconciliation—or obtaining a comprehensive list of a patient's medications and comparing that list against discharge medication orders—is best done at a patient's home. "The home care nurse actually sees how patients' medications are set up, and what other medications are in the home that a patient may have forgot—this is a

ten to tell us about," she says.

Additionally, the home care nurse can go through the kitchen with the patient and see what kinds of food are in the house, and assess a patient's understanding of his or her care plan.

Another postdischarge touch point is a telephone call from an advanced practice nurse, who contacts discharged patients to check whether they are taking medications correctly, monitoring their weight, and eating properly.

Creating a team. Making a successful transition requires a caregiving continuum that extends beyond the hospital.

As St. Luke's began to reevaluate its heart failure care in 2006, it formed a team that represented many perspectives from within the hospital: front-line nurses, nurse managers, pharmacists, discharge planners, and rehabilitation therapists. The team also included representatives from physician clinics, long-term facilities, home health agencies, and—especially important—patients and their families.

"We expanded our ranks and tried to look at it from a bigger picture," says Bradke. "Creating a successful transition is not one person's role. Everybody works together on it."

The heart failure team initially met weekly; now it meets twice a month to review all readmissions, including the causes and whether anything could have been done to avoid the patient's return. When needed, a representative from the emergency department or the palliative care unit joins the group. "A lot of these heart failure patients are end-stage, and we are getting more palliative care referrals to help patients make decisions on what their options are," says Bradke.

Monitoring results. At about \$10,000 a year, St. Luke's share of the complimentary home care visit is the hospital's biggest expense for its Transition to Home program, followed by the time needed for the advanced practice nurse to call heart failure patients at home.

Although the cost for the program is low, the ROI could be huge when Medicare starts reducing its

"We had been viewing heart failure readmissions as our problem; so we were looking only at our little portion of the issue. We soon found out that this is a continuum of care issue."

payments for hospitals with high readmission rates. "This program fulfills the hospital's mission, which is to give the care we would like our loved ones to receive," says Bradke. "We get a lot of support from administration that really helps us. This is all part of the strategic plan."

St. Luke's is currently adapting the heart failure transition practices to its chronic obstructive pulmonary disease patients. However, it is too early to know how the readmission rate for that patient population will be affected by the interventions.

SHARING RISKS VIA A VALUE-BASED CONTRACT

St. Luke's cross-continuum success story sprung out of the hospital's quality improvement efforts. Serendipitously, the hospital's low heart failure readmission rates now promise to benefit hospital finances—as well as hospital patients.

A contrasting, business-driven scenario is unfolding in Wisconsin. Two health systems—Bellin Health and ThedaCare—and more than 600 physicians are partnering to offer a value-based contracting opportunity to private payers in northeastern Wisconsin. By forming a clinically integrated provider network—called the Northeast Wisconsin Health Value Network (NEWHVN)—the health systems are differentiating

themselves in the marketplace on quality measures and the ability to coordinate patient care.

"We are really trying to assume accountability and responsibility for outcomes and cost efficiencies," says Jeff Squier, executive director of NEWHVN.

Now in its third year, NEWHVN serves some 155,000 members in 12 counties through contracts with Anthem Blue Cross and Blue Shield, Humana, and two regional health plans. NEWHVN accounts for about 30 percent of Bellin Health's non-Medicare patient base, says Jim Dietsche, vice president and CFO at Bellin Health.

Bellin Health and ThedaCare are noncompeting health systems in two different markets. Bellin Health serves the Green Bay, Wisc. area, and Theda-Care is based in Appleton, Wisc. Most of the primary care physicians in

NEWHVN are employed by one of the health systems, but the specialty physicians are independent.

The health systems and physicians originally worked together as the joint owners of a health plan that was sold to United Healthcare in 2004. That experience demonstrated the value of being able to contract jointly.

"This is an opportunity for us to work together in a slightly different model, but at least we are able to contract together," says Tim Olson, ThedaCare's CFO.

The providers are working together to thrive through a strong partnership that helps all participants buck the trend of consolidation. "We are starting to hear that independent physicians are going to be a thing of the past and that networks are going to be getting larger and larger," says Dietsche. "But the delivery of health care means delivering quality and

value back to an individual patient—and we think that can be done locally and independently."

"If we meet these objectives, we know that we are helping to promote better health and better care for the communities, and saving contracted employers or payers money."

Key Steps in Implementing Bundled Payment

Baptist Health System (BHS), a five-hospital system in San Antonio, Texas, is one of five participating health systems in Medicare's Acute Care Episode (ACE) Demonstration, a bundled payment pilot that focuses on cardiac and orthopedic diagnostic related groups (DRGs).

Michael C. Zucker, FACHE, senior vice president and chief development officer, outlined the key steps that BHS went through to implement bundled payment:

- BHS put together packaged prices for the 37 cardiac and orthopedic DRGs in the ACE demo, and the organization's bid was accepted by Medicare in a competitive process. The prices were based on historical experience, expected cost savings, volume, and other factors, including some legal and consulting start-up costs; for the most part, the prices were lower than historical DRG payments, but BHS leaders were comfortable taking on "manageable levels" of risk in the expectation of lowering cost structures, improving quality, and potentially growing market share.
- The timeframe for bundled payments was set as hospital admission through discharge.

- A detailed ACE process was developed that delineates the role of each key player—including the health system, physicians, and the physician-hospital organization (PHO)—in enrolling and managing beneficiaries and getting paid for services.
- Marketing efforts were initiated by BHS to create awareness about the program among patients and physicians. Once quality improvements were documented, these were used to bolster the physician recruitment campaign.
- A patient navigator position was created and filled by registered nurses at each of the five hospitals to help guide patients through the program and manage each patient's entire episode of care.
- A new PHO was created, separate from the already existing PHO, specifically for those physician specialties participating in ACE, and a third-party administrator took on key duties related to the collection and administration of bundled payments.
- The system-level finance department, in conjunction with the quality department, took on additional work in managing the ACE program, including the collection of quality/finance data from hospitals and physicians to share with Medicare.

Source: Excerpted from a more detailed case study—"From the Bundled Payment Front: Baptist Health System's ACE Experience"—in the Fall 2010 issue of HFMA's Strategic Financial Planning newsletter (www.hfma.org/sfp).

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Choosing the right model. NEWHVN is patterned after the Rochester Independent Physicians Association in New York, which received the Federal Trade Commission's blessing in 2007. This clinical integration model has two major components:

- A shared electronic health record
- The routine monitoring, measurement, and reporting of physician- and hospital-level quality data

Although all participants do not yet use the same medical record technology, the hospitals and physicians are moving in that direction, says Squier. In the meantime, physicians use an interface that allows them to share patient information electronically across different IT systems. The physician groups who are still using paper charts have those records scanned so the information can be shared electronically.

"This creates a complete record that helps us coordinate care as a patient moves across and through the delivery system," says Squier. "And we can capture data to create report cards for each of our physicians."

The report cards show how NEWHVN physicians perform on a variety of primary care quality measures, compared with other physicians who report to the Wisconsin Collaborative for Healthcare Quality (WCHQ). NEWHVN's goal is that its physicians, as a group, rank in the top quartile.

NEWHVN is also building a patient registry that draws information from the medical record technology, providing information that helps with population health management.

As a clinically integrated network, NEWHVN has single-signature authority to contract with private payers on behalf of all its participants. The contracts provide pay-for-performance incentives that kick in if NEWHVN physicians, as a group, rank in the top quartile of the WHCQ rankings.

The incentive payments add up to about \$500,000 a year. "It is a large enough sum to get the physicians' attention and keep us pushing forward with new initiatives," says Squier.

Within about two years, Squier expects contracts will be built on a shared-savings model that rewards NEWHVN for achieving specific clinical and efficiency objectives, such as lower readmission rates and higher utilization of generic drugs.

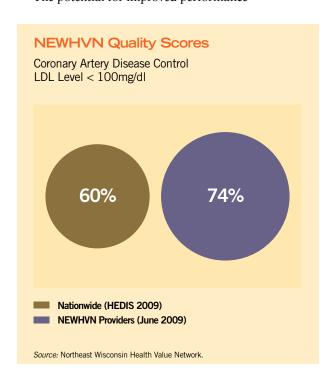
"If we meet these objectives, we know that we are helping to promote better health and better care for the communities, and saving contracted employers or payers money," he says. "The payers will reward us with some of those saved dollars—and that will push the quality program forward even more."

Improving quality. NEWHVN already has a good story to tell. As of June 2009:

- Seventy-six percent of patients treated by NEWHVN providers had their blood pressure under control, compared with 63 percent of patients nationally
- Fifty-five percent of NEWHVN's patients with diabetes were maintaining good hemoglobin A1c levels, compared with 42 percent of patients nationwide
- Seventy-four percent of NEWHVN's coronary artery disease patients had healthy cholesterol levels, compared with 60 percent of patients nationally

The network's medical director develops an annual quality plan that sets priorities and goals for the coming year. The quality priorities are chosen based on:

- The availability of an evidence-based measure or other established national standard
- Relevance to NEWHVN's private-pay customers who are primarily interested in high-volume or high-risk health conditions for people under the age of 65
- The feasibility of collecting physician-level data from medical records, electronic data bases, or other readily available sources
- The potential for improved performance



- The potential to increase the integration or standardization of physician practices
- The potential to increase efficiency

Physicians in the NEWHVN network are notified about their performance relative to the goals at least twice a year. Those who fall short are coached by NEWHVN leaders to improve. A written development plan and significant improvement must be shown or they may be dismissed from the panel.

The ability to review quality data across the NEWHVN network presents new ways of identifying opportunities for improvement. For example, the network's database includes information on 15,000 patients with diabetes in its service areas—and highlights significant variation in quality scores between the contracting health plans.

That prompts the question of what health plans can do to improve their members' health status. NEWHVN works to match its quality initiatives with the improvement goals of various payers and to make sure incentives are aligned, says Squier.

"That was one of the real 'aha' moments," he says.

"Most people think if we could just do things better in health care, if we could just work better with the docs, everything would be fine. But really it is a continuum of having the patients, the employer/payer, the physician, and the hospital all on the same page."

Building trust. Like most partnerships, success in the clinical integration model requires trust. Squier says senior-level members of the health system and strong physician leaders must be highly engaged in discussions from the outset.

"This is not a six-month project—it is a couple-ofyears project," says Dietsche. "A lot of energy has to be put into planning."

One upfront planning decision: who pays for what. NEWHVN's start-up expenses were funded evenly by the two health systems and the physicians, and ongoing expenses have been funded by an annual assessment on those owners. Now that NEWHVN is earning money for quality performance, the network is beginning to accrue a surplus that may reduce or eliminate the need for future contributions from its owners, says Squier.

Another major challenge was committing to a single information system platform. It takes time to decide

how to share information, develop a single-fee schedule, and create a system of quality measures.

Olson says the health systems and specialty physicians see themselves as partners—a dynamic that does not exist in all markets. "We're pretty fortunate because many of the specialty physician groups are forward-thinking, have good leadership, and see value in this," he says.

Beyond that, the network can only be successful if private payers trust its leaders. When independent health systems like Bellin and ThedaCare work together and align themselves with physicians, payers may fear that contract negotiations will become difficult.

"We are starting to hear that independent physicians are going to be a thing of the past and that networks are going to be getting larger and larger. But the delivery of health care means delivering quality and value back to an individual patient—and we think that can be done locally and independently."

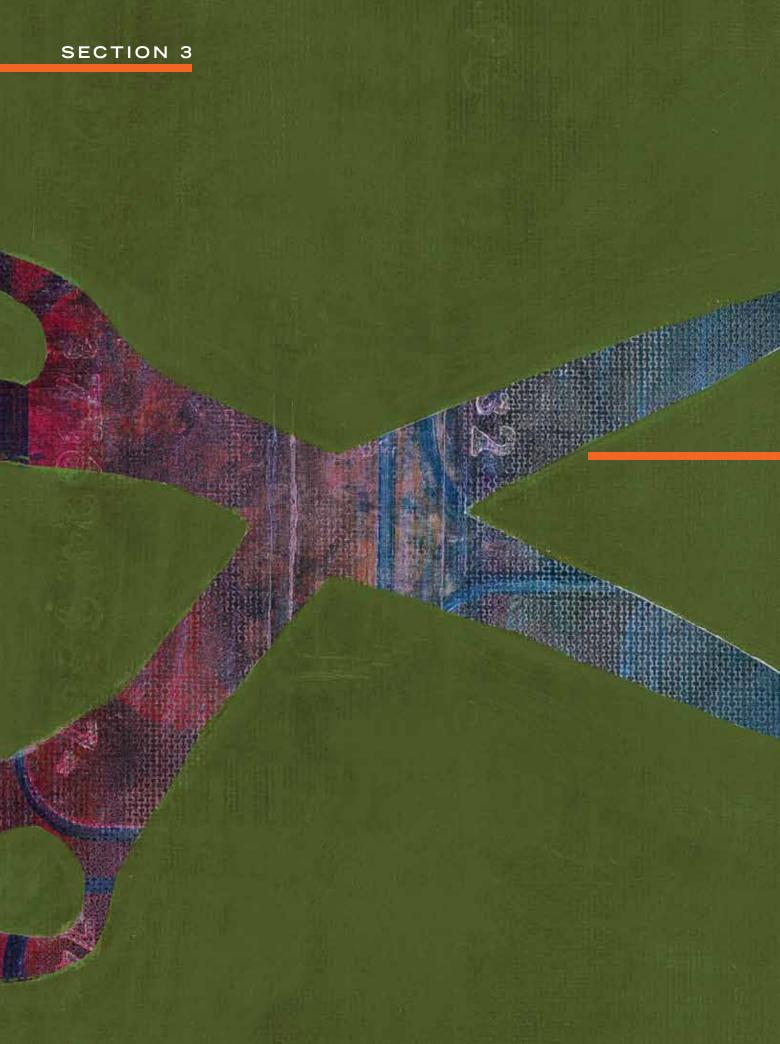
"They see us as two independent systems in two different markets. So that is a challenge that we have to overcome," says Dietsche. "We feel very strongly that increasing the ability to share information and to improve clinical quality will deliver lower healthcare costs, which will benefit the employers in our community."

Positioning for the future. While the clinical integration model is rarely used nationally, Dietsche believes its features—strong physician/hospital alignment, electronic sharing of information and a focus on cost and quality—prepare its participants to succeed in a changing health-care marketplace. The model fits well with the accountable care organization model being pursued by Fairview Health Services, described in Section 2 of this report.

"We think NEWHVN is a vehicle that will easily translate into an accountable care organization, which could become much larger than what we have today," says Dietsche.

NEXT: CUTTING COSTS

Learn how providers are using Lean manufacturing, systems engineering, and other process improvement approaches to reduce costs. See Section 3, page 30, for more.



CUTTING COSTS AS PAYMENTS DECLINE

Four industry-proven and home-grown process improvement approaches are helping providers cut costs, reduce waste, and eliminate inefficiencies—while simultaneously enhancing the quality of care.

any healthcare organizations launched traditional cost containment tactics—reducing labor and supply costs—during the darkest days of the recession. As a result, providers are noticeably leaner. Not-for-profit hospitals have experienced a dramatic drop in median operating expense growth—to 5.7 percent from a three-year high in the mid to high 7 percent range, according to FY09 median report from Moody's Investors Service.

But the belt needs to be tightened several more notches. Hospitals and health systems are gearing up for deep reimbursement cuts—\$148.7 billion in Medicare and disproportionate share hospital payments over 10 years—under the Affordable Care Act. Meanwhile, the slow economy continues to negatively affect patient volumes and investment portfolios.

As a result, providers are pulling out the big guns. They are moving from tactical to strategic cost management, using proven process improvement approaches to transform the way patient care is delivered. The goals: less waste, greater efficiency, and more coordination. As illustrated by the providers in this section, the journey is a constant balancing act between slashing costs and improving quality.

A LEAN APPROACH TO TRANSFORMATION

Mercy Medical Center, an independent, one-hospital system in Cedar Rapids, Iowa, is not afraid of the future under healthcare reform. That's because leaders and staff have the tools they need to achieve critical goals in the years ahead: improving patient care through focusing on quality and safety, timeliness of service, and cost reduction.

Mercy's approach to performance management is the use of Lean manufacturing, a process improvement methodology borrowed from Toyota. "Lean is transformational," says Timothy L. Charles, Mercy's president and CEO.

The most visible evidence of that may be in Mercy's emergency department (ED), where the quality of care for chest pain patients is measured in minutes. For example, the average time from arrival to first EKG is 2.85 minutes, down from 10 minutes in 2005.

This is just one of dozens of improved metrics since Mercy's first Lean efforts in 2005, when ED staff reworked how patients flow through the department. Among other things, the ED has developed a "fast-track" service in which patients with less acute conditions—

an earache, the flu, or a broken finger, for example—are treated and discharged within one hour.

"By removing nonvalue-added process steps in the ED, we reduced the patient length of stay and increased our capacity to handle more patients," says Kathy Berry, Mercy's Lean coordinator. "We had a 6 percent growth in ED patients in a flat market right out of the chute because of those first efforts."

Containing costs through value focus. Berry says that Lean management is not focused on reducing costs, but rather on transforming an organization's culture and changing the way staff members think.

"By focusing on providing value to our customers by removing the waste in our processes, cost savings naturally occur," she says.

Mercy was introduced to Lean principles in 2005 as part of a collaboration between the Iowa Hospital Association and the Iowa Business Council. In the first year, Mercy undertook 12 Lean activities. More than 180 events have been conducted to date, and many have resulted in cost savings:

■ Security calls related to behavioral services patients were reduced by 40 percent, and staff injuries were reduced by 50 percent. Before Lean management was introduced, the cost of staff injuries over a six-month period was more than \$11,000 and climbing. Since then, there have been no injury claims for the past 11 months.

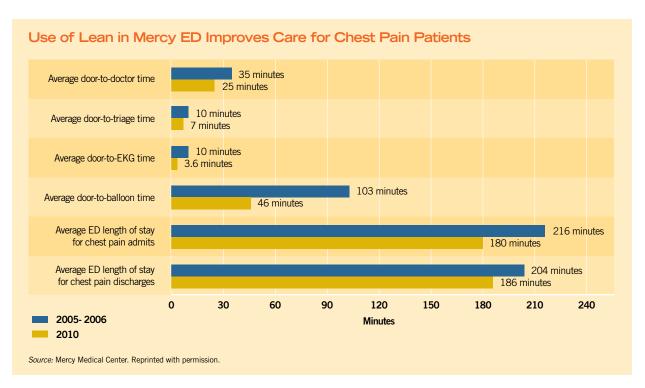
- By removing redundancies in routes and pick-up times for laboratory couriers, expenses fell by more than \$100,000 per year. An additional \$25,000 was saved because improved scheduling eliminated the need to use taxi services when a courier was not available.
- During an event on skin wound care, the team recognized the opportunity to use a different kind of underpad on patients' beds. The new pads are more absorbent and cost less, saving more than \$3,000 per month.

Other Lean events have positively impacted volumes and revenues. For example, process improvements in the Women's Center increased the capacity for accepting walk-in mammography patients by more than 86 percent. Previously, the center was able to accommodate a maximum of seven walk-ins per week; now the center is handling an average of 13 walk-ins each week, increasing revenues by more than \$3,500 a month.

Building a Lean culture. In Mercy's ED, program coordinator Crystal Shannon RN, MSN, MHA, spends most of her time analyzing patient flow data, planning Lean projects, and looking for additional processes that can be improved.

"With all the Lean events that we have participated in, our team has developed a Lean mentality," she says.

Lean management is a challenge in the healthcare industry, says Berry. She joined Mercy in 2007, after



a decade of working with Lean techniques in other industries.

"We have very intelligent, highly technical people in health care, but their training and experience revolves around patient care," she says. "Understand-

ing the organization's strategic goals, how individual efforts align with those goals, and the connection between process improvement and patient care can be difficult concepts for many staff members."

Pressing forward. With so many Lean successes under its belt, Mercy's ED is now extending its Lean influence to other areas of the hospital. The ED set a goal of moving a patient to an inpatient floor within 30 minutes of the admit decision.

Historically, that time lag has exceeded two hours. Currently, it averages 50 minutes.

"We have knocked it down by half, which is significant for our operational efficiency and patient satisfaction," says Shannon. "Our team will continue to apply Lean concepts and analyze operations to meet our 30-minute goal."

Her goal is to make the back end of the ED visit match the front end, which would be the envy of most hospitals. "We hardly ever have any front entry patient waiting," she says. "Our door-to-doc times are averaging around 25 minutes."

PUTTING PATIENTS AND FAMILIES AT THE CENTER

Anthony M. DiGioia, III, MD, admires process improvement approaches like Lean management and Six Sigma. But when he set out to optimize patient outcomes for his own joint-replacement practice at Magee-Womens Hospital of the University of Pittsburgh Medical Center (UPMC), he opted to create his own

Trained as an engineer, orthopedic surgeon

methodology that is "built on the shoulders" of other process improvement approaches.

Unlike industry-borrowed approaches like Six Sigma, DiGioia's approach—called Patient and Family Centered Care (PFCC) Methodology and Practice—was developed specifically for health care, which is unique because of the relationship between patients and their caregivers. A grassroots approach by design, PFCC

involves six simple steps that caregivers can learn in a few hours of training (see the sidebar below).

"Magee-Womens has always been focused on the patient experience, but the PFCC methodology has helped change the mindset of the organization so that

"By focusing

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everyone, no matter what their function or job, is engaged in the patient and family experience," says Magee-Womens' CFO Eileen Simmons.

Measuring the results. DiGioia brought his busy orthopedic practice to Magee-Womens Hospital of UPMC in 2006. Because he was building the hospital's joint replacement program from the ground up, he seized the opportunity to create a "hospital within a hospital" with its own processes rather than adopting traditional approaches.

In doing so, DiGioia and other caregivers worked with patients and their families to develop the new program using the PFCC approach, which requires staff to view all care experiences thru the eyes of patients and families. Inspired by the idea that health care needs "disruptive innovation," as described by Harvard business professor Clayton Christensen, the team envisioned an ideal patient experience and combined the people, processes, and places that were needed to consistently deliver that experience.

The Six-Step PFCC Methodology

- Select a care experience and define the beginning and end points of that experience.
- Assign a care experience guiding council.
- Evaluate the current situation by shadowing patients and families as they travel through the healthcare system. Chart the patient's care experience in a flow map.
- Recruit members to serve on a care experience working group by identifying "touch points"—or points in the care experience where patients or family members have an interaction with any caregiver, including administrative staff members.
- Create a shared vision by writing the ideal care experience as defined and viewed by patients and their families.
- Redesign the care experience by developing PFCC project teams that provide that exceptional care experience every time, all the time.

For example, the joint replacement program features a "one-stop," two-hour preoperative visit scheduled three weeks before surgery, during which all clinical testing and screening, patient and family education, and discharge planning with a social worker takes place. All patients are required to select a "coach" —a family member or friend who will help with postoperative recovery and rehabilitation and serve as the single point of communication between the patient and the care team. In addition, everyone who will be having surgery on the same day meet one another at that time.

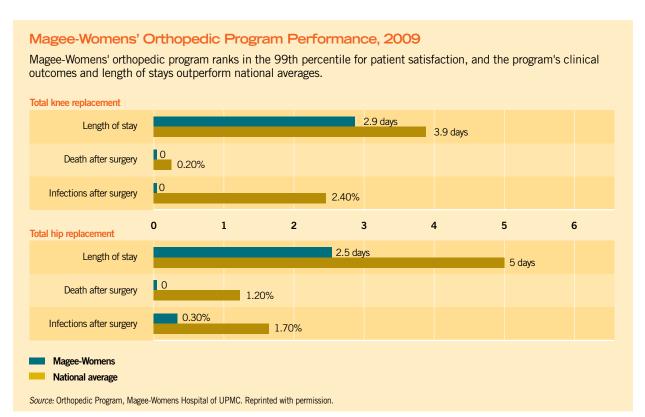
The joint replacement program has grown to include four surgeons, and the program's clinical outcomes and length of stays outperform national averages. For example, in 2009, Magee-Womens had zero infections after total knee replacement surgeries. In comparison, nationally, 2.4 percent of total knee replacement patients develop infections. In addition, the average length of stay after total hip replacement is only 2.5 days—compared with a five-day national average.

Meanwhile, Magee-Womens' orthopedic program ranks in the 99th percentile nationally for patient satisfaction—on both Press Ganey and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys. More than 99 percent of the program's patients say they would recommend the program to family and friends.

"Organizationally PFCC is a proven winner in that it helps to keep costs down—by reducing length of stay, and it also improves the reputation of the facility, as demonstrated by the HCAHPS scores," says Simmons. "The PFCC methodology is an inexpensive way to approach process and performance change. Examining solutions at a caregiver level has resulted in low-tech/low-cost solutions."

Moving forward. PFCC is spreading organically across the 20-hospital UPMC health system, which is based in Pittsburgh, as well as nationally and even internationally through collaborations with the Institute for Healthcare Improvement (IHI) and the Picker Institute.

In 2009, 13 teams—called care experience working groups—completed 93 improvement projects in areas ranging from surgical care and rheumatology to new-hire orientation and caregiver retention. This year, 30 groups are at work. Each team is led by a clinical-administrative pair: a clinical champion (e.g., the nurse, physician, or program coordinator who knows the care experience best) and an administrative champion (i.e., CEO, COO, or vice president).



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Among the results: Staff at UPMC's Children's Hospital of Pittsburgh integrated several techniques to create a painless blood draw for pediatric outpatient rheumatology patients, and an environment and lobby work group arranged for "destination coordinators" to serve as concierges or navigators for all hospital visitors.

DiGioia says the PFCC approach was designed to be a grassroots effort, but its success has attracted the attention of health system executives who want to position the organization for pay-for-performance initiatives. The PFCC methodology is now being adopted as a top-down initiative at two UPMC hospitals—Magee-Womens Hospital and UPMC Presbyterian—

The system engineering team used logistic regression to identify the types of patients and times of day for which appointments are most likely not to be kept. Probability, optimization, and computer simulation methods were also used.

to prepare for the day that Medicare reimbursement is tied to clinical quality and HCAHPS scores as part of the value-based purchasing program described on page 23.

Although the PFCC approach was not originally designed with hospitalwide transformation in mind, DiGioia says hospitals are in the same position he was in when he started to redesign his own practice.

"Whether we're doctors or hospitals, there are only two things that we have absolute 100 percent control over: our own overhead and our patients' and families' care experiences," he says. "We definitely don't control our reimbursement, or all the things that are circling around us. So we need to focus on the things that we have absolute control over and position ourselves for whatever is going to be coming down the pike. That's exactly what the PFCC Methodology and Practice allows us to do."

USING MATHEMATICAL MODELS

Like Mercy Medical Center, Harvard Vanguard Medical Associates relies on Lean techniques and other process improvement approaches. In addition, the physicians group—which includes more than 20 office sites across eastern Massachusetts—is engaging system engineers to resolve certain types of complex problems.

Basic process improvement techniques, such as Lean and Six Sigma, typically generate some 70 percent of the potential maximum improvement, but the remaining 30 percent usually require more advanced methods, says James C. Benneyan, PhD, director of Northeastern University's healthcare systems engineering program and codirector of the NSF Center for Health Organizational Transformation and the VA New England Healthcare Systems Engineering Partnership.

Broadly used in manufacturing and other industries, systems engineering uses mathematical, statistical, and computer models to optimize a wide range of complex logistical processes.

Benneyan and his colleagues are on track to save over \$17 million through a variety of projects on preventable readmissions, inventory logistics, panel optimization, patient safety, surgical suite management, specialty services location, and cancer treatment optimization.

Interest in using systems engineering within healthcare has grown significantly

since the 2005 publication of *Building a Better Delivery System: A New Engineering/Health Care Partnership*, a joint project of the National Academy of Engineering and Institute of Medicine.

Reducing no-shows. Borrowing a concept from the airline industry, the Harvard Vanguard Medical Associates obstetrics/gynecology office in Quincy, Mass., plans to start overbooking selected appointments on a trial basis.

In 2009, the clinic's no-show rate topped 18 percent, costing the practice \$446,000 in lost revenue. After conducting an engineering study, a team led by Benneyan advised the Harvard Vanguard physicians that more than half that lost revenue could be captured by overbooking certain types of appointments in a specific way.

"Occasionally, everybody shows up for their appointments, but that is actually quite rare, and now we have the data to support that," says Constantine N. Kralios, MD, practice leader in the Quincy office.

The process of scheduling outpatient visits is one that cries for optimization, says Benneyan. "When you ask healthcare professionals 'What is causing you misery?," almost everybody will talk about patient no-shows."

For Harvard Vanguard, the engineering team used a three-tiered approach. First, it used logistic

regression to identify the types of patients and times of day for which appointments are most likely not to be kept. Probability and optimization methods were then used to determine to the best amount of overbooking. Finally, these results were used in computer simulation experiments to compare specific ways to overbook, such as clustering double-booked appointments at certain times of day, spreading them out throughout the day, or artificially compressing appointment durations.

In this particular clinic, the engineers found that annual exam appointments generate the highest rate of no-shows, and their mathematical models determined that these appointments should be overbooked by two per day, usually mid-morning. "The math could work out differently in other settings," says Benneyan.

Testing first. Kralios and his colleagues intend to experiment with the recommendation. "As clinicians, we are worried about what will happen when the patients who are overbooked actually do show up at the same time," he says. "We are thinking of doing a phased approach, overbooking one appointment per day and see how that will work."

The study/test/adapt/expand approach is one of the things Susan Haas, MD, MS, likes about systems engineering. "Our temptation is to just implement a recommendation," says Hass, Harvard Vanguard's director of obstetrics/gynecology "But Benneyan says, 'Wait a minute, this is just a model. Try a few experiments and see what you learn."

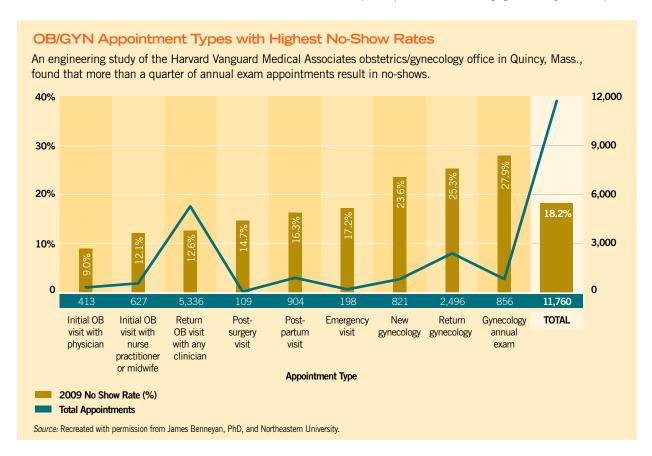
BRAINSTORMING TO REDUCE WASTE

staff members.

While methodologies like Lean and systems engineering are proven waste busters, healthcare leaders should never underestimate the power of plain old brainstorming by highly motivated

Crystal Saric, coordinator of waste services and waste reduction at Fairview Health Services, knows what brainstorming can accomplish. She meets twice monthly with a group of nurses who serve on the University of Minnesota Medical Center's operating room (OR) green team.

"We just come up with different ideas to reduce our waste and reduce our environmental footprint," she says. "The nurses have reduced their energy use significantly. They've reduced their paper use significantly.



They've eliminated Styrofoam in their break rooms. They are saving money, and they are avoiding a lot of waste."

Inspiring change. Like many organizational success stories, the medical center's OR green team is thriving because of a few influential people who showed passion and leadership. The nurses were not assigned to serve on the green team; they were inspired to do so.

That inspiration came from surgeon Raphael Andrade, MD, who decided to reduce the waste and pollution associated with his own surgical procedures. He started by reviewing the standard pick—the set of instruments and equipment for a specific procedure—used for vascular access port placement. He determined that several syringes, sutures, drapes, and dressings were rarely used and could be eliminated.

"OR nurses

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so much waste

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I think it really gets

to them."

Andrade's pick for that procedure was downsized to 27 items instead of 44, and reusable gowns and linens have replaced disposables. The result: A savings of \$50 per case, or \$2,000 a year—plus 80 pounds of waste and 64 pounds of carbon dioxide emissions—from one surgeon and a single procedure.

Spreading success. When Andrade presented his waste reduction story at a department meeting, Lynn Thelen, RN, an OR nurse who is also passionate about environmental sustainability, asked for volunteers to serve on an OR green team that would follow his lead.

"She had a team within an hour," says Saric. "OR nurses are used to seeing so much waste every single day because everything is disposable. I think it really gets to them."

The team reviewed the standard thoracotomy pack and eliminated items that reduced waste by 600 pounds a year while saving \$12,000. A "second pass" over the same pack a year later identified ways to reduce it by another 1,100 pounds and \$11,000 a year.

Seeing the potential prompted the OR green team to review 38 procedure-specific packs earlier this year. Fairview's supply vendor provided a list of all the items in each pack.

"We handed the lists out by specialty so, for example, the nurse who knew the most about eye surgery would take that pack list back to her coworkers, and they would all review it," says Saric. "Having their 'green eyes' on really gave them a different perspective."

Of those 38 packs, 14 were as lean as they could be while another 24 were easily "greened," she says. The focus was on finding disposable items that had little or no value during a procedure, such as a basin that was used to organize items when those items could just as easily be laid directly on the table.

"Dr. Andrade was needed to smooth over some of the changes with surgeons, which is why it is so nice to have a surgeon or physician as a champion," says Saric. "For the most part, though, the items that were eliminated would rarely be noticed by a surgeon and are handled mostly by the nurses and technicians working in the room."

All the individual items are stocked separately by the hospital. If a situation arises in which a certain supply,

such as an extra basin, is really needed for a procedure, it is readily available.

Adding up the savings. The pack changes were sent to the vendor in March of this year, and are being phased in whenever new packs are ordered this year. By Jan. 1, 2011, all new surgery packs will be "greened," and the medical center expects to save \$104,658 a year—and send 7,792 fewer pounds of waste to the landfill.

"That is in addition to the environmental benefits of not manufacturing the unused products, trucking them, packaging them, and so on," says Saric. "In many ways, the benefits of a source reduction project are layers deep."

The key to success, Saric says, is identifying OR staff members who are passionate about environmental sustainability. Then allow them time to work on green initiatives and give them leadership support.

The impact of the green OR will continue to grow as other Fairview hospitals follow the medical center's example; Fairview Riverside Campus is already starting to see similar results.

"It is our hope that this will spread to all our other hospitals," says Saric. "What's nice about this project is we are adding an environmental benefit to our community and saving healthcare dollars. In today's world, what could be more important than that?"

NEXT: ADDRESSING CARE DELIVERY CHALLENGES

Using technology to resolve labor shortages and other challenges. See Section 4, page 40.

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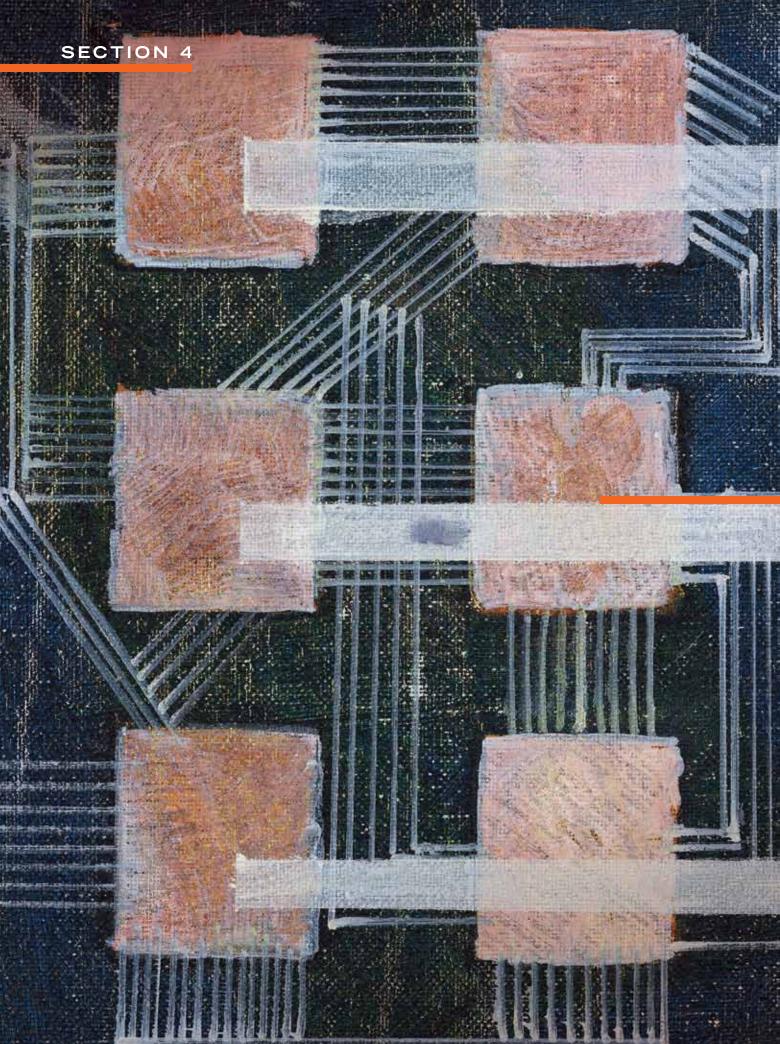
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USING TECHNOLOGY TO ADDRESS CARE DELIVERY CHALLENGES

Providers are using technology to resolve labor shortages, improve coordination, increase access to care, and solve other care delivery shortcomings.

ections 2 and 3 of this report described how providers are redesigning care processes and rooting out wastes and inefficiencies—with the overlapping goals of improving quality and reducing costs.

These are vital endeavors. But the ability to deliver the highest quality and most efficient care possible may not be good enough—if not all patients can access that care, if needed information cannot be exchanged between care sites, or if there are not enough physicians, nurses, or other caregivers to provide care.

In other words, to truly improve the health of the population, providers need to find creative solutions to critical problems—from workforce shortages to a lack of interoperability—that are impeding the successful delivery of quality care. This section highlights how providers are beginning to address some of these behind-the-scene issues through the use of technology.

DEPLOYING EICU TECHNOLOGY

Grinnell Regional Medical Center (GRMC) first considered eICU—electronic intensive care unit—technology as a lure to recruit a badly needed internist to the 81-bed hospital in the middle of Iowa. But the capacity to keep critically ill patients in their hometown hospital has brought other benefits as well.

"The eICU is a perfect example of how technology is creating opportunities for community and rural hospitals to be able to continue to provide services in their communities," says Todd C. Linden, GRMC's president and CEO.

Since 2009, the eICU technology has linked GRMC's critically ill patients to critical care physicians and nurses at the Mercy Health Network about 55 miles away in Des Moines. Using computers, two-way cameras, and video links, information is exchanged in real time, allowing GRMC's physicians, 10 critical care registered

nurses, and six nursing technicians to be supported by Mercy's eICU critical care team.

GRMC currently uses two eICU mobile workstations, which can be moved to any of the five ICU beds or two emergency department trauma bays as needed. Linden expects to add more eICU systems in the future.

Recruiting physicians. Linden first explored the eICU as one solution to a staffing problem. Three internists who served as GRMC's hospitalists had all moved away,

By acquiring the eICU technology, Grinnell Regional Medical Center was able to hire a new hospitalist, maintain its ICU, and actually improve the quality of care delivered there.

forcing the hospital to transfer its sickest patients to Iowa City or Des Moines. As Linden began recruiting an internist to move to Grinnell, he thought of an idea to sweeten the offer.

"The eICU lets our physician go home after taking care of sick patients all day. She can get a good night's sleep knowing that her patients are being well cared for," he says.

The incentive worked. By acquiring the eICU technology, GRMC was able to hire a new hospitalist, maintain its ICU, and actually improve the quality of care delivered there. The remote monitoring system is designed to alert caregivers to subtle changes in a patient's health metrics that simple observation might not catch. In addition, it allows for a different level of around-the-clock care. Since going live at GRMC with the eICU in 2009, there have been 70 interventions by the Mercy physicians that occurred during the night shift.

"In the typical community ICU, the patient is managed during the day and usually simply monitored at night," says Linden. "In the eICU, you've got active management 24 hours a day, often reducing the length of stay and improving outcomes."

Overall, there has been a slight increase in the average monthly ICU patient census—from 26 to 28 patients—since the eICU program began at GRMC. Although this is only a slight increase, it occurred during a time when overall inpatient census decreased because of the recession and the shift from inpatient care to outpatient services.

Collaborating with larger systems. GRMC is the first rural hospital in Iowa to use an eICU system. By being the pioneer, GRMC received a favorable fee arrangement in return for helping Mercy develop its protocols for interacting with other potential eICU clients in the future.

The eICU has had a positive impact on hospital finances, says Linden, although calculating a reliable ROI is very difficult. The most valuable part of eICU capability is to have the extra monitoring of the eICU

patients during times when our hospitalist is not available to provide the best care for our patients.

"The eICU has had a positive financial impact because our patient census is going up in our ICU. Plus, we were able to recruit an internist, and we believe it's going to help us continue to recruit internists," says Linden. "So there are much

greater benefits than just counting up our ICU visits."

CREATING A COMMUNITYWIDE EHR

While rural hospitals like Grinnell are improving the quality of care via telemedicine-type technology, large health systems are also gaining valuable benefits by hooking up electronically with other providers.

Take PeaceHealth, a seven-hospital system that serves Washington, Oregon, and Alaska. Back before many hospital leaders knew what the term electronic health records (EHRs) meant, PeaceHealth started building an EHR system that would link all providers in the communities it serves. The health system developed its vision for the Community Health Record (CHR) in 1994. In 1996, PeaceHealth hospitals began installing EHR technology.

"We chose the name 'Community Health Record' to imply that the record would span the continuum of care—hospitals, clinics, the outpatient environment, and home—and also to show that this would be a community asset that was used to improve the quality of care," says John Haughom, MD, senior vice president of clinical quality and patient safety at PeaceHealth. "We felt that it was a necessary infrastructure to support the integrated care delivery system."

Guiding cross-continuum process improvement. Today, the PeaceHealth CHR is a database that includes information about 1.8 million patients in three states.



FOLD A TO B.

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More Ways Technology Is Helping

As health systems strive to provide more care at lower costs, leaders are leaning on technology—and to good effect.

Smart Hospital Rooms

"Smart room" technology at the University of Pittsburgh Medical Center (UPMC) automatically provides caregiver-specific information on a monitor near the patient's bed when the nurse, physician, or other caregiver enters the room.

First tested at UPMC Shadyside, the SmartRoom capabilities have been expanded to 24 rooms at UPMC Montefiore in Pittsburgh. Using small ultrasound tags, the SmartRoom system identifies healthcare workers wearing the tags as they walk into a patient's room, displaying the person's identity and role on a wall-mounted monitor visible to patients.

At the same time, the SmartRoom solution automatically provides the clinician with relevant, real-time patient information pulled from the electronic medical record, including allergies, vital signs, test results, and medications that are due. The information shown on the caregiver's monitor is tailored to the needs of the specific worker. A hostess who delivers meal trays, for example, will see only dietary orders and allergy information. A physician will see different information than a nurse.

"Our SmartRoom solution tackles the everyday problems of simplifying workflow, making documentation easier and giving nurses more quality time at the bedside," said Michael Boroch, CEO of SmartRoom, a company wholly owned by UPMC. "It's estimated that only 30 to 40 percent of a nurse's time is spent on direct care. With SmartRoom, we believe that we can raise that number for the benefit of caregivers and their patients."

Care Coordination Software

The Care Management Plus program, developed at Intermountain Health and Oregon Health & Science University, uses care managers and an electronic tracking and reminder system to coordinate care for seniors with multiple chronic illnesses in primary care clinics.

Research shows that the program increases physician productivity, reduces cost of care, and dramatically improves health outcomes for diabetes patients.

Through a grant program, the Care Management Plus software is available free for primary care practices that want to adopt the model. Training for care managers and assistance in redesigning care processes is also available from OHSU.

Mobile Care

A mobile clinic—called the Family Van—rolls through disadvantaged neighborhoods in Boston each week, screening, testing, and coaching patients on nutrition, diabetes, heart disease, and other health concerns.

A service of the Harvard Medical School, the van is staffed by medical, dental and allied health students who use portable screening tools to identify high-cost conditions such as diabetes and hypertension. The program's goal is to train people to prevent and manage chronic disease and maintain overall good health.

Because the van accepts walk-ins and does not charge insurance copays, patients show up for blood pressure monitoring and other preventive services more frequently than they would if they had to book appointments at a regular clinic. The van serves about 5,000 patients a year and costs approximately \$500,000 to operate.

Researchers at Harvard have calculated that, for every \$1 invested in the Family Van in 2008, a total of \$36 will be saved over time. Other mobile clinics that have used Harvard's ROI calculator report a 20:1 ROI.

High-Tech House Calls

Wireless access to a patient's electronic medical record lets clinicians with the Washington Hospital Center view lab results, X-rays, and specialty consults alongside the patients during a home visit.

The Washington, D.C., house call program is one of many such programs around the country that serve elderly or disabled patients who have trouble getting to physician clinics. And many more programs will start soon: a nationwide house call demonstration project will start in 2012, courtesy of the Affordable Care Act.

The physicians and nurse practitioners who conduct calls carry some high-tech devices in their black bags: miniature vascular doppler, portable EKG machines, blood analyzers, and X-ray equipment.

The Virginia Commonwealth Medical Center house calls program in Richmond, Va., has been operating for 23 years and has reduced hospital costs by 60 percent for high costs beneficiaries with multiple chronic diseases. In the Bronx, the five-year-old house call program has shown a 42 percent reduction in hospitalizations and a 33 percent reduction in total costs of care.

Online Care

Several major insurers have arrangements with a technology company that connects patients and physicians any time day or night. Using a web-based interface, a patient can choose from primary care physicians and specialists who are "on duty" when the patient wants advice about a child's high fever in the middle of the night or to check out a rash without taking time off work.

Webcams allow patients and physicians to see one another, and the physician forwards notes about the encounter to the patient's medical record. Among other attributes, the CHR is improving patient health. Nearly 1,800 expert rules are embedded into the system to support physician decision making. And the system allows retrospective analysis of patient records to identify what works and what can be done better.

For example, PeaceHealth cardiovascular physicians have used CHR data to guide process improvement activities that have reduced door-to-balloon time for heart attack patients to an average of about 60 minutes,

well below the goal of 90 minutes set by the American College of Cardiology.

"In one of our regions, we have demonstrated that over about a year and a half we have saved 85 lives," says Haughom.

Improving coordination. PeaceHealth's 7,500 employed physicians, nurses, and other caregivers use the record, of course—but so do another 16,000 clinicians in PeaceHealth's service area. One them is Melissa Edwards, MD, a gynecologist at 16-physician Women's Care in Eugene, Ore.

"I access it multiple times a day," she says. "It is an integral part of the daily functioning of any physician in this community."

The CHR provides a repository for most the laboratory, imaging, and outpatient pathology reports for Edwards' patients—because PeaceHealth is a primary provider of diagnostic services for the community. Edwards checks the CHR to track the progress of her hospitalized patients. And if a patient mentions that her primary care physician recently ordered a cholesterol test or a CT scan, Edwards pulls up the CHR to check the results.

Gearing up for the next stage. Edwards is president of Medical and Surgical Specialists, a collaboration of seven independent specialty groups that shares its own EHR system. When those physicians made their purchasing decision three years ago, they opted for one specifically for ambulatory practices rather the hospital-oriented system PeaceHealth uses. A large multispecialty clinic in Eugene uses yet another system.

"That's going to be the biggest challenge going forward: How do we start to link up these various EMRs in a way that will really move the CHR to that next level?" says Edwards.

Haughom says that is the challenge of the day, a side effect of PeaceHealth's leadership in proving the value of sharing patient information. For many years, PeaceHealth executives worked to encourage physicians to participate in the community enterprise; now the tables have turned. "In all of our communities we serve, between 80 and 100 percent of the independent physicians now have EHRs. Now they are pushing us to aggressively link in to our CHR," he says.

Nearly 1,800
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PeaceHealth's
Community Health
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EMPLOYING E-VISITS

More than 30 percent of primary care physician visits at Group Health Cooperative, which serves Washington state and parts of Idaho, are now conducted through secure electronic messages—like email exchanges through the health system's patient website MyGroupHealth.com. Additionally, each month, 10 percent of Group Health members review medical test results online, 10 percent go online to request medication refills, and

thousands of patients schedule their own appointments after checking their physicians' availability.

Electronic communication with patients is a key part of Group Health's medical home approach. The integrated delivery system, which combines a 988-physician multispecialty group practice with a 630,000-member health plan, is a national leader in implementing this alternative primary care delivery model.

Tying technology to medical homes. Group Health connects with patients through the patient website (MyGroupHealth.com) of its EHR. Group Health began investing in EHR technology nearly a decade ago, as part of an initiative to improve access, boost physician productivity, and improve the organization's overall financial performance.

EHR technology did help improve productivity. Physician panels swelled to 2,300 patients—but physician burnout ensued.

In 2006, Group Health transformed one of its Seattle-area clinics into a primary care medical home model. The pilot clinic reduced the size of its physician panels and added an array of other staff to build stronger relationships with patients, increase care coordination—and address the problem of physician

burnout. Based on the successful results of that experiment, Group Health has converted all its 26 clinics to the medical home model.

The medical home uses a staffing model that allows for longer patient visits and daily time allotted for staff members to plan and coordinate patient care. Indeed, the physician panels are down to 1,800 patients. For every 10,000 patients, Group Health employs 5.6 physicians, 5.6 medical assistants, 2 licensed practice nurses, 1.5 physician assistants or nurse practitioners, 1.2 registered

"Until they experience it for themselves,
physicians are not necessarily going to believe
this—but patients don't really take advantage of
the opportunity to communicate electronically."

nurses, and a clinical pharmacist. This was a staffing increase of 15 to 18 percent for physicians, medical assistants, and nurses; 44 percent for physician assistants; and 72 percent for clinical pharmacists.

President and CEO Scott Armstrong is expecting a huge ROI from the medical home initiative. Group Health has invested \$10 million to extend the model to all clinics and, based on the results of a two-year pilot, it expects to generate annual cost savings of \$40 million in 2011 and thereafter (Meyer, H., "Group Health's Move to the Medical Home: For Doctors, It's Often a Hard Journey," *Health Affairs*, May 2010, vol. 29, no. 5, pp. 844-851).

Adding up the benefits. "There are a lot of ways that electronic communication with patients reduces the cost of your operation," says Gwen O'Keefe, MD, medical director for informatics and quality.

For one thing, electronic communication has allowed Group Health to reallocate many staff members who used to spend all of their time on the telephone with patients. When Group Health began allowing patients to look at their physicians' schedule and book an appointment online, the phones stopped ringing so often.

Meanwhile, the no-show rate for in-person appointments made online is lower than for appointments made over the telephone, says O'Keefe. Patient satisfaction is higher, and they are less likely to go elsewhere looking

for medical services. "One of the goals of any healthcare system is to reduce churn of patients, and this definitely helps with that," she says.

In fact, a survey of Group Health patients found that those in the medical home clinic reported higher satisfaction with coordination of care, access to care, quality of physician-patient relationships, and patient satisfaction and involvement.

The real ROI, however, comes from the utilization patterns for patients in a technology-enabled medical

home pilot clinic. These patients had more communication with caregivers despite fewer clinic and hospital visits, compared to patients in other clinics (see the exhibit below).

The bottom line: The cost of providing primary and specialty care increased in the medical home model, but the reduction in inpatient, emergency, and urgent care visits more than

offset that. Group Health estimates a total savings of about \$10.30 per member per month.

For every \$1 Group Health invested in the medical home pilot, it has saved \$1.50. Although the EHR technology and patient website are essential to success, this ROI calculation does not include technology costs because the system had already invested in its \$40 million EHR system before the pilot was conceived.

Group Health's Technology-Enabled Medical Home Pilot Clinics

Medical home patients had more communication with caregivers—and fewer clinic visits or hospital admissions—compared with other patients.

Fewer (but longer) in-person primary care visits
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80%	More	e-mail	thread
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5%	More telephone encounters with
	members of the primary care team

29% Fewer emergency and urgent care visits

6% Fewer inpatient admissions

Barriers to E-Visits

Nearly 40 percent of U.S. physicians communicated with patients online in 2009, according to a Manhattan Research survey reported by the American Medical Association. But most of them did not get reimbursed by an insurer.

That is because most physicians—whether they are employed by a health system or independent—are not set up with the technology or the insurance contracts to allow reimbursement.

That includes physicians in the Partners HealthCare in Boston, says Joseph C. Kvedar, MD, director of the Center for Connected Health at Partners.

Kvedar is one of the nation's top advocates for delivering patient care outside the traditional medical setting. But when he exchanges e-mail with his dermatology patients, there is no reimbursement—and he does not expect that to change in the immediate future.

He cites three barriers to widespread adoption of e-visits:

Although patients want e-visits—in fact, the California
Healthcare Foundation reports that 78 percent of survey
respondents said they wish to interact with their physicians
online—Kvedar's focus group research suggests patients

- want e-visits in addition to face-to-face contact with their physicians, not as a replacement. That makes payers wary that e-visits will be an added expense.
- Physicians who grew up with e-mail are open to communicating online with patients. However, physician enthusiasm will be mixed until older physicians retire.
- Payers currently reimburse for e-visits at a lower rate than for office visits, creating a disincentive for physicians to substitute an office visit for an e-visit.

Kvedar believes these barriers will melt away when the fee-forservice payment system is replaced by systems that incentivize providers to improve the quality of care and lower costs. That is why physicians and hospitals that are integrated with insurers or preparing to enter into risk-based contracts—are at the forefront of online care.

"You better believe that when we get into bundled payments and capitation, providers will be much more incentivized to use these alternative forms of care," he says. "So that points to adoption of e-mail visits eventually. But adoption will be slow until we get beyond the economic and the psychological barriers."

Source: This sidebar is excerpted from "Payment Challenges Around Phone and Electronic Visits," which appeared in the September 2010 issue of HFMA's Patient Friendly Billing publication (www.hfma.org/publications).

Getting patients and physicians on board. With seven years of experience using electronic communication to engage patients, Group Health has a lesson to share with others: While worth the effort, this work is not easy.

"The two most important keys are overcoming physician resistance and assertively marketing electronic communication to patients," says O'Keefe.

Group Health highlights its online communications options in its advertising campaigns, but it does not wait for patients to initiate online access themselves.

"We work with our front office staff to get patients signed up any time they come into one of our clinics," she says. "Patients very much want to have this convenience of being able to do this, but physicians are initially skeptical."

All Group Health physicians are salaried, so the issue of reimbursement for online communication with patients is not the barrier for Group Health that it is for some other providers. Still, many physicians fear they will be inundated with messages from their patients—until they start interacting with patients online.

"Until they experience it for themselves, physicians are not necessarily going to believe this—but patients don't really take advantage of the opportunity to communicate electronically," she says.

O'Keefe suspects that the process of logging into the MyGroupHealth website reminds patients that they are interacting with a healthcare professional and this isn't the place for meaningless chat.

Group Health physicians are expected to answer secure messages from their patients within 24 hours. Although a few physicians continue to dislike it, most have fully embraced electronic communication as a significant part of their practice within a couple of years.

"Our younger physicians now say they cannot imagine practicing any other way" says O'Keefe.

NEXT: LESSONS LEARNED.

A number of key lessons can be gleaned from the provider case studies in this report. See the Last Word, page 48.

REFORM-MINDED TAKE AWAYS

s the innovative providers in this report move along the path to reform, they are identifying their own unique strategies and setting their own agendas. Despite their differences, the featured providers point to key lessons that all healthcare organizations can keep in mind as they work to enhance the value of patient care—and secure their own financial viability.

All of these lessons relate to learning how to do more with less. As transparency increases and payments decrease, providers will need to double up efforts to enhance quality, reduce costs, and improve efficiencies.

Invest to improve quality and efficiency. St. Luke's Hospital is spending about \$10,000 a year to ensure that all heart failure patients receive a post-discharge home care visit—a key strategy in reducing heart failure readmissions. However, St. Luke leaders expect that expense to be repaid many times over when Medicare starts reducing its payments for hospitals with high readmission rates (page 24).

After Grinnell Regional Medical Center invested in eICU technology, the rural hospital successfully recruited an internist and increased ICU census (page 41).

Build on your strengths. Fairview Health Services is well positioned to become one of America's first accountable care organizations—because the health system already has a lot of the necessary structural components and services in place (page 11).

Consider more than one process improvement approach.

The best process improvement approach to use varies, depending on an organization's culture, the type of problem/opportunity being examined, and other factors (page 31). For example, Mercy Medical Center has improved dozens of emergency department metrics using Lean manufacturing, an approach borrowed from industry. In contrast, Magee-Womens Hospital has demonstrated success with a home-grown approach that is uniquely geared to health care.

Harvard Vanguard Medical Associates has found that sophisticated systems engineering approaches are helpful in solving complex problems. On the flipside of complexity is brainstorming—a tactic that nurses at the University of Minnesota Medical Center used to successfully reduce operating room waste.



Access to information drives quality and efficiency. Physicians in the Northeast Wisconsin Health Value Network (NEWHVN) share patient information across different IT systems (page 25). NEWHVN report cards show how each physician performs on a variety of quality measures. Results to date are impressive: 74 percent of NEWHVN heart disease patients have healthy cholesterol levels, compared to 60 percent nationally.

PeaceHealth points to similar results with its Community Health Record, an electronic health record that links all community providers. Physicians have used Community Health Record data to reduce door-to-balloon time for heart attack patients to an average of 60 minutes, well below the 90-minute goal (page 42)

Work toward trust in cross-continuum partnerships. One key: identify corresponding goals. Bellin Health aims to improve the health of students in Green Bay elementary schools. While school partners agree that is an important goal, they also hope their union with the health system will pay off in better math and reading scores (page 8).

Also vital to creating trust: Upfront discussions about top-of-mind issues. For instance, when building NEWHVN, senior leaders from Bellin and ThedaCare, as well as strong physician representatives, spent considerable time discussing business and implementation issues—from who pays for what to how to create a system of quality measures (page 25).



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