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healthcare financial management association

HFMA'S VALUE PROJECT:

AN INTRODUCTION

Health care's focus is shifting from volume to value. With insights from HFMA's 4th Annual Thought Leadership Retreat, learn what quality and costing strategies will be needed to succeed.

SPEAKERS AT HFMA'S THOUGHT LEADERSHIP RETREAT

HFMA wishes to thank the following speakers for sharing their expertise and dedicating effort to value-driving transformations in care.

- Jonathan Perlin MD, PhD, MSHA, FACP, FACMI, president, clinical services, and chief medical officer, HCA
- Tony Rodgers, CMS deputy administrator for the Center for Strategic Planning
- Kenneth Kaufman, CEO, Kaufman, Hall & Associates, Inc.
- James A. Diestche, vice president and CFO, Bellin Health
- Garri L. Garrison, RN, CPC, CMC, CPUR, 3M Health Information Systems

HFMA'S VALUE PROJECT: AN INTRODUCTION

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Healthcare Financial Management Association
Two Westbrook Corporate Center, Suite 700
Westchester, Illinois 60154-5700

Correspondence: resourcecenter@hfma.org

ABOUT HFMA'S VALUE PROJECT

Healthcare organizations are under increased pressure to drive down costs and enhance quality. Yet the resources needed to successfully advance healthcare value through such efforts often are lacking. With this in mind, the Healthcare Financial Management Association has developed HFMA's Value Project, an initiative that has gathered leading healthcare organizations to:

- Identify critical areas of health care where quality and cost intersect
- Identify metrics for measuring performance related to the intersection of cost and quality
- Identify processes to improve communication of information about cost and quality
- Develop and identify practices to enhance value of care
- Provide tools for measuring performance, applying successful practices, and improving value

The following report serves as an introduction to the project by highlighting insights on value shared at HFMA's 4th Annual Thought Leadership Retreat.

To support the initiative going forward, HFMA has formed a Value Advisory Council. Among its representatives are organizations that are high performers in the areas of quality of care and cost containment. The council will build a new body of knowledge regarding:

- The information needed (content and format) to make effective decisions on cost and quality improvement
- Costing techniques that provide current and accurate costing of clinical and administrative processes
- Metrics and analytics that allow executives to understand the impact of improvement projects on financial performance
- How resources should be allocated among various components of the care delivery process

Other phases of the project will include industry research into benchmark practices to enhance value and issues around the key enablers needed to successfully manage value. HFMA is conducting this research with assistance from Deloitte Consulting, LLP. Findings will be released in 2011 at HFMA's ANI: The Healthcare Finance Conference.

ABOUT HFMA'S THOUGHT LEADERSHIP RETREAT

The Thought Leadership Retreat, held Oct. 7–8 in Washington, D.C., featured top experts on healthcare value as well as moderated breakout discussions among more than 100 participants. HFMA convened the invitation-only event as a means of gauging industry perceptions on value of care and sharing insights on ways hospitals are identifying quality metrics, costing clinical and operational initiatives that drive value, and defining organizational roles around value efforts, particularly the CFO. This is the fourth year HFMA has held the event, with past events focused on payment reform and physician integration. For more about these efforts and outputs from past discussions, see www.hfma.org/paymentreform.

FOCUSING ON VALUE

How do healthcare organizations provide value? Perhaps it's physicians using electronic tools to identify low-cost medicine with best efficacy among alternatives. Or it's a communications plan between hospital staff and home care nurses to minimize readmissions. Or maybe it's dietary education that prevents someone with risk factors from developing diabetes.

Healthcare value—high-quality care at low cost—can take many forms. And hospitals increasingly need to recognize these opportunities and allocate resources appropriately to pursue them. The forces driving hospitals to a high-value strategy are numerous: eroding rates of payment (and the potential for further erosion), the shift from volume to value as a basis for payment, rising costs, softening patient volumes, and intensifying competition.

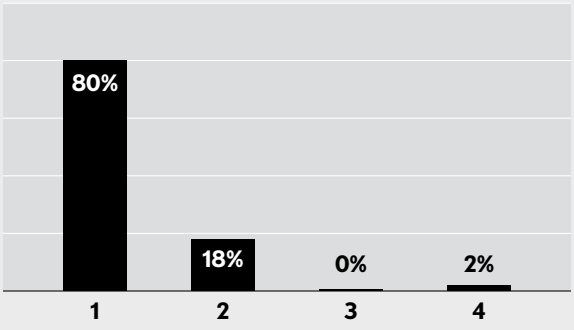
VALUE = QUALITY / COST

Of more than 100 hospital executives attending HFMA's 4th Annual Thought Leadership Retreat, 80 percent said they believe value will be a key factor in hospitals' financial success within the next five years. Another 18 percent believe it will be important, but beyond the five-year term.

With this in mind, it's important for hospital financial executives to examine the strategic significance of value and the current state of value, and explore what will be needed in terms of the organization's quality agenda and costing for a value-driven organization.

THE STRATEGIC SIGNIFICANCE OF VALUE

In the future, value (quality and cost) will be an important factor in my organization's financial success



1. Yes, within 5 years
2. Yes, but beyond 5 years
3. No
4. Not Sure

WHY VALUE?

Many factors are contributing to value's growing strategic significance. To some extent, this higher priority is resulting from value-driving provisions of the Affordable Care Act, such as outcomes-based payment and reduced payment for hospitals with high volumes of hospital-acquired conditions and avoidable readmissions. In addition, ACA-backed pilot projects, such as exploration of accountable care organizations, indicate interest in having providers take on much greater financial risk for clinical performance and improve their efficiency and effectiveness through greater coordination of care.

Others argue that the need for enhanced healthcare value emanates from a much stronger force. "What's happening in the industry is the destruction of the current business model and its replacement with an entirely new one. Reform has accelerated this change, not created it," said retreat speaker Kenneth Kaufman, CEO, Kaufman, Hall & Associates, Inc.

In many ways, the current model no longer meets the needs of the day. Fee-for-service payment rewards quantity without regard to quality. Healthcare providers that avoid duplicative or unnecessary services are not rewarded and, even worse, poor outcomes or errors that result in greater consumption of services may provide additional reimbursement.

Also, the current healthcare system is expensive. National health expenditures account for an increasing percentage of gross domestic product (GDP) and are anticipated to continue to rise. Total spending on health care in the United States, including both private and public spending, was 4.7 percent of GDP in 1960. In September 2010, Office of the Actuary projections—taking into account the healthcare reform law—anticipate U.S. healthcare spending will make up nearly 20 percent of the economy by 2019.

What's more, despite this high expense, population health is not benefiting correspondingly. Total health spending in the United States ranks far ahead of other industrialized countries, such as France, Switzerland, Germany, and Canada, yet the nation lags behind in life expectancy and other core measures of health status.

Information and safety gaps also are common, noted retreat speaker Jonathan Perlin, MD, PhD, FACP, FACMI, president, clinical services, and chief medical officer, HCA.

Perlin cited several statistics from The President's Information Technology Advisory committee as just a few examples: One in seven hospitalizations occur because previous records are not available; 12 percent of physician orders are not executed as written, and more than 20 percent of laboratory tests are requested because previous studies are not accessible. "And virtually every patient experiences some gap in care from best-evidence or most-effective practice," he said.

It stands to reason then that healthcare business models incorporating cost and quality controls become an increasing priority for providers, payers, and consumers.

"We must move off the unsustainable path we are on," noted HFMA President and CEO Richard L. Clarke, DHA, FHFMA. "Payment systems that have evolved over the past 40 years have created a healthcare system that we simply can't afford any more and that does not reward high-quality outcomes or cost-efficient care."

As the industry addresses many of the current system's challenges, several paradigm changes will need to occur. Most notably, healthcare leaders can anticipate the need for strategic shifts in the following five areas.

- **Costing/efficiency.** Currently, reduction is viewed in terms of discrete projects. The future will require a system approach of continuous process improvement.
- **Quality.** Instead of just linking limitedly to payment, quality will drive payment.
- **Physicians.** Value—rather than volume—will be physicians' key focus.
- **Collaboration.** Financial success can occur with limited collaboration under the current system. In the future, however, all healthcare stakeholders—hospitals, physicians, employers, and consumers—will need to work together.
- **Financial risk.** Rather than risk revolving solely around cost position, it also will depend on appropriate utilization of services across the continuum of care.

Specifically, hospitals can expect to bear a degree of financial risk in terms of outcomes related to value-based payment. Additionally, the per-unit amount of fee-for-service revenue an organization receives will be directly correlated to its quality.

"New capabilities must be developed to survive and thrive in the value-based environment," Clarke said. "We must develop ways of transforming care and collaborating to mitigate risk."

CURRENT STATE OF VALUE

Many hospitals, physicians, and payers already are making notable strides in project-based efforts around value. However, a widely embraced system approach to sustainable process improvement is lacking.

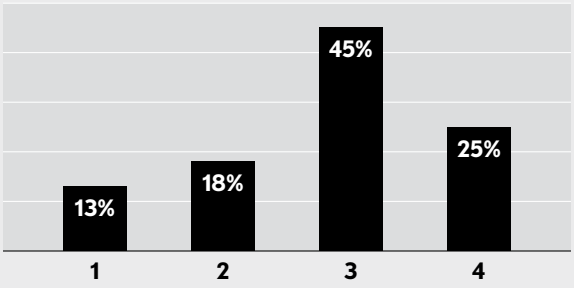
To develop and identify practices that will enhance value of care, the industry needs to better understand the intersection of cost and quality, noted Clarke.

"In too many of our organizations, financial impact of quality efforts is not adequately measured," he said. "Comprehensive costing techniques are not widely used, and financial practices are not well suited to reengineering clinical processes. Do we know when spending money actually impacts outcomes in a sustainable fashion, or even where that money should be best spent? We need the data and frameworks to make these informed resource decisions."

Even though many industry stakeholders can agree on the need for a value-based payment system, determining the right strategy to achieve it is very challenging. "Although the new model is needed, it will be about 50 times harder to implement than what we're used to under fee for service, which provides predictable cash flow," noted Kaufman. "It will require new competencies and organizational abilities that we don't have in many of our organizations."

QUALITY INCENTIVES

To what extent is achievement of key quality metrics an important factor in your organization's pay and reward system?



1. Not important
2. Somewhat unimportant
3. Somewhat important
4. Very important

Perhaps it's this need that explains why—even though almost all of the more than 100 attendees at the Thought Leadership Retreat identified value as key to their organization's future financial health—most do not have systems in place at the moment where achievement of key quality metrics is an important factor in the organization's pay and reward system. Only 25 percent said the extent of quality achievement was "very important" in this regard within their current structure.

THE QUALITY AGENDA

At its most fundamental level, transitioning to a value-based system will require an understanding of quality. Although everyone can recognize that inefficient, ineffective, or redundant practices do not support high-quality health care, driving to what truly defines level of quality isn't as easy.

As just one example, there are more than 1,400 national quality measures. "Being a leader in quality is a moving target, given how fast the number and types of quality metrics are increasing," noted one attendee.

Common sources of quality data include CMS's Hospital Compare Measures, the Agency for Healthcare Research and Quality, The Institute for Translational Health Science, the Health Resources and Services Administration's Center for Quality, as well as private payer initiatives.

At the end of the day, however, doing well on such measures may not be enough. Efforts also must be made to draw consumers into the equation. "The consumer needs to be educated first about quality before you can even begin to discuss value," as one attendee noted.

For many consumers, high-quality hospitals often are the "big brand" providers recognized nationally. Less recognizable names at the regional or local level may not be as well regarded, even when performing as well—or better—on common quality measures.

Also, consumers may not place the same priority on industrywide rankings of outcomes or adherence to safety protocols as one might suspect. Factors such as quality of food, comfort of rooms, or friendliness of staff can be just as important, if not more, than detailed information on clinical performance to many individuals. Patient satisfaction is a key quality indicator. Patients simply expect clinical practices will be safe and high quality and place great emphasis on experiential dynamics, which tend to be more within their immediate ability to discern. As one attendee explained, "I may not know exactly how a car is built, but I know which cars are comfortable to drive."

Even when one considers common measures of quality embraced by the industry, greater competencies for developing and using this information are still needed.

As noted by speaker Garri Garrison, RN, CPUR, CPC, CMC, director of acute care consulting, 3M Health Information Systems, data in use often are inaccurate or fail to tie appropriately to financial functions as a result of such challenges as incomplete documentation, incorrect or incomplete coding, improper sequencing of coded data, and lack of understanding regarding complexity (both severity and risk of mortality).

For data quality to be robust, users generally define the data as detailed, valid, useful, accurate, and used. When asked how "robust" their systems for measuring and reporting quality data are, over half of retreat attendees said "somewhat non-robust" or "not very robust."

The ability to attain—and agree—on use of robust data becomes particularly important when the industry seeks to uniformly track the patient experience in different care settings and various stages of health. To truly improve the health status of communities, hospitals need collaborative collection and reporting of quality information with other key healthcare stakeholders across the care continuum.

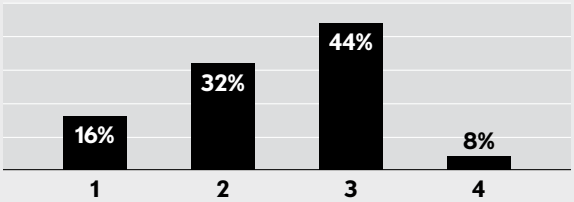
"Are we measuring at the treatment level, preventive level, or population health level? Too many of us focus chiefly on treatment, with limited attention to prevention efforts," one attendee noted.

The good news is that significant strides are likely to be made in this particular area as electronic health records improve connectivity among patients, providers, and payers.

HCA's Perlin noted that enhanced communication facilitated by electronic records will not only contribute to better quality of overall care but also greater understanding of the populations served and intensity of treatment required. Viewed with providers' performance data, this information will allow for easier recognition of high-quality care. "Information will be a great equalizer in the environment ahead," Perlin said.

QUALITY DATA

How robust (detailed, valid, useful, used, accurate) are your systems for measuring and reporting quality data?



1. Not very robust
2. Somewhat non-robust
3. Somewhat robust
4. Very robust

NEXT-ERA COSTING

Also elusive are proper costing strategies for a value-based environment. In the difficult economic climate, hospitals are under tremendous pressure to reduce expense. The situation is predicted to become only more difficult as payment that healthcare organizations receive for the care and service they provide doesn't keep pace with the costs associated with this care and service. Reform legislation calls for payment cuts to hospitals of $148.7 billion over 10 years from Medicare market basket updates and Medicare and Medicaid disproportionate share payment.

Many organizations are addressing these challenges by pursuing formal process improvement initiatives in administrative and clinical areas aimed at cost and waste reduction. Common approaches in use are Lean, Six Sigma, Deming's Total Quality Management, and ISO9000 (manufacturing).

These efforts have resulted in some financial success, although sustaining improvement proves challenging. Year-over-year cost improvement is reported at less than 1 percent by more than half (57 percent) of attendees, and between 2 percent to 3 percent by nearly one-third (33 percent) of attendees.

A bright note, however, is that improvement is being seen in multiple settings. The majority of attendees see evidence-based process improvement as creating cost reduction and improved quality in administrative areas (67 percent of attendees) and clinical areas (78 percent).

Many attendees said sustaining cost reductions could be easier with improved data. Key challenges cited are that data are not timely enough to make effective decisions (41 percent), costing assumptions and cost allocations produce results that are not helpful or useful for decision making (21 percent), and data are reported in a manner not useful to the decision maker (16 percent).

In large part, macro-level costing methods are used more often by hospitals than micro-level methods because financial executives find it difficult to obtain and trust micro-level data and provide the data in a timely fashion.

Yet the ability to micro-cost and manage data by individual is what will be needed for the environment ahead. For value-based readiness to occur, data and analytics will need to measure how changes in clinical practices affect utilization and outcomes across care settings and over time.

Many hospital leaders are looking to greater collaborations with payers as a means for accessing the data needed to cost services across the continuum of care, as much of the data needed resides within payer databases.

Systems also need to be in place to better link cost efforts with quality. When asked about the relationship between cost reduction strategy and quality improvement efforts, nearly one-third of retreat attendees said this link was "very limited."

"Often clinical performance improvement results in cost avoidance, instead of true savings," noted one attendee. "You're looking at instances where expense isn't as bad as if you hadn't made a change, and these sorts of improvements are much more difficult to measure and demonstrate."

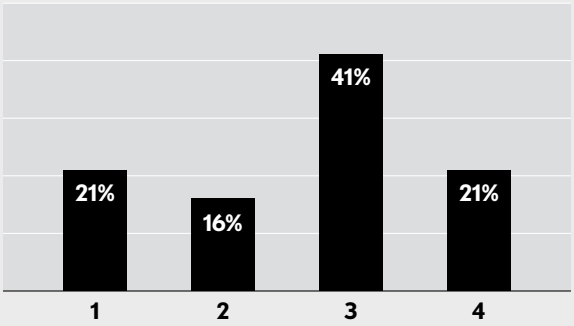
Noted another: "In my experience, hard cost savings typically come from supplies and drugs because it is difficult to translate efficiencies in care practices to true reductions in staff." Often, efficiencies made to one area simply free up resources for use in another area.

Or worse, savings in one area may shift costs to another. As an example, a reduction in nursing may yield short-term savings but result in greater use of expensive temporary staff that leads to higher costs in the long term.

The multitude of factors influencing clinical practice and effects of change on cost centers elsewhere in the organization often demand sophisticated analysis.

COST DATA

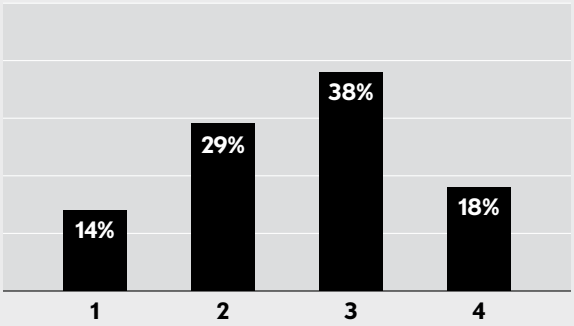
Users of your organization's costing data likely would say:



1. Costing assumptions and cost allocations produce results that are not helpful or useful for decision making
2. Data are reported in a format that is not useful to the decision-maker
3. Data are not timely enough to make effective decisions
4. Costing data are appropriate and useful

QUALITY AND COST LINKAGES

Which statement best describes the extent to which your cost reduction strategy depends on clinical quality improvement efforts?



1. Cost reduction strategy is not linked to quality improvement.
2. Links between cost reduction and quality improvement are very limited.
3. Links between cost reduction and quality improvement are somewhat limited, but increasing.
4. Quality improvement efforts are key to cost reduction strategies.

"It's difficult to select the best costing method when looking at clinical improvement initiatives, as each purpose often requires a unique method of examination," explained one attendee.

Adapting costing practices of peer "role models" to improve value generally isn't as effective as one might hope. Individual system experiences, techniques, and results often are not easily relatable due to differences in organizational design, clinical integration, and access to resources. As one attendee said: "What the Mayo Clinic does to drive quality and control cost may be right. But it may not be right for us, because we are not Mayo."

Hospitals' costing competencies become even more important—and challenged—when applied at a strategic level. Understanding the sophisticated relationships between cost and ability to provide high-quality care is needed as market shifts force hospitals to view existing service offerings in new ways.

"Hospitals will need to develop a whole new perspective on the cost environment," Kaufman said. "The focus should be on cost structure, which is very different than cost management. Cost structure problems result from *what* organizations do in providing care on a day-to-day basis that causes fixed costs to be so high, not so much *how* they do it."

Today's hospital leaders should examine ways to restructure costs, notes Kaufman, as opposed to simply managing variable costs. In the next one to two years, many organizations will need to consider ways to reduce their fixed costs at both the entity level and the service line level.

MOVING FORWARD

As organizations ready themselves for value-based care structures, several key areas will need to be explored: roles, metrics, and comparative goal setting.

Roles. The financial executive's role in a value-based environment is evolving. "In the past, CFOs were not involved in clinical processes. Their role tended to be one of keeping score," Clarke said. "However, it is clear senior financial executives will need to be much more engaged in clinical process improvement because the relationship of value—quality and cost—to payment is becoming tighter."

Some attendees expressed the need for better collaborations between financial executives and clinicians to not only identify the best data for use but also the most effective ways to use data.

Eighty-four percent of attendees said they need to "join process improvement efforts," and the remaining 16 percent indicated they need to "learn more about clinical process improvement activities."

Some stressed the biggest benefit of financial executive engagement may be influence on other key decision makers in the organization.

"The senior management team plays a key role in establishing a culture that supports quality and cost-efficiency. It has to be a top-down effort to truly drive organizational change," noted one attendee.

Metrics. The right metrics will be needed to help organizations identify value-driving opportunities, monitor progress, and develop optimal practices. At the heart will be better information to link costing practices to clinical strategies. "Safety and clinical quality receive more focus and attention than other areas when it comes to performance improvement, yet the changes undertaken do not necessarily produce the desired results and advances made are often difficult to measure, yet alone sustain," said one attendee, echoing the sentiments of others.

Comparative goal setting. To truly advance the organization's position on delivering value, hospital leaders need to not only understand how to measure and monitor internal quality and cost practices, but also compare performance to that of peers. A system of external performance evaluation will be important to drive and define the organization as a value leader.

Efforts also may need to align with other stakeholders. As one attendee noted, "Sustainable performance improvement requires collaboration with payers, employers, physicians, and patients because all have a strong influence on resource utilization."

To help hospitals transition to the value-based environment ahead, HFMA is focusing on these areas with its new initiative. HFMA's Value Project will identify critical areas where quality and cost intersect, metrics for measuring performance related to this intersection, and processes to measure and enhance value of care.

Insights from the Thought Leadership Retreat will feed into ongoing efforts of HFMA's Value Advisory Council in supporting the initiative and building a new body of knowledge regarding information needed to make effective decisions on cost and quality improvement, costing techniques for value initiatives, metrics for understanding impact on improvement projects, and optimal benchmarking.

Regardless of advancements made in these areas, healthcare leaders need to begin readying their organizations for value-based change now.

"At the moment, we're straddled between the environment of today and the environment of the future," Perlin said, comparing hospitals' struggle in transitioning from volume- to value-based payment to "someone with one foot on the dock and one foot in the boat."

Hospitals face risk from either clinging too long to outdated practices suited to fee-for-service payment or being ill-prepared for the new competencies needed in a value-based model, such as proficiency in managing population health and in communicating and collaborating across the care continuum.

Perlin warned that waiting until all of the pieces are in place is a sure mistake. "We can't wait too long to determine strategy for a value-based environment," he said, "or we will be in an incredibly unstable position."

ABOUT THE SPONSORS OF THIS HFMA REPORT

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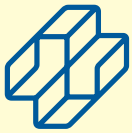

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The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 35,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. We provide education, analysis, and guidance; we lead change and innovative thinking; and we create practical tools and solutions that help our members get results. Addressing capital access to improved patient care to technology advancement, HFMA is an indispensable resource on healthcare finance issues.

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