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THE HIGH STAKES OF POPULATION HEALTH

Why healthcare organizations need to improve population health management by:

- Optimizing risk-based contracts
- Better engaging patients
- Partnering with community organizations

David Nash, MD, MBA, dean of the nation’s first school of population health, gives a progress report on the healthcare industry’s transition to managing patient populations. Page 6
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GOING TO SCHOOL ON POPULATION HEALTH MANAGEMENT

In the new reality of value-based payment, success will be defined by a healthcare organization’s ability to manage patient populations. David Nash, MD, MBA, dean of the Jefferson College of Population Health, assesses how organizations are faring in key aspects of this paradigm shift.

CARE TRANSFORMATION

POPULATION HEALTH: THE “UPSTREAM” EFFORT

Partnerships with community organizations are vital to population health management programs, and also signal downstream opportunity.

TAKING A COMPREHENSIVE VIEW OF POPULATION HEALTH

True population health management will require novel approaches and partnerships, says Trissa Torres, MD, of the Institute for Healthcare Improvement. Here’s why.

QUALITY/COST

BUILDING MEANINGFUL INCENTIVES IN VALUE-BASED CONTRACTS

As value-based contracts become more prevalent in health care, many organizations are experimenting with innovative strategies to ensure quality and financial incentives align properly.

ROOTING OUT DIAGNOSTIC ERROR

In the wake of a new Institute of Medicine report on diagnostic issues in health care, four prominent experts discuss how to bolster patient safety.
PATIENT EXPERIENCE

40 ACTIVATING PATIENT ENGAGEMENT FOR POPULATION HEALTH
Effective patient engagement involves both intense, one-on-one personal care and high-tech tools that guide patients in changing their behavior and improving their health.

46 7 TIPS FOR IMPROVING EMERGENCY DEPARTMENT PATIENT FLOW
Florida Hospital Tampa increased overall ED patient satisfaction from the 6th to the 80th percentile by using an immediate-bedding and team triage patient flow system.

48 COLUMN: PATIENT ENGAGEMENT: A CRITICAL SUCCESS FACTOR
By Joseph J. Fifer, president and CEO, HFMA

INNOVATION

38 TAKING TELEHEALTH TECHNOLOGY FROM SHIP TO SHORE
An interview with Neal Sikka, MD, of The George Washington Medical Faculty Associates

BUSINESS PROFILE

20 TRIMEDX
Elevating and Streamlining Clinical Engineering

AVAILABLE ONLINE

The Role of IT in Population Health Management
hfma.org/Leadership/PopulationHealthIT

Using IT to Help Underserved Communities
hfma.org/Leadership/TrumanMedicalCentersIT

Blog: Reducing Admissions from Skilled Nursing Facilities
hfma.org/Leadership/Blog/SNFAadmissionReduction

Video: Metrics to Track When Engaging in Population Health Management
hfma.org/Leadership/PopulationHealthMetrics

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Eric Topol, MD
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AN INTERVIEW WITH DAVID NASH, MD, MBA

GOING TO SCHOOL ON POPULATION HEALTH MANAGEMENT

The dean of America’s first college of population health issues a midterm progress report—and hands out some homework.

By Lola Butcher

The January 2015 announcement by Sylvia Burwell, secretary of the U.S. Department of Health and Human Services, might be framed as a timed test for America’s healthcare providers.

By the end of 2018, Medicare intends to make 50 percent of its payments through alternative payment models such as accountable care organizations and bundled-payment arrangements. In announcing the target date, Burwell gave health systems, physicians, and other providers three years to figure out how to succeed when they are financially at risk for the quality and cost of the care they provide.

Of course, many organizations have been tiptoeing into this new era of accountability. But knowing that the nation’s biggest payer sees 2018 as the payment reform tipping point makes the clock tick more loudly.

Alternative payment models have many success factors, but none is more important than the ability to manage patient health at the population level.

“So if you think of it as a three-year journey, we’re about one-third of the way there,” says David Nash, MD, MBA, dean of the Jefferson College of Population Health at Thomas Jefferson University in Philadelphia. “I would say we’re making good progress toward population health.”

His comment was based on recent visits to some of the largest national and regional health systems, where he found population health initiatives that appear poised to pay off. For example, Mercy Health Partners in Cincinnati hired nurse care coordinators to give one-on-one attention to patients with chronic conditions; for patients who had been in care coordination for six months, admissions per 1,000 patients, emergency department visits per 1,000 patients, and inpatient days per 1,000 patients all fell by more than 20 percent on an annualized basis.

That said, not all provider organizations are reading from the same study guide.

“It goes from independent community hospitals that really are hoping this will all go away to national systems like Trinity and Ascension that are devoting millions of dollars in new resources to population health,” he says. “The range is pretty remarkable.”

CLASS IN SESSION

Nash has been focused on the intersection of payment reform and population health management for years. When the Affordable Care Act became law in 2010, he summarized it in four words—“no outcome, no income”—and the phrase has since become his mantra.

Trained as an internist, Nash received a master’s degree in business from the Wharton School at the University of Pennsylvania in 1986, long before the MD and MBA credentials became a popular combination. He started the Department of Health Policy at Jefferson Medical College in 2003, and five years later he became the founding dean of the College of Population Health.

Currently serving just under 300 students, the first-of-its-kind school offers master’s degrees and certificate programs in population health, health policy, and healthcare quality and safety, among other disciplines. The average age of students is 45, and most are already credentialed as nurses, pharmacists, radiation technologists, or other healthcare professionals. About 70 students are physicians.

“These are folks who are mid-career, working online with us—weekends, early morning, late at night—on a career trajectory to become leaders in the change from volume to value,” Nash says.

MIDTERM SCORES

In an interview with Healthcare Executive last year, Nash recommended several strategies that healthcare leaders should use to advance population health management. Almost every item has been on the work plan of forward-thinking provider organizations. But that doesn’t mean all of the recommendations are being successfully applied throughout the industry. Nash offered this progress report:
“Leaders are recognizing how inextricably intertwined social determinants are with the health of the population,” says David Nash, MD, MBA. “Medical care is 20 percent of the story.”

Begin population health management efforts with the employee population. “We are doing a terrible job with this because, regrettably, our whole industry has not placed sufficient interest and resources in the health of their own employees,” Nash says. “I would give us a C grade.” Employers in other industries are way ahead. He encourages healthcare executives to follow the example of manufacturers, supermarket chains, and other companies that recognize the economic benefit of encouraging workers to adopt healthy habits, get recommended screenings, and avoid inappropriate imaging and other wasteful services.

“Your employees are your captive at-risk population, although most delivery systems have not viewed their own employees in that way,” he says. “And then we wonder why our benefits continue to increase in cost.”

Provide appropriate guidance for those who will lead patient-centered medical homes. A good clinician may not have the skills and attributes needed to proactively manage a population of patients. “There is a false assumption, in my view, that physicians should automatically become capable leaders of patient-centered medical homes,” Nash says. “My point is they need additional training, resources, and support.”

Increase the use of patient registries. Nash is waiting for the day he can walk into his office, open his laptop, and click on the “How am I doing?” icon. “That’s what I want the icon to be called,” he says. “And when I click on it, up comes an amazing registry, with several categories. One category shows all of my patients who have insulin-dependent diabetes, or chronic obstructive lung disease, or stable angina, the bread-and-butter diagnoses of primary care practices.

“And in that registry, it also shows how I’m doing with regard to key population-based measures. Am I doing the right screening tests? Have I made the appropriate referrals? Am I ordering the appropriate generic drugs? And then that registry is also going to compare my performance with local, regional, and perhaps even national benchmarks.”

Although patient registries have been in use for many years, they are not yet standard practice for organizing a physician’s work. Until they are, Nash says, physicians are working without all the information they need to provide optimum care.

“When we have that kind of robust, agile registry, then I think we’ll really be practicing population-based medicine,” he says. “Right now, the folks who know more about our patients than we do are the payers.”

Partner with retail clinics. The clinics embedded in drug and grocery stores can support population health management in at least two ways: reducing use of high-cost emergency department visits for simple conditions such as strep throat and increasing access for patients with chronic conditions.

“I’d like to see the nurse practitioners in these retail clinics working more closely with, as an example, the faculty of Jefferson Medical College,” Nash says. “There’s a big opportunity here, especially with regard to patient education, given how often patients are in these retail settings versus how often they see their doctor.”

Partner with managed care plans. By “partner,” Nash does not mean “acquire.” “I cringe a little bit when I hear providers say ‘We’re going to start our own insurance plan,’” he says. “My first question is ‘How many actuaries do you employ?’”

Nash, who serves on the Humana board of directors, thinks insurers have two capabilities that providers typically lack: the actuarial expertise to assess and spread financial risk and the infrastructure to handle care coordination.

He is encouraged to see local and regional health plans working with providers on population health initiatives. “It would be great if we could bump this up to a national strategy,” he says. “I can envision a world where the Humanas, Aetnas, Cignas, etc., will have a large number of partnerships with providers in different geographies across the country.”

Provide funding for physician leadership training. “Am I pleased with what we see here? Definitely not,” Nash says.

Physician leaders need training in quality and safety, a systems approach to healthcare delivery, the application of Lean principles, and other competencies that are not taught in medical school.

In his view, health system CEOs recognize the importance...
of physician leadership but generally have not allocated resources to adequately train physicians for the bigger roles they are playing.

“Therefore, the board needs to be asking: How are we training the physician leaders of tomorrow? It’s so important that this is a governance responsibility,” Nash says.

**TODAY’S HOMEWORK**

Nash acknowledges that his CEO to-do list will expand as population health management gains momentum. One of the biggest challenges: establishing and executing an action plan to address factors that, until recently, seemed far beyond a healthcare provider’s purview.

“Leaders are recognizing how inextricably intertwined social determinants are with the health of the population,” he says. “Medical care is 20 percent of the story. The real story is poverty—that’s the critical, most important predictor of health—and other subsidiary issues related to that, including crime and access to food and all the rest.”

That list includes personal behaviors—many of which are tightly related to socioeconomic status—that health systems cannot afford to ignore when they become financially accountable for the health of a population.

Tax-exempt hospitals, required by the Affordable Care Act to conduct a community health needs assessment, are coming to see that this is not just busywork to comply with a regulation. “Last year’s hypertension-screening day in the public park is going to seem pretty rudimentary very soon,” Nash says. “Leaders are hiring all kinds of new people to assess the situation, and they are going to learn pretty quickly how to address these challenges—and it’s going to be complicated.”

Nash serves on a National Quality Forum task force that is creating measures of hospital engagement with communities and will issue a report this fall. “There are many members of the task force who are adamant that hospitals should grow crops to feed the poor,” he says.

“That may work in some places. Growing crops at Jefferson would be a big problem.”

**CURRICULUM MATTERS**

As the healthcare industry remakes itself to succeed in the value movement, the roles and responsibilities of its leaders are changing—starting at the top.

Nash sees a dramatic change underway in board structure as clinically integrated networks move to competency-based governance. “We’re going to move from today’s typical hospital board, which may not have a single content expert, to boards with very specific competencies,” he says.

One example: Integris Health, the largest health system in Oklahoma, recently recruited Mark Werner, MD, a Minnesotan who has served as chief clinical integration officer for Fairview Health Services, president of Carilion Clinic Physicians, chief innovation officer for Medica Health Plans, and board chair for the American Association of Physician Leadership.

Moving from a volume-oriented business model to one that rewards value—and penalizes organizations that cannot deliver it—means a board comprised of local civic leaders with no healthcare experience is no longer sufficient. The senior leadership team needs a new degree of support from board members who have a big-picture perspective on the value journey.

“Recruiters are getting overwhelmed with requests from not-for-profit hospital chains to find board members at the national level,” Nash says. “These big systems know that they have to look nationally to find the board member of the future.”

The roles of healthcare CEOs and CFOs also are changing along with the health system business model. “The blue-and-white hospital sign of the future is going to stand for health and healing, not acute and emergent care,” Nash says. “That’s going to determine the kinds of leaders we are going to need, and they will have a different skill set, for sure.”

As payment reform gains momentum, healthcare organizations will succeed only if their top executives embrace and implement the competencies needed to achieve the Triple Aim, Nash says.

“Improve the health of the population? That involves all the population health management skills, which means formal training in epidemiology and health risk assessment,” he says. “Reduce per capita cost? That’s all the systems thinking about efficiency, reducing unexplained variation. And of course the third part of the Triple Aim is to improve the individual experience of care. That requires understanding behavioral economics and related fields.”

The rest of the healthcare workforce also is redefining roles. The American College of Nurse Executives is developing its own list of population health competencies in recognition of how nurse responsibilities are increasing. Patient navigators, community health workers, and other emerging positions will become ever more important as health systems learn to proactively support a population of patients.

It adds up to the cultural change to which Nash has devoted his career.

“This change management is going to require tremendous leadership,” he says, “So are we training the right kinds of leaders? To me, the rate-limiting step—like in a chemistry equation—is leadership training. Without that, none of the other things can be done.”

**+**

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POPULATION HEALTH: THE “UPSTREAM” EFFORT

For healthcare organizations, potential partnerships with community groups represent both a new challenge and a significant opportunity.

By Ed Avis

Leaders at the James M. Anderson Center for Health Systems Excellence at Cincinnati Children’s Hospital had a question: Why were young asthma patients treated at the hospital coming back so frequently and so soon after they were released?

“It appeared that although we effectively treated them in the hospital, they would promptly come back after we sent them home,” says Dr. Uma Kotagal, senior vice president, quality, safety and transformation, at Cincinnati Children’s.

Kotagal, executive director of the Anderson Center, and her colleagues in other departments—including primary care, pulmonology, and the emergency department—dived into the asthma mystery. They soon realized the issue extended far beyond the hospital walls. Parents couldn’t get to the pharmacy. Families didn’t understand how to prevent or deal with asthma attacks. And the children’s homes were often moldy and otherwise full of allergens and other known asthma triggers.

“For children to thrive, the focus of health care can’t be just doing well in the hospital,” Kotagal says. “We must go outside the walls. That’s not to say we can’t do a lot better within hospitals, but for a variety of reasons the solutions are often outside.”

Population health issues are increasingly vital to clinical and financial success in today’s healthcare environment, and more and more organizations are learning, as Kotagal’s did, that working with “upstream” organizations is essential.

BY THE NUMBERS

25
Percent reduction in admissions per 10,000 pediatric asthma patients at Cincinnati Children’s Hospital between 2009 and 2015.

$35 million
Amount of Cincinnati Children’s Hospital’s total revenue—1.7 percent—that is capitated.

$380,000
Total budget for ThedaCare’s Rural Health Initiative, which provides health care to farmers in their homes.

UPSTREAM SOLUTIONS FOR POPULATION HEALTH

If a healthcare organization takes on the actuarial risk for a population and is able to keep that population healthy, it can reap some of the savings. More broadly, if a population overall remains healthy, society saves money that otherwise would be spent on health care (for more on the definition of population health, see the sidebar on page 12).
In fact, population health initiatives aim to keep people out of the healthcare system. And that’s where upstream solutions come into play.

“Healthcare organizations on the leading edge see community partnerships as strategically important,” says Niñon Lewis, an executive director at the Institute for Healthcare Improvement (IHI) in Cambridge, Mass.

Lewis says such partnerships can take many forms. Among IHI’s initiatives is the Triple Aim of improving the health of populations, enhancing patient experiences and outcomes, and reducing the per capita cost of health care. Lewis says healthcare organizations striving to achieve the Triple Aim are discovering no shortage of community help.

“What we’re finding is that many communities are resource-rich and coordination-poor,” Lewis says. “That’s what healthcare organizations have to realize—the resources they can tap into are much more broad than what’s within the walls of the healthcare delivery system. That’s the next frontier for healthcare organizations. It’s both the challenge and the beauty of the opportunity—there are a lot of hands in the community to help serve the needs of the populations they care for, and the key is knowing where they are, developing the skills to collaborate with new partners, and finding the means to pay for addressing the social determinants of health.”

ATTACKING ASTHMA IN CINCINNATI

The Anderson Center was founded in 2010 to expand Cincinnati Children’s work in transformational improvement. In the area of community and population health, Cincinnati Children’s and The Anderson Center currently focus on five areas of care: infant mortality, obesity, asthma, unintentional injuries, and early childhood development.

Kotagal says asthma was an obvious problem to tackle, given that the disease afflicts nearly one in six children in Hamilton County, Ohio. The condition ranks third nationally among causes of pediatric hospitalization.

“We learned that there were well-documented geographic discrepancies between more affluent neighborhoods and those with limited access to resources,” Kotagal says. “When we run data for injuries or asthma hospitalizations, we find there are five- to tenfold differences in utilization and occurrence rates depending on the neighborhood you come from. These discrepancies were consistent across several conditions.”

When The Anderson Center’s asthma improvement team looked for the root cause of the problem, several culprits emerged, including a lack of access to pharmacies in some neighborhoods and a lack of family knowledge about asthma. The hospital could address those issues directly, by providing medications and speaking...
with families about asthma symptoms and remedies. But two other issues—home environmental factors and identification of at-risk children—required partnerships with community organizations.

The environmental issue came to the forefront when the team realized that asthma is substantially more prevalent among children who live below the poverty line. One characteristic of many of those children is that they live in homes with mold, dust, cockroaches, and other factors that contribute to poor air quality. “We knew we had to tackle some issues around housing,” Kotagal says. “So we formed a partnership with the Legal Aid Society of Greater Cincinnati, which enabled us to work with community landlords to ensure houses were mold-free and safe for children and their families.”

Another community partner in the asthma battle is the Cincinnati Public Schools district. The Anderson Center team met with school nurses to discuss asthma and how to identify students in need of intervention. Many of the nurses also attended training courses, called rapid-cycle improvement courses, offered by The Anderson Center and Cincinnati Children’s.

“School nurses are very interested in keeping kids in the classroom, so many of them joined one of our improvement training programs. They were then able to spread their knowledge to other nurses,” Kotagal says. “School nurses remain a very important part of the program. Through the school-based health centers, kids with asthma are better identified and tested.”

The asthma program has been effective, Kotagal says. “Our work on asthma has reduced hospitalizations significantly,” she says, noting that admissions dropped from 7.2 per 10,000 pediatric Medicaid patients with asthma in 2009 to 5.4 per 10,000 in 2015. “And that is our initial primary measure. As we move forward, we would like to collaborate with schools and community agencies to reduce absenteeism in children with asthma. By doing so, we hope to ensure that these kids are studying and learning at the same rate as their peers who are unaffected by the condition.”

Examining the financial impact. Absent performance incentives or penalties from payers, a hospital and affiliated physicians operating on a fee-for-service model do not have a financial incentive to reduce utilization. Even with incentives and penalties, there is rarely a correlation between reducing hospitalization and increasing compensation/profit.

Nathan Kaufman, managing director of Kaufman Strategic Advisors in San Diego, asserts that what is being touted as healthcare cost reductions resulting from population health initiatives actually is a case of the government and commercial payers squeezing savings through hospital payment rate reductions.

“The government’s value-based payment programs—for example, accountable care organizations (ACOs)—have had no material impact on bending the cost curve thus far,” Kaufman says. “With the Medicare
Shared Savings Program, I estimate 80 percent of ACOs do not break even because only a select few have been able to generate material Medicare savings. In addition, in most cases where commercial insurance companies are promising ACOs and other networks an increase in volume in exchange for deep discounts, the volume has not materialized as promised. I find in most cases the CFOs are the voice of reason since many of these reimbursement schemes just don’t pencil out.”

The line between reducing healthcare costs and increasing profit is clearer when a system takes actuarial risk for a population. In those cases, the system profits if the capitation revenue exceeds the cost to care for that population. But even that situation may be complicated: What if the fee-for-service revenue previously earned from that population exceeds the capitation revenue?

Given all those considerations, determining the financial impact of a population health initiative requires substantial analysis. Fortunately, Cincinnati Children’s has conducted that analysis.

According to its 2014 annual report, the organization’s income last year included $35 million in capitation revenue, about 1.7 percent of its total revenue. That revenue was from two Ohio Medicaid plans that paid the system to assume responsibility for the cost of caring for 35,000 children. Cincinnati Children’s calls that program the Health Network.

The Anderson Center’s total body of work has had a measurable impact on that group of individuals, according to Michael Taylor, MBA, FHFMA, vice president of revenue cycle management for Cincinnati Children’s.

“We have seen that since we have taken responsibility for this population, we have been able to reduce overall medical service expenses by 10 percent while providing these children with increased access to primary care and reducing their unnecessary use of the emergency department,” Taylor says.

Furthermore, Taylor says the hospital has analyzed the financial impact of the Health Network’s capitated model compared with maintaining the prior fee-for-service payment model for that population. “To date, the impact has been the same—so there has been no margin improvement, but also no negative impact on the margin,” Taylor says.

Taylor says the hospital plans to increase the number of lives for whom it takes responsibility: “Our goal is to expand it to cover all 150,000 children enrolled in managed Medicaid plans in Ohio in our service area.”

FARMERS IN NEED

Rhonda Strebel remembers the three generations sitting at the table in a Wisconsin farmhouse she visited early in her tenure as executive director of the Rural Health Initiative.

“I went there to do a health screening on a couple,” Strebel says. “I can see that the man’s blood sugar is elevated. I’m not a doctor so I can’t diagnose, but I can ask him questions. So I said, ‘Are you thirsty a lot?’ He said,
‘Of course I am, it’s summer.’ Then I ask, ‘Do you urinate a lot?’ He says, ‘Yes, I’m up all night.’ He had just been dismissing these signs. So I asked him numerous other questions like these and finally he said, ‘What’s going on?’ I said, ‘From the numbers it looks like you may be diabetic.’”

Strebel says the man, who was about 60, mentioned that his mother was diabetic, but he had never considered that he too might have been.

“And his adult son was sitting there at the table, and his sons, too,” Strebel says. “And they were having their carbohydrates for breakfast and soda to wash it down. And the son said, ‘What can I do?’”

Those were the magic words. Strebel counseled the family on diet and weight loss and referred the father to a physician. The man eventually lost 10 pounds and got his diabetes under control.

“Had I not done that testing at his kitchen table,” Strebel says, “he would have gone how long with that chronic disease unnoticed?”

The anecdote illustrates the effectiveness of the Rural Health Initiative, one of many community-based initiatives launched by ThedaCare, a health system in northeast Wisconsin.

“We knew in the late ’90s that we wanted to do more to affect community health,” says Paula Morgen, manager of community health for ThedaCare. “We were thinking, ‘We are the biggest healthcare organization in the area. Let’s get our doctors and professionals together and decide what to do in the community.’ That lasted about a year.”

Morgen says the organization soon realized it needed to work with the community to influence health care beyond its walls. A workshop at the American Hospital Association in 2000 solidified that resolve.

“We learned that you can’t solve a problem you don’t own,” Morgen says. “In our early model we thought we had the solutions, but when you look at what really affects health, only 20 percent of it has to do with the health system.

“Forty percent is socioeconomic factors like income, jobs, and community safety; 30 percent is lifestyle and behavior; and 10 percent is the physical environment. So if only 20 percent is attributed to the health system, we needed a model that involved all those other pieces of the pie. That was probably the biggest ‘aha’ moment.”

In 2001 the system launched the Community Health Action Team (CHAT). The primary activities of CHAT revolve around “plunges,” which are day-long field trips that allow 60 or so community members, ranging from elected officials and business owners to clergy and leaders of not-for-profit organizations, to investigate a particular community health challenge. The participants

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**CHILDHOOD ASTHMA: REDUCTION IN MEDICAID ADMISSIONS**

The exhibit shows the rolling 12-month average number of admissions per 10,000 Hamilton County, Ohio, Medicaid patients ages 2-17, as measured by Cincinnati Children’s Hospital.

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*Source: Cincinnati Children’s Hospital. Used with permission.*
travel in a school bus—helping them focus on the problem at hand rather than luxuriate in a charter bus—and visit places and people related to the given problem.

For example, the group has taken “plunges” into domestic violence by traveling to shelters to talk to victims, into the needs of the African-American community by visiting a church and local businesses owned by African Americans, and into the health challenges of rural residents by visiting farms.

“What we find is that the participants really get it, the lightbulbs go on,” Morgen says. “They start to understand problems in ways they could not from a boardroom. Secondly, the stereotypes of people in these situations fall to the wayside. They see that these are real people with real needs. Then they are really motivated to be part of the solution.”

The plunges are followed by meetings to contemplate the findings of the bus trip, and eventually by the formation of programs designed to address the issue, such as the Rural Health Initiative.

“What was happening was that our farmer friends were not coming to see the doctor soon enough,” Strebel says. “Furthermore, back in 2004, 14 percent of farm families had no insurance. With the Affordable Care Act most have insurance now, but it’s catastrophic-type plans.

“Farmers have too many assets to qualify for Medicaid-like programs. It looks on paper like they make too much money, but in essence they are very pocket-poor.”

The CHAT plunge to farms in 2003 revealed this problem. In subsequent discussions, one member of the group asked a farmer’s wife what would persuade farmers to visit the doctor.

“She said, ‘They are not going to come in. If you want to see them, you will have to come to the farm,’” Strebel remembers. “That was the ‘aha’ moment. Everything gets delivered to the farm—animal feed, veterinary care, etc.—so we said, ‘Why don’t we meet them where they are at?’”

Outreach coordinators with agricultural backgrounds and medical training visit farms in four counties in northeast Wisconsin. They come by invitation only, and perform what Strebel calls “kitchen wellness,” including asking the individual to answer a 30-item health questionnaire, taking blood pressure and other vitals, and drawing blood for a lipid panel. The results are delivered on the spot, and if signs of a serious problem emerge, the coordinator provides a reference to a physician or other care provider.

When appropriate, the coordinator goes beyond just providing basic results. “Farmers are very isolated,” Strebel says. “They may see no one other than family on a given day or week, other than maybe at church. So they don’t tell anyone, ‘My kids are out of control’ or ‘The wife and I are not getting along.’ But when you sit at the kitchen table with them, often these topics come up in a private conversation, especially if you have built up trust with them.”
When issues arise that may be addressed by other social services, the coordinators are ready with recommendations. “We like to know every resource that’s available to them in the community,” Strebel says. “There are a great deal of resources out there. But most are nonprofit organizations that don’t market themselves.”

Examining the financial impact. The Rural Health Initiative does not charge for its services, and payers are not involved. Half of the initiative’s $380,000 budget comes from healthcare organizations including ThedaCare and others that treat residents of the four counties. The other half comes from community fundraising.

The same general funding arrangement exists with most of the other programs that ThedaCare launched from the CHAT plunges. ThedaCare contributes money to two foundations, which in turn support CHAT initiatives.

“In the end these aren’t ThedaCare projects; they are community-owned,” Morgen says. More than 20 programs resulting from plunges are in operation, including programs that address mental health problems, domestic violence, and health issues common to the Latino population.

ThedaCare payment models are primarily fee-for-service, so a healthy community does not necessarily help its bottom line. But like any not-for-profit, ThedaCare has a community benefit requirement, and the CHAT programs help fulfill that requirement. Furthermore, the system is moving in the direction of population health, so any progress in that direction ultimately will help it perform better in such a model.

“Our long-term goal is for between 40 percent and 60 percent of our contracts to be risk- or value-based,” says Tim Olson, ThedaCare’s CFO. “We’ve slowly migrated toward these types of arrangements, the largest being our successful involvement in Medicare’s Pioneer ACO program.

“Today, close to 50 percent of our contracts have some risk elements with a fee-for-service base, most being small-upside-type agreements. Ultimately we do not benefit from less frequent visits, but we believe a population health approach is the expectation of our community and patients. If we are not doing this, we are not doing our job.”

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OTHER EXAMPLES OF UPSTREAM POPULATION HEALTH INITIATIVES

Community HUB and Pathways: This model, developed by the Community Health Access Project in Mansfield, Ohio, connects nurses, social workers, and other healthcare workers with at-risk populations. The program uses a risk checklist to identify problem areas, then connects participants to primary care providers, prevention programs, housing initiatives, educational opportunities, and other programs. Details: http://chap-ohio.net/press/

Health Leads: This program places service desks in healthcare organizations and staffs them with volunteers from area colleges. The physicians and other caregivers at the organizations “prescribe” food, heat, and other necessities to patients in need. The patients take the prescriptions to the Health Leads desk, where the student volunteers connect them with local resources. Details: http://www.healthleadsusa.org/

Healthy Homes East Bank: This organization, sponsored by three healthcare organizations and other groups in Des Moines, Iowa, helps families with children with asthma by repairing their homes and providing education to help them manage the condition. Details: http://www.healthyhomeseastbank.org/
AN INTERVIEW WITH TRISSA TORRES, MD

TAKING A COMPREHENSIVE VIEW OF POPULATION HEALTH

Health systems should look outside their own walls to develop new partnerships, says a leader of the Institute for Healthcare Improvement.

By Chris Anderson

The Institute for Healthcare Improvement (IHI) has a broad mission statement: Improve health and health care worldwide. In the United States, much of its effort centers on guiding healthcare organizations through the transition from fee-for-service to value-based payment models. At the core is the Triple Aim, which IHI defines as reducing the total cost of health care, improving the quality and experience of care, and improving the overall health of populations.

“Ultimately, driving toward improving the health of populations and communities depends on the role of the healthcare delivery system and all the changes we need to make,” says Trissa Torres, MD, senior vice president, who is responsible for executing IHI’s strategy in North America. “But we will also need to partner with many other entities because of all the other social determinants that impact the overall health of patients and communities.”

Torres, a preventive medicine physician by training, says improving the health of individuals, attributed populations, and even entire communities requires health systems to better understand the different factors that may affect patients’ health—housing, transportation, poverty, and mental health, among others.

PARTNERING FOR POPULATION HEALTH

While health systems understand that improving population health requires management of patients outside the care setting, Torres says, they need to look beyond the prevalent models. Appointing nurse case managers to help frail individuals may not hit the target, for example. “Nurses address the medical aspects of what that patient needs—medications, symptoms, and follow-up—but what they often miss is the loneliness, and it is the loneliness that is driving everything else,” she says.

To address this issue, a healthcare organization may look to form partnerships and relationships with area churches that have programs to spend time with shut-ins. Transportation can also be a significant roadblock for some patients, but that doesn’t have to mean starting a transportation business. Instead, healthcare organizations should take time to understand what resources are available in the community and how to effectively marshal them, as needed.

“What we really need to do is partner differently,” Torres says. “Where I think health systems and leaders are going to help us advance is by partnering with organizations and others that we have never even thought of partnering with to provide these things. We don’t need to do them ourselves, and we don’t necessarily need to pay for them directly. Initially, we just need to know they are available and make the connections. Ultimately we need to help ensure that resources flow to support these services over time.”

A BALANCING ACT

Making the transition to value-based care is not easy, but Torres thinks the process will rally the healthcare community. “We know we need to drive costs down,” she says. “But we also know that if we just focus on healthcare costs and don’t pay attention to quality, bad things happen. One of the reasons these new payment models that also focus on quality are so important is they provide an opportunity for us not to be in direct conflict with ourselves in terms of driving down costs.”

While decreasing payments will put health systems under pressure as they make the transition, looking for short-term revenue fixes may be misguided. Instead, Torres suggests health leaders focus on how they want to provide care differently to their patients and populations. That simple question puts the care model first and payments second, and the very act of putting patient care first will provide pathways for how to fund these activities in both the near and long term for a sustainable health system, she says.

“The key thing is for leaders to always bring meaning back to the equation: What is best for the patient and what is best for the community?” Torres concludes. “Because everybody can gather around that, and that is where you find the answers.”

Chris Anderson is a freelance writer.

Interviewed for this article:
Trissa Torres, MD, senior vice president, Institute for Healthcare Improvement, Cambridge, Mass. (ttorres@ihi.org).
Tell me a little bit about your organization.
TriMedx is a leading healthcare technology management organization that elevates clinical engineering through innovative programs and solutions. We are a vendor-neutral, third-party service provider for health systems that delivers impartial analyses and recommendations for capital equipment planning, medical equipment management, and healthcare technology service solutions. Created by and for healthcare organizations in 1998, TriMedx started as a clinical engineering department at St. Vincent Hospital in Indianapolis. Today, the company has more than 900 skilled biomedical, laboratory, and imaging technicians and managers and serves over 1,500 facilities globally, from large health systems to small clinics, surgery centers, and laboratories. TriMedx provides a cost-effective, low-risk model for hospitals to swiftly move toward clinical engineering excellence. We use your existing clinical engineering staff and advance their capabilities and skills by providing the training, technology, and teamwork necessary to achieve high performance.

What are some of the biggest challenges you see affecting healthcare organizations?
Hospital and vendor consolidation are bringing greater awareness to the potential savings opportunities that exist within nonclinical purchased services. Clinical engineering in particular is a significant cost contributor to this area. Whether in-house or outsourced, the clinical engineering function accounts for a deceptively large share of purchased services. Uncovering all costs associated with clinical engineering and consolidating this function can deliver up to 20 percent in cost savings. The biggest challenge lies in the fact that the clinical engineering spend has some of the toughest costs to uncover. For most health systems, the function is severely fragmented and the expenses tend to be spread across various departments in the general ledger.

Without knowing how to navigate these challenges, hospitals run the risk of incurring ongoing, escalating expenses in hidden areas and missing out on significant and sustainable savings opportunities. Often a root cause of high clinical engineering costs is poor management of service contracts or lack of planning around demand for services.

How does your product or service offering(s) help address these needs?
Over the years, TriMedx has led healthcare providers to considerable savings and newfound efficiencies that support high-quality care. We do this by decreasing medical equipment service costs while increasing uptime and response time without compromising care. Our approach is an insource model that augments the availability and expertise of internal staff, which immediately reduces reliance on costly vendor service contracts. Building on the skillset of your existing team, the transition to a fully insourced program is seamless, low-risk, and allows for improved service quality and patient safety—not to mention affords considerable cost savings for a hospital systemwide.

In addition, our proprietary computerized maintenance management system offers service and financial reporting tools that let hospitals monitor equipment performance, track program effectiveness, and meet regulatory standards. Users receive key device information, such as age and value; maintenance service

This TriMedx business profile discusses how to control costs and uncover savings opportunities by optimizing the clinical engineering function.
cost histories; preventive maintenance schedules; work order views; device reports; and inventories.

Also, when it comes to parts procurement, TriMedx is a leader. Our seasoned sourcing specialists manage the parts purchases and invoices for more than 10,400 purchase orders every month, giving us bulk purchasing power to obtain the best part for each repair based on quality, service cost, and uptime requirements.

Our dedicated regulatory compliance team ensures that customers receive expert regulatory guidance for all devices in their inventory. The team also facilitates instant electronic communication about safety recalls and alert notices that impact a hospital’s equipment.

What are some key considerations for healthcare leaders when choosing this type of product or service?

First, you must partner with a provider that is able to directly align with your hospital’s long-term vision. For example, if the organization’s goal is to be the leader in cardiac, cancer, or emergent care, then the service partner must be able to align capital planning appropriately to guide the purchase, service, and maintenance programs to support the organization’s objectives.

You should also consider access to resources. TriMedx utilizes the best technology in the clinical engineering service industry to deploy a comprehensive lifecycle management program that provides optimal savings and operational efficiencies with all medical equipment. Our state-of-the-art, computerized maintenance management system is the most innovative, comprehensive, and reliable platform in the industry. It provides our team with real-time data so we can best manage healthcare equipment maintenance and repair requests. Because we have information on all of an organization’s inventory available at the touch of a finger, TriMedx has some of the fastest call response times in the industry.

As healthcare organizations implement use of your product or service into their day-to-day operations, what advice would you offer so they can best set themselves up for success?

Uncovering the true spend is the first step to centralizing clinical engineering. The TriMedx process begins with our staff performing a current state assessment to understand an organization’s true medical equipment spend and identify savings opportunities. This process is important because it is so easy for clinical engineering costs to remain hidden because of miscoding and the function’s decentralization throughout many departments. A current state assessment looks at all costs both listed in clinical engineering and in each department in the general ledger. We also manually track down hard copies of every service agreement throughout the facility. Once the assessment is complete, you have an overview of the clinical engineering program’s current state as well as an idea of how to most effectively move to a centralized process that will immediately reduce costly service contracts, improve medical equipment uptime performance, and ultimately increase patient throughput—all of which lead to reduced non-clinical purchased services spend and improved savings.

Are there any educational materials you would like to share to help healthcare providers in these efforts?

Yes, we offer several useful tools on our TriMedx.com website, including two white papers addressing cost containment and improved throughput: Reducing Costs and Increasing Throughput through Non-Clinical Purchased Services and Five Ways Comprehensive Lifecycle Management Can Help Reduce Total Cost of Ownership.
BUILDING MEANINGFUL INCENTIVES IN VALUE-BASED CONTRACTS

As value-based contracts become more prevalent in health care, many organizations are experimenting with innovative strategies to ensure quality and financial incentives align properly.

By Laura Ramos Hegwer

Years ago, contracting primarily was left to the contracting department. Yet since the advent of value-based payment contracts, healthcare organizations increasingly have relied on multidisciplinary teams to help shape the design of these programs, including how quality and financial incentives are aligned.

One reason is that providers are wary of repeating the same mistakes they made in the past. “In the early 1990s, many provider organizations that negotiated capitated agreements with payers failed because they didn’t understand population management agreements,” says S. Patrick Hammond, CEO, Emory Healthcare Network, and chief market services officer, Emory Healthcare, Decatur, Ga. “Although a contract may have sounded reasonable because it was based on averages, the reality is that no population is based on averages.”

BRINGING TOGETHER THE RIGHT TEAM
To help vet population-based contracts, Emory’s contracting team has expanded to include an outside actuary, who helps leaders understand actuarial trends, how data are risk-adjusted to reflect patient severity, and the financial ramifications of the agreement. Emory’s CMO/chief quality officer also is on the negotiating team. “He can tell us if a metric will be meaningful to the doctors,” Hammond says.

BY THE NUMBERS

10%
Portion of bonus for Emory Healthcare Network’s primary care physicians that hinges on overall ACO performance.

25
Quality measures, out of a starting list of more than 200, selected by Northwell Health for use in value-based contract talks.

65%
Portion of Dartmouth-Hitchcock’s unique primary care patients who are attributed to an ACO or risk-based model.
**Find the right structure.** Emory Healthcare Network, which includes 1,800 physicians and six hospitals, moved from contracting via a clinically integrated network (CIN) to a commercial accountable care organization (ACO) model in 2014. “When we looked at how much we were going to earn under a CIN agreement, it really wasn’t sufficient to justify the investments in infrastructure and the dollars that would be moving out of fee-for-service,” Hammond says. “So we jumped in sooner with an ACO to take more upside and downside so we could negotiate to retain a higher percentage of what we saved.”

Today, Emory’s ACO is piloting population health management agreements with Blue Cross and Blue Shield of Georgia to manage 35,000 members. The ACO demonstrated a 25 percent improvement on 37 quality metrics collectively and cut medical costs by 3 percent in CY14. The health system is piloting a similar program with Aetna that includes 17,000 members.

**Create a tiered approach to align incentives.** To cascade the goals of its population-based contracts down to its physician practices, Emory Healthcare Network has created a tiered incentive plan. Ten percent of the bonus for primary care physicians hinges on overall ACO performance. Approximately 20 percent is based on how the physicians’ local health network performs against quality and cost targets (the ACO is comprised of six local health networks). The remaining 70 percent reflects individual performance based on approximately 25 metrics that are used to calculate an individual score.

**Pursue a solution for specialists.** “With primary care, you can basically attribute membership back to the primary care physicians, and they have a lot of direct impact on the measures,” Hammond says. “Assigning a patient to specialists is a much bigger challenge because the number of attributed patients they treat is much smaller.” Another issue is that most quality metrics in payer arrangements are claims-based, but metrics for specialties should be based on medical record data because such data offer a deeper level of clinical information, Hammond says. Although the incentives are still somewhat broad for specialists, leaders at Emory Healthcare Network are in discussions with payers regarding how they can structure their metrics more accurately using electronic health record (EHR) data.

**MAKING CONTRACTS ACTIONABLE**

Northwell Health (formerly known as North Shore-Long Island Jewish Health System), a 21-hospital,
$8 billion health system based in Great Neck, N.Y., currently manages 200,000 lives in value-based contracts with government and commercial payers. The organization also has shared savings arrangements with many managed care companies, including Humana, Aetna, and Empire Blue Cross and Blue Shield.

Rich Miller, senior vice president, payer relations and contract development, and his team have developed an extensive template for evaluating every proposed population health arrangement. When reviewing a contract, some of the questions they consider include:

- What is the proposed member attribution model?
- What are the opportunities to mitigate risk? For example, is there an outlier provision or a risk-adjustment provision?
- Are there minimum savings thresholds?
- What are the measurement periods?
- How are baselines and targets determined?

**Involve physician leaders.** Once the template is complete, Miller’s team shares it with the health system’s value-based payment model work group, which includes physicians and leaders from finance, care management, managed care, legal, and IT who review value-based arrangements in the contracting phase. “We thought it was imperative to get clinical input up front before any of these value-based contracts were executed,” Miller says, adding that it is not always a nimble process: “It typically takes months to vet a contract, but we feel very strongly that we shouldn’t enter into an arrangement unless we are comfortable that the provisions serve all the parties involved, including patients.” The work group also meets biweekly to review how current value-based programs are performing and to suggest clinical and operational changes that may be needed.

Two years ago, Northwell Health also formed a multidisciplinary pay-for-performance task force at the health system level to provide feedback on quality performance measures included in value-based contracts. Most members are physicians, although some are leaders from finance, IT, and provider network operations. “The physicians are so passionate about this that in some cases, they have asked us to set up conference calls with payers to make the case with the clinical leadership of a health plan regarding how a measure was being used,” Miller says.

**Develop a preferred list of measures.** Getting convergence on the measures used by different payers in these contracts is a challenge for many organizations. “We’ve accumulated more than 200 different measures, and some are similar measures just calculated differently,” says Joseph Schulman, executive director of Care Solutions. Northwell Health, suggesting that providers incorporate a preferred list of metrics in their contracts.
Solutions, Northwell Health’s new care management organization, which is responsible for the performance, management, and implementation of risk-based contracts and population health management programs. To that end, Northwell’s pay-for-performance task force developed a list of approximately 10 inpatient and 15 outpatient measures that clinicians felt were aligned with the organization’s quality agenda. Whenever possible, the contracting team incorporates the preferred list of measures in the organization’s value-based contracts.

**Appeal to providers.** To ensure provider engagement, Northwell Health has developed a provider incentive program that recognizes performance on quality metrics as well as care coordination. “These endeavors lend themselves to alignment because exceptional outcomes for patients is the measurement of success in these programs, and that is what is most appealing to our providers,” Schulman says.

**CREATING ALIGNMENT FROM THE TOP DOWN**

The success of population health programs depends on having incentives that reflect organizational goals at every level, says Cathy Jacobson, CPA, president and CEO, Froedtert Health. “You have to make sure that all of your incentives are aligned through your corporate goals, your system goals, and ultimately your contracts.”

Froedtert Health and the Medical College of Wisconsin (MCW), both based in Milwaukee, have created an affiliation in which they set system goals together (Ramos Hegwer, L., “How Healthcare Organizations Can Strengthen an Affiliation Without Merging,” *hfm*, April 2015). Froedtert Health and MCW also belong to the eight-member Integrated Health Network (IHN) of Wisconsin, an accountable care network that is exploring risk-sharing and population management strategies with employers and payers. The network includes 45 hospitals and 5,700 physicians. Each member of IHN develops its own physician compensation model to create incentives that can drive change. At Froedtert Health, 10 percent of community-based physician compensation is at risk for a variety of clinical and financial measures.

**Create a value council.** As part of their affiliation, Froedtert Health and MCW have formed a joint healthcare value council, which is led by the enterprise CMO and includes physician leaders from the community physician practice and the academic physician practice. The CMO, who also sits on the IHN clinical integration committee, is responsible for making sure that the physician practices’ goals align with IHN’s goals and for offering feedback on contracts. “Through IHN, we’ve had some great conversations with commercial payers on how certain diabetes metrics they are using are being replaced in the medical literature, and we have suggested newer metrics instead,” Jacobson says. “That speaks to the power of a network. They might not have listened to us if it was just Froedtert and MCW.”
Focus on quality performance. IHN is finishing its second year of participation in a shared savings contract covering United Healthcare’s commercial population in the region. Froedtert’s finance team worked with IHN’s finance council to determine how shared savings would be distributed to members after IHN meets its network-wide goals. “The debate centered on how much of the reward should be based on financial performance versus quality,” Jacobson says. “We decided to increase the shared savings that a member would earn back based on quality metrics. Because we are a member of the Wisconsin Collaborative for Healthcare Quality, which publicly reports quality metrics, we thought our focus on quality performance should be increased.”

FOCUSING ON POPULATION HEALTH
At Dartmouth-Hitchcock, an academic health system with more than 1,200 physicians based in Lebanon, N.H., the system’s physicians are salaried, although their compensation is still based on relative value units (RVUs) to measure productivity. This approach means clinicians, particularly specialists, may see value-based care as the “flavor of the month,” says Lynn M. Guillette, FHFMA, CPA, vice president of finance, payment innovations. “Right now, some specialists don’t see how these value-based payment models really affect them,” she says. “The challenge is to help them understand that this is not a gatekeeper model, but rather primary care and specialists working together to make sure patients’ needs are met in the most cost-effective manner possible.”

Build on early success. From 2005 to 2010, Dartmouth-Hitchcock was one of 10 providers that participated in the Medicare Physician Group Practice (PGP) Demonstration, which created physician incentives to improve quality and reduce the total cost of care for a set of Medicare patients. The model is considered a forerunner to the ongoing Medicare ACO models. During its participation in the PGP demonstration, Dartmouth-Hitchcock began the difficult but necessary work of reorienting how it delivered primary care to better manage this set of patients. Dartmouth-Hitchcock did not set out to create patient-centered medical homes (PCMHs) through the transition process, as that model had yet to be widely adopted, but the practice transformations resulted in PCMH-type practices nonetheless, Guillette says.

In 2008, Cigna approached Dartmouth-Hitchcock about piloting a PCMH program for its commercial members. Today, the program has evolved into the Cigna Collaborative Accountable Care program, an upside-only model that involves more than 100 health systems across the country. Dartmouth-Hitchcock in 2010 entered into a two-sided risk contract with Anthem based on quality measures, and inked a similar agreement with Harvard Pilgrim Health Care in 2011. In 2012, Dartmouth-Hitchcock became one of 32 Pioneer ACOs. Today, 65 percent of the health system’s unique primary care patients are attributed to an ACO or risk-based model.

“Aligning incentives is likely to become a more widespread concern as efforts to improve value and achieve the Triple Aim become more prevalent.”

Create a new division. To support these contracts, Dartmouth-Hitchcock has launched a population health management division, headed by a chief population health officer who is also a physician. Dartmouth-Hitchcock’s contracting department works closely with the chief population health officer and the clinical operations, quality, and analytics teams to vet contracts and determine whether the metrics included are realistic. “Typically, these metrics are still not negotiable with payers, so if there is one metric that we don’t collect or buy into, we want to make sure there are enough other measures to offset it,” Guillette says. For example, Dartmouth-Hitchcock is an early adopter of new mammography screening guidelines from the U.S. Preventive Services Task Force that do not recommend yearly mammograms for women ages 40 to 50 without a family or medical history of breast cancer. Most payers have not adopted these guidelines. “We are not always able to get agreement with payers because we may have adopted a different approach based on more current science,” Guillette says. In such cases, the organization will move forward with a contract only if there are other metrics that are actionable.

A PAYER’S POINT OF VIEW
Back in 2008, Blue Shield of California, San Francisco, laid the foundation for one of the country’s longest-running ACOs, serving members of the California Public Employees’ Retirement System (CalPERS). Blue Shield of California’s partners in the ACO, which is active today, are Dignity Health, the largest hospital provider in the state, and Hill Physicians, a practice with 3,800 providers.

Create a global budget. To create financial alignment across all partners, ACO leaders established a global budget and risk-sharing elements tied to mutually agreed-upon metrics (Markovich, P., “A Global Budget
While the partnership with CalPERS was a significant pilot project, the three ACO partners provided an immediate premium credit that totaled $15.5 million, sharing both upside and downside risk for total health care expenditures. Each partner’s level of risk—that is, the portion that a partner must cover if the ACO misses the savings target—was based on its ability to influence per member per month costs in areas such as ancillary services, pharmacy, and professional services.

**Offer and solicit input.** “Initially, we took the lead in designing how the financial arrangement would work and how the clinical engagement would work,” says Kristen Miranda, senior vice president, strategic partnerships and innovation, Blue Shield of California. “But since then, we have had considerable input from our ACO partners that has led us to refine our model over time.” At the start, the model was focused on improving care coordination, as well as reducing readmissions and avoidable bed days. The partners since have expanded their focus to include ambulatory programs, such as home care and palliative care.

Blue Shield of California today has 26 ACOs across the state, managing care for more than 325,000 members, each involving a physician practice and most involving at least one hospital or health system. “Because the populations are so different and the systems’ initial levels of performance and sophistication are so different, we’ve had to tailor the programs to meet our partners’ needs,” Miranda says.

**Establish a forum for clinical leaders.** To help design meaningful incentives, Blue Shield of California has established an ACO quality council comprised of clinical leaders from most of its ACOs. “We’ve let a lot of our provider partners drive the discussion on which metrics matter,” Miranda says. “We recognize that we can’t have ACO leaders across the state managing to a completely different set of metrics for Blue Shield than they are for other insurers.”

The health plan also shares unblinded quality data across all of its ACOs to encourage providers to share best practices.

**LESSONS LEARNED**

Aligning incentives is likely to become a more widespread concern as efforts to improve value and achieve the Triple Aim become more prevalent. Healthcare leaders who are on the front line of negotiating value-based contracts and developing population health management programs suggest the following strategies.

**Build a better contract.** “Value-based care starts with a culture that supports innovation, and it requires collaboration, and contracts can help move people toward that transformation,” says Jeff Micklos, executive director, Health Care Transformation Task Force, Washington, D.C.
The task force represents provider, payer, patient, and purchasing organizations dedicated to shifting 75 percent of their business into value-based agreements by 2020.

The task force recently published an action memo on key elements to consider in ACO agreements (available at www.hctff.org). The memo includes some of the financial issues that should be covered in ACO agreements:

- A statistically sound, financially transparent model designed so all providers can participate
- A clear division of financial responsibility between all parties involved
- Access to raw patient claims data and prescription drug claims data, if included in contracts
- Periodic contract reviews that allow for midcourse corrections to make sure everyone is properly incentivized
- A performance period that spans several years, allowing the ACO enough time to build the programs and tools it needs to succeed

“Whatever the financial structure of a contract is, it should have two options available,” Micklos says. “One model should be based on historical claims, which is more effective for moving high-cost providers into structures that decrease costs. The other model should be based on regional cost trends so providers can continue to become more efficient.” Ideally, an ACO that starts in the first model would shift to the second model over time, he adds.

Work toward a consistent set of measures. One of the task force’s goals is to bring together members so they can whittle down the number of measures that have emerged from private-payer, Medicare, and Medicaid population health management programs.

“We need a more streamlined, consistent set of metrics across all payers and health systems, recognizing that there will need to be some variability depending on the patient population,” Micklos says. He believes the right measures should be based on quality outcomes, rather than process measures, which are less likely to drive improvements in care.

Focus on cost targets. “The initial development of the cost target or benchmark is critical,” Dartmouth-Hitchcock’s Guillette says. “What you think is true about the initial benchmark may not be true if your ACO changes in size or composition.” Dartmouth-Hitchcock left the Pioneer ACO program in 2015, having entered in 2012 and lost more than $3 million in 2013-14. Guillette says the Pioneer ACO model was not flexible enough to accommodate changes in participating providers, including one year in which Dartmouth-Hitchcock doubled the size of its ACO by adding three nonaffiliated health systems. “In essence, we had three different ACOs year after year,” Guillette says.

Charge an executive team with governance over the agreement. “The team can provide clear accountability and a process for escalating issues,” says Miranda of Blue Shield of California. “There will be issues that come up, and you have to have the kind of provider-payer relationship where you can determine what adjustments need to be made when things don’t go as planned,” she says.

Include specific data-sharing terms in the agreement. The agreement should include the frequency and timeliness of data transfer, as well as the content that will be transferred, Northwell Health’s Miller says. “In our contracts, we have started to include the specific field level that should be included in the claims data that are transmitted to us,” Miller says.

Emory Healthcare Network requires that all payers in its shared savings agreements provide a monthly download of claims data on all patients attributed to the network’s primary care physicians. “It may take more than a year into the contract to get consistent, accurate data feeds from payers,” says Hammond of Emory Healthcare Network. “It’s one of the biggest challenges we have as providers.”
“When choosing partners to carry out population-based contracts, HCSC looks for strong physician leadership at the practice level. Among hospital-based partners, HCSC also values executive leaders who have invested in clinical and programmatic changes to better manage populations.”

Build an IT infrastructure for sustainability. “Sharing performance data only gets you half of the way there,” says Froedtert’s Jacobson. “You need to support practices to help them do the work.” Such support includes hardwiring inpatient protocols that reduce variation in physician practice, as well as building the right IT infrastructure.

Emory Healthcare Network requires physicians to have one of a select list of certified EHRs that can connect to the network’s health information exchange. This cohesion allows providers to connect to Emory’s cloud-based support tools, which include disease registries that help physicians see care gaps in real time during the patient visit.

Create a population health management university. Recognizing that the skills needed to manage populations are different from managing acute episodes, Emory Health Network has created a yearlong program that prepares practices to apply for certification as Level III PCMHs from the National Committee for Quality Assurance. Ten practices are enrolled in the program, including a neuroscience practice that aims to become a medical home for Alzheimer’s patients.

Understand payers’ perspectives. “The biggest challenge for us is engaging with provider partners who understand that our customers are demanding not just a lower trend, but a lower absolute price point—and without sacrificing continuous improvements in clinical quality, patient safety, and service,” says H. Scott Sarran, MD, senior vice president and CMO, government programs, Health Care Service Corporation (HCSC), Chicago.

When choosing partners to carry out population-based contracts, HCSC looks for strong physician leadership at the practice level. Among hospital-based partners, HCSC also values executive leaders who have invested in clinical and programmatic changes to better manage populations. “If they have not started to make changes in how their executives and physicians are compensated—for example, if physicians are still compensated on a pure RVU basis—it is hard to see how they are going to succeed out of the gate.”

PREPARING FOR THE FUTURE

Despite the challenges of aligning quality and financial incentives in value-based contracts, Guillette of Dartmouth-Hitchcock believes providers should feel encouraged. “Although there is no perfect model yet, these models are heading in the right direction,” Guillette says. “If you look at the quality outcomes from these models, you can tell we are making a difference for patients.”

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Interviewed for this article: S. Patrick Hammond, CEO, Emory Healthcare Network, and chief market services officer, Emory Healthcare, Decatur, Ga. (Patrick.Hammond@emoryhealthcare.org); Rich Miller, senior vice president, payer relations and contract development, Northwell Health, Great Neck, N.Y. (RiMiller@NSHS.edu); Joseph Schulman, executive director, Care Solutions, Northwell Health, Great Neck, N.Y. (jschulma@nshs.edu); Cathy Jacobson, CPA, president and CEO, Froedtert Health, Milwaukee (Cathy.Jacobson@froedtert.com); Lynn M. Guillette, FHFA, CPA, vice president of finance, payment innovations, Dartmouth-Hitchcock, Lebanon, N.H. (Lynn.M.Guillette@hitchcock.org); Kristen Miranda, senior vice president, strategic partnerships and innovation, Blue Shield of California, San Francisco; Jeff Micklos, executive director, Health Care Transformation Task Force, Washington, D.C.; H. Scott Sarran, MD, senior vice president and CMO, government programs, Health Care Service Corporation, Chicago.
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In the wake of a new Institute of Medicine report on diagnostic errors in health care, four prominent experts discuss how to bolster patient safety.

By Lauren Phillips

According to the Institute of Medicine (IOM) report *Improving Diagnosis in Health Care*, released in September, most people are likely to experience at least one diagnostic error in their lifetime—sometimes with devastating consequences. Diagnostic error, defined in the report as “the failure to (a) establish an accurate and timely explanation of the patient’s health problem or (b) communicate that explanation to the patient,” has widespread consequences:
- It is experienced by some 5 percent of U.S. adults who seek outpatient care.
- It accounts for 6 to 17 percent of hospital adverse events.
- It contributes to 10 percent of patient deaths.
- It is the leading type of paid medical malpractice claim.

Systemic causes of diagnostic error include inadequate collaboration and communication among clinicians, patients, and their families; a work system not designed to support the diagnostic process; limited feedback about diagnostic performance; and a culture that discourages transparency and disclosure of errors. Other
LEADERSHIP WINTER 2016

The IOM talks about cognitive biases being at the root of many diagnostic errors. What are these, and what can we do about them?

Graber: They’re the same kind of mistakes we all make in our everyday lives; it’s just that doctors are making them in a high-stakes environment. Our intuition does a great job, but every once in a while it will lead us astray. Three of the most common and troublesome ‘biases’ in medicine are framing and context biases (for example, a patient who complains of pain in the stomach area makes us tend to think the cause might be gastrointestinal, when really it’s something else entirely), premature closure (the tendency to be happy with the first plausible diagnosis that comes to mind, without considering other possibilities), and various confirmation biases (for example, we tend to favor evidence that’s consistent with our initial diagnosis and discount evidence that might suggest something else).

If every time we came up with a diagnosis, we stopped and asked ourselves what else it could be, this would tend to counteract all three of these bias tendencies. Constructing a differential diagnosis would accomplish the same thing, as would taking advantage of one of the several excellent web-based, differential-diagnosis programs that can provide suggestions in just a few seconds. When you’re really puzzled about a case, you’re going to automatically slow down, maybe do a little reading or get a consult; it’s when you’re making a very common diagnosis on the basis of very familiar symptoms that you need to double-check your thinking.

In the same way surgeons use checklists, physicians might benefit from using a checklist for diagnosis:

- Obtain your patient’s history yourself.
- Perform a focused, purposeful exam.
- Take a “diagnostic time-out” to ask yourself some questions. Was I comprehensive? Did I consider the inherent shortcomings of using my intuition? Was my judgment affected by bias? Do I need to make the diagnosis now or can it wait? What’s the worst-case scenario? What else could this be?
- Embark on your treatment plan, but ensure follow-up and feedback by making the patient an active partner in the diagnostic process.

The IOM concluded that solving the problem requires a broad focus on improving diagnosis. Toward that end, the institute has issued eight recommendations for hospitals and health systems, physicians, IT vendors, regulatory bodies, educators, and patients:

- Facilitate more effective teamwork in the diagnostic process among healthcare professionals, patients, and their families
- Enhance healthcare professional education and training in the diagnostic process
- Ensure that health IT supports patients and healthcare professionals in the diagnostic process
- Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near-misses in clinical practice
- Establish a work system and culture that support the diagnostic process and improvements in diagnostic performance
- Develop a reporting environment and medical liability system that facilitate improved diagnosis through learning from diagnostic error and near-misses
- Design a payment and care delivery environment that supports the diagnostic process
- Provide dedicated funding for research on the diagnostic process and diagnostic errors

Leadership spoke with four experts who are intimately involved in bringing this change about:
Singhal: We need to teach medical students and physicians about critical thinking, about how to overcome cognitive biases. For example, we know that premature closure is one of the most common causes of diagnostic error: Once a diagnosis is made, thinking stops, whether it’s an ED [emergency department] physician accepting the diagnosis of a patient’s primary care practitioner or an attending accepting the diagnosis of an ED physician. While you respect that opinion, you need to consider other possibilities, especially if you have new information.

I’m personally susceptible to authority bias—as a hospital-based general pediatrician, I work with a lot of subspecialists, and early on I might have disregarded internal misgivings if one of them said a patient had a particular condition. Now I’ve learned to take that recommendation into account, but also to listen to my own experience.

Grabber: The first thing is that healthcare organizations need to start finding diagnostic errors and studying them and thinking and talking about them. Right now the tools—both process and technological—that hospitals have to detect patient safety problems don’t pick up diagnostic errors.

There are some pilot programs. There’s one in Maine Medical Center, where one of the hospitalists told his colleagues, “I’m interested in diagnostic error; please tell me about the cases you think are candidates.” In six months, he got 36 reports of errors, none of which were detected by the usual safety-monitoring tools in operation at the time. All it took was a champion.

Start encouraging second opinions, and make it easier to get one—one way is to enlist and promote physician volunteers interested in providing second opinions. Spend a tiny bit of money and make those web-based differential-diagnosis programs available. Get proactive about feedback: Bring back autopsies and close the loop on diagnostic test results—send them to patients and monitor how many critical results are acted on within 30 days. Empower nurses to ensure tests get done, facilitate communication between patients and physicians, and monitor for new and resolving symptoms.

Singhal: Number one is raising awareness. One of the best ways to do this is with grand rounds, which have great reach—our invitations go out to about 400 people in and outside the hospital—and great impact, because they’re typically used to deliver cutting-edge information. This is a powerful way to deliver a message.

One interesting model is Harvard and its affiliated hospitals’ use of a malpractice company to educate their physicians in diagnostic error. Because at least initially a lot of the data about diagnostic errors came from malpractice claims, and usually if an attorney’s speaking, a physician is going to listen.

Schiff: Holding M&M [morbidity and mortality] conferences where clinicians follow up on missed or mistaken diagnoses can be quite successful, but organizations have to establish a culture of patient safety, where everyone is passionate about sharing and learning together from mistakes and physicians feel safe from punitive action.
Another thing we can do is close the feedback loop, perhaps by having nurses call patients two days after they are seen in the ED. We’ve been experimenting with an interactive voice response system in a variety of ways. This might mean the patient gets a call that says, “This is Brigham and Women’s Hospital following up on your visit with Dr. Schiff: Press 1 if you’re better and 2 if you’re not better.” If they press 2, they get to speak with a nurse. However we do it, the key, in addition to helping the patient, is to use such feedback to create learning systems, hardwiring follow-up both literally and figuratively.

Kanter: We have implemented two programs to improve diagnosis in ambulatory care that have proven to be very effective. One is our Sure Net program, which uses electronic clinical surveillance to identify potential lapses in the diagnostic process, such as by monitoring patients on medications, reevaluating high-dose acetaminophen prescriptions, and following up on abnormal prostate-specific antigen (PSA) smears. That last example is one of our biggest successes out of almost 40 Sure Net programs; we do about 50,000 screening PSA tests a year, and in a three-year period Sure Net identified 8,076 patients who looked like they needed some kind of follow-up; 3,833 got a urology appointment, 2,200 underwent biopsy, and we found 745 cancers. We can’t really translate that into lives saved, but clearly the program has made a difference. We used to have a couple of lawsuits a year over the failure to catch prostate cancer, and since we started it we’ve had none.

The other thing we did was establish a centralized reading center for diabetic retinopathy (DR) imaging, in which specially trained certified ophthalmological assistants and technicians read all the images from 13 medical centers under the supervision of a retinal specialist. Previously, we had significant unexplained variation among our medical centers in the rate of DR diagnosis, suggesting there was some misdiagnosis even though we could not identify exactly which patients might have been affected. As a result of our centralized reading center, the variation in the rate markedly decreased and our DR prevalence went from 10.1 percent of those tested in 2009, far below the national average, to 22.1 percent in 2012—meaning we caught more cases of DR, which is the leading cause of blindness among adults.

How can providers encourage patients to become partners in the diagnostic process?

Kanter: One thing is giving them access to their own information. Our patients can see their lab results, their problem list, their medication records, etc., on our patient portal. Another tool on that portal is their online personal action plan, which lists what care elements they need and how to get those things done; for example, it will say you need a mammogram and here’s the phone number to call to schedule that. Patients actually get an email alert to log on and see what they’re missing.

On our appointment reminder cards, we can inform patients that it’s important to make sure they understand their diagnosis when they see the doctor and what they should be doing. After a visit, they also get a plainly written summary of everything that went on in the visit.

Singhal: We also need to empower patients and their families to question the doctors. At Texas Children’s, we have a rapid response team that we can call if a
How can electronic medical records (EMRs) be used to help cut down on diagnostic errors?

Schiff: I think the most obvious way is access to data. If an EMR is searchable and properly organized and interoperable—which, unfortunately, most are not—you can quickly find biopsy reports and medication lists and records from other hospitals, all of which are important in making an accurate diagnosis. For example, if someone has a low platelet count, the EMR could remind me that the patient is on a drug that can lower platelets.

We certainly have a long way to go to make the EMR more efficient in terms of input efficiency and information display. For example, it would be useful if we could use our electronic notes to think out loud—What do I think is going on with this patient? What is the differential diagnosis? What am I unsure about?—and share that information with our colleagues. If your diagnostic assessment is buried in 10 or 20 pages of pasted-in data, it’s going to be hard to locate and not terribly useful.

Another aspect of this is transparency, so someone else can come along and see in my differential diagnosis that I haven’t considered something—or that I indicated I was uncertain. It would be great, for example, if every admitting note from the ED would say not just, “I think this person has a pulmonary embolism,” but also how certain that physician is in his or her diagnosis.

Whether current EMRs are helping or hindering our communication is still an open question. It may be that the most potent source of clinical decision support that EMRs now provide is streamlined access to information—for example, electronic textbooks such as Up-to-Date or Dynamed. It turns out that about half the time, doctors end patient encounters with unanswered questions—What are the causes of shortness of breath and blood in the urine? Can X actually cause Y?—they would like to follow up on but often don’t, because they simply don’t have the time.

Grabber: Providers should take advantage of every opportunity to encourage patients to speak up, to ask questions: What else could this be? What should I expect? When and how should I follow up if symptoms persist or worsen? What resources can I use to learn more? Is this test worthwhile—can we wait? We should encourage them to keep good records of their symptoms and how they respond (or don’t) to treatment, their medications, and their test results.

child is getting sicker; someone from the ICU [intensive care unit] will come up and provide a consult. A physician or nurse can call this number, but so can a parent.

One thing that’s really important to me as a pediatrician is whether the parents agree with my diagnosis. I look for non-verbal cues from parents, and then I might say, “Mrs. Smith, you’re the expert on your child, does this make sense to you?” I think the same thing would be especially useful with families of geriatric patients.
What other technological tools could play a part in improving diagnosis?

Schiff: Taking this deployment of technology a step further, one could imagine ubiquitous real-time telemedicine, using the camera on our computer: I see an unusual lesion on somebody’s leg, and I hit a button and the dermatologist is there to weigh in.

I’m a big believer in voice-recognition technology. The accuracy has gotten remarkably higher in recent years, and it’s likely to play a big role in recording clinical history and assessments. This will make it easier for us to maintain eye contact with patients rather than having to look at the screen, which is helpful if you’re trying to engage them in coproducing a diagnosis.

One project we’ve been working on is including the indication, the why, in drug prescriptions, so we can link all the medications a person is taking to each diagnosis and make mistakes stand out. We’re trying to use this as a safety check and a patient education vehicle; it could also help inform clinicians why somebody is taking a particular medicine and be a cross-check on diagnosis to make sure the doctor and patient are on the same page.

Are you optimistic that the healthcare system can reduce the prevalence of diagnostic errors?

Graber: The first step is for healthcare leaders and professionals to accept that we have a problem with diagnosis. There’s been an assumption that we’re doing OK here, and there is a good basis for that assumption: It is a testament to the quality of our physicians and healthcare organizations that the correct diagnosis is reached around 90 percent of the time, because there are over 10,000 diseases and uncertainty is a constant at every step of the diagnostic process. But given the harm that we know ensues from diagnostic error, we really need to do better, to get to 92 percent, then 95 percent, as quickly as we can. I think that’s very doable—so many of the problems we’ve identified are preventable.

Schiff: I’m optimistic, with qualifications. We’re moving toward being able to use the EMR to get real-time support, reminders, help, and communication, but at the same time we’re also moving in the opposite direction with information overload and inefficient work flows. The EMR was supposed to make charting more efficient, yet to date it’s had quite the opposite effect. These things have seemingly not been priorities for the EMR vendors. But the transformative potential is there, and we’ve outlined more than a dozen ways we need to challenge the EMR and electronic documentation to live up to that potential. +

Lauren Phillips is president of Phillips Medical Writers, Ltd., Bellingham, Wash., and a frequent contributor to Leadership (lauren-don-phillips@comcast.net).
AN INTERVIEW WITH NEAL SIKKA, MD

TAKING TELEHEALTH FROM SHIP TO SHORE

This physician is adapting telehealth expertise developed for the maritime industry to improve follow-up care for emergency department patients.

By Lola Butcher

Improving value in health care requires contributions from throughout an organization, and the Department of Emergency Medicine at The George Washington Medical Faculty Associates (MFA) has empowered its clinicians to turn their ideas into action.

With more than 750 providers, MFA is the largest independent physician practice in the Washington, D.C., metro region. The multispecialty practice is affiliated with The George Washington University and the GW Hospital.

Emergency physician Neal Sikka, MD, leads his department’s Innovative Practice and Telehealth section, which leverages physician skills beyond the hospital and clinic settings. For example, the section provides emergency medical services at marathons and, via telehealth technology, health services for corporate executives traveling in remote locations.

Designed to create new revenue streams, the department’s entrepreneurial efforts were established long before the healthcare industry started emphasizing value-based care. Now that all provider organizations must figure out how to reduce costs while improving patient outcomes, Sikka and his colleagues are well-positioned to contribute innovative ideas.

“We’re trying to use these experiences to see how they apply to population health,” he says.

STARTING WHERE YOU ARE

For example, MFA emergency physicians have been treating patients onboard ships via telemedicine since 1989, but they have not offered telehealth access to their regular patients—until now. The organization’s new ConnectER program helps reduce unnecessary emergency department (ED) use by patients after an initial ED visit.

ConnectER leverages MFA’s Worldwide Emergency Communication Center, the call center built to support the practice’s maritime telehealth program. The call center is staffed by emergency medical technicians who greet patients when they call in and complete their consent process. Then the technician connects the patient with an ED physician, who conducts an online consult, using HIPAA-compliant technology platforms, for a flat fee of $35.

CUTTING DOWN ON REPEAT VISITS

Ideally, of course, patients would receive follow-up care from a primary care provider. But many patients do not have a regular provider or cannot get an appointment in timely fashion. Research suggests that more than 8 percent of patients return to an ED within three days of an initial visit, and nearly 20 percent do so within 30 days (Dusjea, R., et al., “Revisit Rates and Associated Costs After an Emergency Department Encounter: A MultiState Analysis,” Annals of Internal Medicine, June 2, 2015).

ConnectER eliminates some of those visits. “In some cases, we just need to offer reassurance to someone who is having a symptom about whether it is concerning or not,” Sikka says. “Or if we need to do further testing, we can refer them to an outpatient diagnostic center rather than having them come back to the ED again.”

The availability to follow up with a patient also makes it easier for ED physicians to be judicious in their use of resources during the initial patient encounter. “If I don’t know whether the patient will have follow-up care, I might do one more test,” Sikka says. “But if I know the patient can be followed up online, I can hold off and see if more testing is needed.”

Lola Butcher writes about healthcare business and policy topics for HFMA (lola@lolabutcher.com).

Interviewed for this article: Neal Sikka, MD, emergency physician, The George Washington Medical Faculty Associates, Washington, D.C. (nsikka@mfa.gwu.edu).
ACTIVATING PATIENT ENGAGEMENT FOR POPULATION HEALTH

Effective patient engagement involves one-on-one personal care and high-tech tools that guide patients in changing their behavior and improving their health.

By Karen Wagner

As the healthcare industry transitions to value-based care, determining how to effectively engage patients in their care has become a growing challenge for hospitals and health systems. Just as care practices and technology have evolved over the years, so too has the concept of patient engagement, as several industry leaders who presented at HFMA’s Thought Leadership Retreat in October described in subsequent interviews.

“Patient engagement in the past was really about educating patients,” says James Merlino, MD, president and chief medical officer of the strategic consulting division for Press Ganey, a patient-experience consulting firm. “It kind of evolved into this concept of empowerment. First, you’re getting patients a little more involved, then you’re giving them tools and asking them to do more. Now, it’s about activation and partnership.”

William Appelgate, executive director of the Iowa Chronic Care Consortium, which designs and implements population health management and health coach training programs for healthcare organizations across the United States, agrees that activation is the key to successful patient engagement in today’s healthcare environment. “Just telling people what to do doesn’t engage them and doesn’t get the kind of desired results or changes in behaviors that we’d like,” Appelgate says. “We really need to build self-care skills and inspire patient accountability.”

By the Numbers

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<tr>
<td>800</td>
<td>Number of patients with diabetes, heart failure, or heart disease in each physician’s panel in AtlantiCare’s Special Care Centers.</td>
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<td>2,000</td>
<td>Approximate number of customers who have visited Ochsner Health System’s two “O Bar” retail stores since they opened in 2014.</td>
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<td>96</td>
<td>Percentage of deceased patients with a written care plan as measured by Gundersen Health to assess its Respecting Choices program.</td>
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He adds: “If we can’t get to the 98 percent of health care that actually takes place in the bedrooms, bathrooms, and kitchens of people’s homes, we are not going to have the change in the outcomes that we want to have.”

GUIDING PRINCIPLES OF ENGAGEMENT

Strategies that incorporate technology and human expertise often are necessary to help patients understand the need to engage, and how they can become more active in monitoring their health conditions and making informed decisions about their care, Merlino says.

Merlino describes four key principles that healthcare organizations should use when developing their patient engagement strategy.

**Identify key touchpoints.** It may be impossible to engage with patients at every point along the continuum of care, but patient engagement is critical at certain touchpoints along the continuum. These are areas that can have a direct impact on outcomes, such as points at which conditions can worsen due to inaction or improper care—or improve because of appropriate care. These touchpoints should be similar across healthcare organizations, based on the disease being managed.

Employing appropriate monitoring devices for various conditions at critical touchpoints will enable patients to be active in their care. For example, patients with hypertension should regularly monitor their blood pressure levels to prevent spikes that can send them to the emergency department (ED). Likewise, patients with congestive heart failure should regularly monitor their weight for signs of weight gain, which can indicate that the body is retaining fluid. “You have to ask: What are the critical touchpoints that are going to be high-value?” Merlino says.

**Recognize the psychological barriers.** Providers often focus on giving patients care instructions and not on how or whether the patient is able to follow those instructions. Because many challenges with chronic disease management involve care practices in the home, providers should be more aware of what can go wrong outside the acute care setting and invest more time in addressing these barriers. For example, patients may not be able to afford brand-name medications and, therefore, may not fill their prescriptions. Merlino says providers should inform patients when low-cost generic alternatives might be available.

Overall, Merlino says, the issue centers on, “How do we start to better understand the psychology and the social determinants of patients that are going to help us drive—or are going to be barriers to success in driving—patient engagement and patient activation? We don’t talk about that a lot.”

**Train providers to engage.** Just as engagement is about preparing the patient, “it is also about preparing caregivers to better understand how to communicate,” Merlino says. Providers should be able to recognize when patients do not understand their directions or are not capable of fulfilling them. Providers must be trained, whether through internal expertise or outside programs, to probe for social determinants that will factor into the patient’s ability to seek appropriate care. Can the patient afford her medications? Does she need help to receive care? Is there a caregiver who will help administer medications or other kinds of care, as necessary? “It’s teaching providers how to use that information, when to use that information, and looking at leveraging the resources they have available to help try and fix the issue,” Merlino says.

**Employ technology when appropriate.** It seems as if a new piece of technology for engaging patients is discovered every week. However, not all technology

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**REDUCTION IN UTILIZATION MEASURES**

Since implementing its Special Care Centers (see page 43), AtlantiCare has reduced key utilization measures.

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*Source: AtlantiCare. Used with permission.*
is effective, and technology is only part of the solution, Merlino says. Providers should determine the appropriate role of technology in their patient engagement strategies and ensure its effectiveness. Before implementing a new tool for engaging patients, providers should seek evidence from manufacturers and vendors to verify any claims about improving outcomes or changing behaviors.

**INNOVATIVE PATIENT ENGAGEMENT**

The following three examples showcase how to put these guiding principles into practice by implementing innovative patient engagement strategies.

**AtlantiCare’s Special Care Centers.** Bending the cost curve and forming patient relationships that improve care delivery are the goals behind the Special Care Center (SCC) program developed by Atlantic City-based AtlantiCare, an integrated health network owned by Geisinger Health System, Danville, Pa.

The SCC program provides dedicated care counseling to patients with diabetes, congestive heart failure, and heart disease. Patients work with a health team, composed of a physician and a medical assistant who serves as a health coach, to develop individualized care plans.

“Our goal is to engage the patient in his care in such a way that we improve health while maintaining or reducing costs, especially costs of overutilization of the emergency department,” says Sandra Festa, administrative director of the SCC program.

Patients can choose to use the center on their own or may be referred by their employers, who use predictive modeling to identify health plan members who are either high users of health services or at high risk for becoming high users, thereby increasing costs, Festa says.

AtlantiCare’s two SCCs, one in Atlantic City and one in Galloway, N.J., serve as ambulatory practices. Patients switch from their regular primary care physicians to the SCC physicians.

The SCCs serve about 2,000 patients under both fee-for-service and per-member-per-month payment models. Health coaches have between 175 and 200 patients in a panel, while each physician has 800 patients.

During a welcome session, the patient meets with the medical assistant/health coach and physician. The health coach educates the patient on his condition and discusses the patient’s expectations and role in his care. The coach coordinates various care services, including physician visits and any necessary screenings or diagnostic testing. The physician determines the appropriate visit frequency, which generally decreases as the patient’s condition improves.

“Give us a good three months, and we can drop the A1C [level for diabetes] on average about 2.6 points,” Festa says. “As that patient becomes stable, and if that patient does really well, he doesn’t have to come as often. The care doesn’t have to be highly expensive.”

With providers who are available 24/7 and elimination of copayments for physician visits and medications, Festa says, the program improves patient access and removes barriers to using unnecessary services.

Festa says another important element of the program is determining personal barriers to appropriate health care. A physician may create a strong care plan, but a patient’s personal issues, such as marital or financial problems, may complicate or prevent his ability to seek care. The health coach works with the patient on such issues to try to remove or at least mitigate the barrier.

Utilization and outcomes demonstrate the success of the program, Festa says. For the past eight years, readmission rates for SCC patients at AtlantiCare have averaged 5 percent annually, well below the 17.5 percent rate for all-cause, 30-day readmissions for Medicare fee-for-service beneficiaries reported in May 2014 by the U.S. Department of Health and Human Services. ED visits for high utilizers have been reduced by 50 percent, as have hospitalization rates, Festa says.

When patients reach targeted care goals, they can choose to go back to their original primary care physician or stay in the SCC program and receive lower-intensity services. Leaving the choice to patients is all part of the patient engagement focus.

“If you really believe in population health, you shouldn’t let patients sacrifice when they’re doing well,”
Festa says. “You should continue to engage, but adjust the frequency and intensity of interventions, which will reduce costs.”

**Ochsner Health System’s “O Bars.”** The O Bars at Ochsner Health System (OHS) offer healthcare products and apps that help users monitor their chronic conditions and achieve healthier lifestyle habits (e.g., smoking cessation).

Currently available at two OHS primary care clinics, the O Bars are similar to “genius bars” found at stores that sell computer technology. OHS includes 25 owned, managed, and affiliated hospitals and more than 50 health centers in Louisiana.

“Technology has the capacity to help patients self-discover and the potential to be an enabler of patient engagement,” says Richard V. Milani, MD, chief clinical transformation officer for OHS.

The first O Bar, located at the Ochsner Center for Primary Care and Wellness in New Orleans, opened in 2014; a second O Bar is housed at Ochsner Health Center-Covington, and a third is scheduled to open early next year.

The apps are vetted and approved by Ochsner subject matter experts for ease of use and potential benefits to users. The vetting process is important because studies have shown that many healthcare apps on the market today offer no actual benefits to users, Milani says. The stores also offer interactive health technology, such as blood glucose monitors and scales and blood pressure cuffs, that work with either a smartphone or an online app, which can transmit results data from the technology to providers (e.g., via electronic health records).

The stores are staffed by technology experts who explain the types of apps that are available and how patients can download them to personal devices.

The retail service also ties in with the health system’s focused programs in chronic disease management. A physician may recommend that a patient with hypertension wear a wireless blood pressure cuff for remote monitoring, for example. Rather than having the patient search for a device on his own, the physician can suggest the patient visit the O Bar to see what devices are available, Milani says. In a short period of time, the patient can also be shown how to set up and use the device with a smartphone.

“There needs to be a customer-focused, user-friendly technology interface for individuals to be able to have appropriate access and understanding of how to use technology,” Milani says.

More than 2,000 customers have visited the stores since they opened, Milani says. Some of the apps purchased most often track nutrition, fitness, diabetes, medication, and smoking.

Because the stores are open to the general public, OHS does not measure the results of app usage on its chronic care populations. Milani says anecdotal feedback from app buyers has been positive, with users reporting benefits such as improved quality of life after losing weight. Users can fill out an emailed survey that asks questions about their experience with the apps.

“We have those stories in abundance,” Milani says. “Survey data have been very, very positive in terms of how the O Bar has been an enabler; it’s improved their engagement.”

**Gundersen Health’s “Respecting Choices.”** Patient engagement generally is associated with helping patients who have chronic conditions. However, helping patients make plans for potential future healthcare decisions should they become incapable is equally important for the patients and for their family and friends, says Bernard “Bud” Hammes, PhD, director of medical humanities and of bereavement and advance care planning services for Gundersen Health System, La Crosse, Wis.

Gundersen Health’s Respecting Choices program, formally started in 1991, is designed to get patients thinking about their end-of-life care so they can make more thoughtful, informed decisions about accepting and refusing treatment.
“We can engage our patients and those close to them in planning well for healthcare decisions,” Hammes says. “We want to be in a position where when any of our patients get really sick and are unable to tell us what’s important to them, we have a good idea of what they want out of health care—and we’ve made the commitment to honor that. We want to know and honor the informed thoughts and values of our patients even when they cannot tell us themselves.”

The program uses trained facilitators—many of whom are nurses, social workers, or chaplains—to help patients consider their options and plan their care by getting patients to express their views, values, preferences, and goals regarding end-of-life care. These choices are then documented and stored in the patient’s electronic health record for easy access by caregivers when the time comes to make decisions, including life-or-death decisions, Hammes says.

Facilitators, who are trained internally, elicit patients’ perspectives by asking them about their experiences with medical treatment decisions when they or a loved one previously faced a critical situation. “It’s out of those personal experiences then that we start to examine the values that they have,” he says. “It is this person-centered approach that makes the planning engaging and helpful to both the family and the providers.”

Facilitators are trained via an online course encompassing about six hours combined with classroom sessions totaling eight hours that focus mainly on communication skills and how to facilitate discussions with patients, Hammes says. The training also covers how to document the patient encounter and enter the information into the patient’s electronic chart.

In addition to creating the role of facilitator, Gundersen adjusted its electronic health record system by creating a link to patients’ advance directives so physicians and other care providers can easily enter and retrieve the information at any time across care settings. Physicians are trained on how to access the information and how to use the patient directives in making treatment decisions. For example, if a patient has appointed another person to make treatment decisions, the physician must understand when the directive should be consulted in the decision-making process and when to discuss care with the appointed person as opposed to the patient, Hammes says.

Gundersen disseminates information about the Respecting Choices program through presentations to church groups, service groups, and elder groups, among other audiences. The health system also works in conjunction with Mayo Clinic Health System-Franciscan Healthcare, a competing health system in the La Crosse market, to train facilitators, market the program, and present it to the public, Hammes says.

To gauge the effectiveness of the program, Gundersen periodically measures the prevalence and use of advance directives at the time of death across care settings in La Crosse County, the immediate geographic area served by the health system. In Gundersen’s last measurement, covering a seven-month period from 2007 to 2008, 96 percent of adults who died had a written care plan, and 99 percent of the time that plan was in the medical record of the healthcare organization providing services at the time of death, Hammes says.

In surveys, patients and family members have indicated a high level of satisfaction with the quality of communication they have experienced in the Respecting Choices program, Hammes adds.

### THE ROI OF ENGAGEMENT

The ROI of implementing practices that help patients monitor their own health and reduce the need for more costly interventions is only beginning to become evident, Merlino says. Currently, the evidence comes from the success of individual initiatives. Merlino says it is up to financial leaders of healthcare organizations to measure the ROI and inform colleagues of the results, letting others know the value of investing in patient engagement strategies to improve clinical and financial outcomes.

“It’s a growing field with evolving metrics. But it passes the sniff test,” he says. “It’s the right thing to do, it’s going to make care better, and it’s going to save money.”

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**Web Extra**

For an explanation of the Iowa Chronic Care Consortium’s clinical health coaching model, visit hfma.org/Leadership/Winter2016.
Florida Hospital Tampa increased overall ED patient satisfaction from the 6th to the 80th percentile by using an immediate-bedding and team triage patient flow system.

By Angie Esbenshade, Stephanie O’Bryon, and Wenzel Tirheimer

When Florida Hospital Tampa (FHT) moved into its new tertiary emergency department (ED) in November 2014, improving patient flow was a top priority. Volumes were increasing 38 percent annually despite a 21 percent staff turnover rate, and the ED ranked in the lowest 25th percentile for employee engagement. Patients also ranked ED physicians in the bottom 9th percentile nationwide. Furthermore, FHT, part of the 41-hospital Adventist Health System, knew that its subpar performance could put both market share and payment at risk when the Centers for Medicare & Medicaid Services (CMS) begins requiring public reporting of ED patient satisfaction scores through the Emergency Department Patient Experiences with Care Survey (ED PECS), which is under development.

To better prepare for the financial impact that publicly reported data will bring and also improve the hospital’s reputation in the community, FHT introduced a flexible patient flow strategy—Doc1stER—to ensure patients were seen almost immediately by physicians. The strategy combines two flow tactics—immediate bedding and team triage—and flexes between them depending on the number of patient arrivals in the ED.

Within two months of introducing Doc1stER, FTH was recognized as the most improved ED in the Adventist system.

HOW IT WORKS
Immediate bedding bypasses the triage process and places patients in beds as soon as they arrive when beds are available. All patient input is done at the bedside as soon as patients have received an armband identifier, in the same way as is typically done for emergency medical services patients who arrive by ambulance.

When there are no beds available, the ED shifts to team triage, where a nurse and a physician do an initial patient screening together in a triage room once the patient has received an identifier and a technician has performed a blood draw. The goal is a 90-second patient interaction. The physician moves between patient rooms as needed, triaging patients to a fast-track care space, acute-care bed, or results-pending area, placing initial orders for tests and treatments.

The results? One year after implementation, patients at FHT ranked physicians in the 85th percentile for satisfaction. Overall patient satisfaction for the ED has risen from the 6th to 80th percentile, even as ED volume grew by 30 percent and inpatient volume grew by 20 percent. Left without being seen (LWBS) patients also dropped dramatically, for an annual ROI of $400,000 (based on capturing approximately 1,000 additional patients at a cost of $400 per patient).
And finally, FHT reduced door-to-provider time from 19 to 9 minutes, a key metric that is anticipated to be reported on the coming ED PECS survey (which likely will ask patients whether they were seen by a provider within 30 minutes).

7 TIPS FOR SUCCESS
FHT credits its success to the following actions:

*Diagnose before you treat.* By plotting six months of historical patient arrival data, FHT could anticipate when it would need to redeploy resources from immediate bedding to team triage to match physician and nurse staffing. Hospital leaders asked: When do patients typically arrive? When do things wind down?

*Explain the “why.”* Physicians came on board quickly once FHT’s CEO, Brian Adams, connected the new process with better clinical outcomes for patients. Likewise, nurses, emergency medical technicians, and administrative staff agreed that front-loading resources made sense once leaders explained that the goal was to eliminate unsafe treatment delays by expediting patients.

*Ensure strong support from administration, physicians, and ancillary staff.* Nurses can’t do it alone. FHT leaders recognized the ED sets the tone for the rest of the patient experience, with 70 percent of inpatients arriving via the ED. At FHT, nurses and physicians round together on patients, which creates alignment and engagement among team members. Lab and radiology staff also understand the new process and work diligently to move patients through efficiently to meet goals.

*Hold planning sessions to avoid delays.* FHT included everyone who would participate in the new triage process to make sure they understood expectations regarding the need to keep patient flow moving smoothly. For example, lab testing would be delayed if radiology also lost time trying to locate patients. Likewise, patient access staff would be delayed in completing full registrations if they were unsure where to find emergent patients who did not go through the usual admitting process.

*Test changes along the way.* To help FHT staff prepare and become accustomed to the changes, the hospital tested the new process on less busy days or during single shifts for 30 to 60 days before launch. Throughout the pilot, FHT staff reflected on what worked well, barriers that needed to be addressed, and opportunities for improvement. For example, if a physician needed to request more tests after the patient was triaged, the patient’s stay increased in duration. As a result, FHT staff clarified when this type of action is appropriate.

*Deliver unwavering consistency and repetition.* First, frontline leaders and nurses at FHT helped design new work-flow processes. Then they practiced using them. They recognized that change is hard, given that the human brain needs time to hardwire a new behavior. Every new ED hire participates in simulated training for constant revalidation to ensure training sticks.

*Step up communication.* FHT leaders rounded on clinicians and employees daily to collect feedback and consider changes based on how the process is working. They asked: What’s working well? What are your observations about the process? They also used a quick huddle at shift changes to ensure everyone had a shared understanding of real-time flow performance compared with goals and the number of LWBS patients.

THE ED TRANSFORMATION
As health care continues to transform itself, EDs are transforming too. A smooth work flow in the ED sets the tone for the rest of the patient experience, given that more than two-thirds of inpatients arrive via the ED. With CMS tracking of ED patient satisfaction expected to be implemented soon, hospitals and health systems that build strong support from administration, physicians, and ancillary staff for efficient and patient-friendly EDs are likely to experience strong patient loyalty and a positive impact on the bottom line.

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If you would like to share innovative care or operational approaches being implemented by your hospital, health system, or physician practice, please contact Nick Hut, Leadership managing editor, at nhut@hfma.org.
PATIENT ENGAGEMENT: A CRITICAL SUCCESS FACTOR

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“The biggest changes are likely to come from reimagining the role of the patient—the single most underused person in health care.” — David Cutler, PhD, professor of applied economics, Harvard University

The benefits of value-based payment models, including population health management, are not always apparent to patients. Even the language of value-based payment can be unfamiliar and scary. A frequently cited study found that to consumers, medical home sounds like a nursing home, value implies low cost and low quality, and integrated care sounds like “a sales pitch in a cheap brochure.”2 It’s a safe bet that population health management (PHM) is not a term that will resonate with consumers, either.

Beyond semantics, the concept underlying PHM is unlikely to appeal to patients, at least on the face of it. Patients are more interested in their individual health care than in the health of some abstract population—and rightly so. Neither are patients interested in how physicians and hospitals get paid. Another study found that patients had strongly negative reactions to the idea of “rewarding” physicians for providing high-quality care. They were shocked that physicians would need to be paid more to “provide good care.”3

LEARNING FROM PAST MISTAKES

Let’s remember the lessons learned from the managed care backlash of the 1990s. Public reaction against managed care (a previous incarnation of PHM) was so strong that legislation was introduced in nearly every state—more than 1,000 bills by 1998—aimed at retaining the cost-saving features while trying to calm consumers’ fears that they would lose control of their health care.4

There has been a lot of talk in healthcare circles about why it will be different this time around. Many cite the vast improvements in data and analytics since the 1990s, along with our enhanced ability to identify high healthcare utilizers. Although those surely are important success factors, without consumer buy-in they will not be enough. We need to look at PHM and other payment models through the patient’s eyes. What are the benefits of PHM for patients? What makes PHM better than current care models from a patient’s perspective? Our collective success in managing population health depends on finding solid answers to these questions and acting on them. And the best way to do that is by listening to patients.

THROUGH THE PATIENT’S EYES

Historically the healthcare industry has done a lousy job of involving patients in both naming and developing new products and services. When it comes to naming, we tend to fall back on industry jargon. We need to get the patient’s perspective so we can develop terminology that is more descriptive and less threatening, and that conveys the idea that patients will be cared for, both clinically and financially, as they make their way through the healthcare system. Terms that suggest that hospitals, physicians, post-acute providers, and health plans are working together, coordinating their activities, and sharing clinical and financial information—all for the patient’s benefit—are likely to be well-received and to provide a market advantage.

The good news is that some healthcare organizations already have patient engagement mechanisms in place. At HFMA’s Thought Leadership Retreat in October, nearly six in 10 respondents said their organizations actively and sincerely solicit patient input on both clinical and operational processes through formal structures, such as patient advisory councils. (Another 39 percent said they welcome patient input, although they have no formal structure for receiving it.)

Today’s consumerism initiatives focus on the issues and challenges that consumers are dealing with right now. But we also need to engage consumers in shaping the healthcare system of the future. Because ultimately that system—and our future prospects for success within it—belongs to them. +

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