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Investing for a Changing Physician Role

In this HFMA Executive Roundtable, sponsored by KeyBank, financial leaders discuss ways hospitals and health systems are investing time, money, and creative energies to forge win-win relationships with physicians and create new value-driven structures. Whether acquiring physician practices as a means to expand preventive care competencies or investing in data connectivity to support continuity of care, health-care organizations’ value-driving efforts are influencing not only the capital investments they make, but also how they strategically view existing resources.

Rapid acquisition of physician practices is changing the competitive landscape, particularly as providers prepare for reform. What are your views on acquisition?

Clint Adams: Ardent Health Services employs physicians in all three of its markets. Our focus is on primary care, but we also employ specific specialties depending on the market’s needs. We take a market-centric view when examining physician operations to ensure we generate the necessary returns on employment. It’s not enough to look at a physician group on its own or by facility. We do a lot of analytical work to determine what a group can contribute to all of our facilities across the market in helping to achieve the targets we set for them.

Roberta Hurst: The rush to acquire primary physicians in response to the value-based care mandate looks to be slowing and even shifting from outright acquisitions to more strategic affiliations, such as shared services contracts, bundled payment arrangements, and accountable care alignments. And the market-centric view mentioned seems to be common, with different types of provider alignments in the more populated areas versus rural areas or even state to state, depending on how the particular state has responded to federal healthcare regulations. Also, specialist groups seem to be under less employment pressure, with some hoping to remain independent. At the same time, we see forward-thinking specialty groups becoming proactively part of discussions to be part of the new accountable care delivery model that emerges in their market.

Other than relying on employment, how can healthcare providers improve alignment across the continuum of care?

Ralph Pascualy: We think the future is about creating a high-performing network that includes a healthy balance of independent and employed physicians. As an example,

PARTICIPANTS IN THIS HFMA EXECUTIVE ROUNDTABLE

Clint B. Adams is CFO, Ardent Health Services, Nashville, Tenn.
Diane Cecchettini is president and CEO, MultiCare Health System, Tacoma, Wash.
Roberta Hurst is senior vice president, healthcare corporate finance, KeyBank Corp., Seattle
Ronald R. Long, FHFMA, is executive vice president and CFO, Texas Health Resources, Arlington, Texas
Ralph Pascualy, MD, is senior vice president, physician services, Swedish Health, and CMO, Swedish Medical Group, Seattle
we’re developing a new musculoskeletal service line, and many of our partners in this venture are independents—physicians, nurses, physical therapists, and imaging technicians. And the independent and employed physicians are collaborating on protocols. We also are focusing on clinical integration, forming an accountable care organization (ACO) with our independent physicians and other community partners to jointly contract for services. And we are engaging our independent physicians in actual core activities. As just one example, we are including them in the process of developing a breast cancer center of excellence.

Adams: We are a participant in the Medicare Acute Care Episode Demonstration project, which has generated strong alignment with our orthopedists and cardiologists. We will participate in the next round of bundled payment structures because of this successful experience. In addition, we are engaged in a Comprehensive Primary Care initiative with Blue Cross, along with roughly 60 of our employed primary care physicians. We’re receiving a management fee, per member per month, to provide more interactive participation in members’ care. In year three of the program, we will have an opportunity to participate in risk-sharing. Also, in one market, where we own a health plan, we provide bonuses to physicians who meet quality targets. In addition, in the Amarillo area, we entered into a surgical hospital joint venture with physicians; we own 66 percent of the hospital.

Ronald Long: We take a house-of-many-rooms approach to physician alignment. We support community physicians with an electronic health information exchange and assist them with the purchase of an electronic health record (EHR) system within compliance guidelines. We also are entering joint ventures, which mostly involve surgical hospitals. We have purchased two acute care hospitals this way as well; they operate under a wholly owned management company in which we own 51 percent. We also are working with several independent practice associations (IPAs) to develop accountable care agreements. We are even in the third year of a Pioneer ACO demonstration project with one IPA and are actively negotiating with major commercial payers in that market. And we have an existing accountable care relationship with a Medicare Advantage product.

Through our ACO contracts, we are engaging both employed and community primary care physicians in population health management. In addition, we are partnering with a company to offer wellness programs, both to employers and through the physician-directed population health contracts.

Diane Cecchettini: Our physician alignment model ranges from medical directors for certain specialty services, to shared management contracts with our large imaging and cardiology groups, to an affiliate model, in which an independent group of physicians can affiliate with MultiCare in different ways. For example, we have a large pediatric practice in one market, and we jointly plan systems of care.

What key investments are healthcare providers making to ensure they strategically evolve into a value-based care model and remain attractive to physicians?

Cecchettini: Our No. 1 investment has been the purchase of an EHR that provides basic connectivity among all our facilities, starting with our physician practices in 1998. About 100 independent physicians currently access our EHR using an application service provider approach, while others can access our system through their own specialty niche systems. We also have invested in practice management components, such as scheduling and billing, to accompany access to our EHR. Physicians also appreciate our knowledge trust, which is clinical data intelligence that allows us to engage in predictive modeling. With the technology, physicians can receive alerts at the first sign of a complication, for example, so they can intervene early.

Hurst: With the stimulus funding for HIT systems—EHRs, in particular—starting in 2011 and the deadlines fast approaching, providers have made large capital investments already. We expect significant spending to continue, as the Meaningful Use rules help to move providers to HIT systems that provide clinical outcomes, care protocols, relative cost data, and business intelligence, a “Meaningful Use—Phase 2,” so to speak, that builds on the initial EHR and helps to create a quality-based, preventive, and proactive care environment.
Adams: Having the ability to look at quality, outcomes, and costs in a timely manner, in a way physicians and hospitals can agree on, will be critical. We are executing a “connected care” strategy focused on achieving data sharing in a meaningful way through structures such as physician portals, but it’s not easy to find the tools to allow this to happen. We have committed a significant amount of time, effort, and resources to putting the clinical infrastructure and consistent clinical processes for this—such as the use of standardized order sets—in place.

How can hospitals and health systems ensure capital planning efforts support their physician strategy?

Long: We have a separate group at the system level called the Resource Development and Deployment Council, which includes the chief clinical officer and the rest of the C-suite. It oversees the capital planning process for the next budget cycle year as well as three years out. We tie that process tightly to our strategic plan, in which physician alignment is a major priority. The strategic plan serves as a template for making capital decisions, such as investing in EHR capabilities and physician acquisition.

Pascualy: For our employed physicians, our preferred route is physician governance: They have a physician executive council and full component of board committees—it looks like a multispecialty private group that owns and runs itself. The council is engaged in organizational strategic planning, including capital projects. The independent physicians are less involved, but we do bring them together with our employed physicians if we are investing in something significant that requires their involvement, such as our cancer institute, so they can participate and hear presentations by the CFO and CEO. The challenge is getting independent physicians away from their busy practices for a day. Gainsharing has been one successful strategy for us in this regard, since they can see benefit from how their engagement will result in improved outcomes.

Adams: Our market and facility executives, including physician leaders, update our strategic plan annually, using a market-centric approach. That plan generates the annual operating and capital budgets. We tend to spend about half our capital on maintenance and the other half on strategic or growth initiatives. We meet monthly with the facility executives to review both operating results and key factors that could change our strategic direction, such as investments we see competitors making.

The shift to value-based care is expected to drive volume to lower-cost care delivery settings. How is this trend influencing your strategy?

Cecchettini: Fifty-two percent of our revenue comes from ambulatory care. We have urgent care, retail, and physician clinics. We also are using technology to virtually connect with our patients so they don’t necessarily have to come to a clinic. We do e-visits, we have an “ask a physician” capability through our EHR patient portal, and we use telemedicine to reach our outlying communities.

When it comes to brick and mortar, we are looking at underserved markets, deciding what services we need to locate there, and then working with a developer to build clinics that we then lease. We just completed a couple of projects where we developed primary care clinics in areas with high growth.

Long: We’re doing a lot of ancillary outpatient development work. We’ve entered into joint ventures with national companies for home health and rehabilitation services and are looking at another for skilled nursing. We’re developing ambulatory surgery centers and imaging services with external partners. We also have an internal development strategy to create integrated health campuses in key geographical areas. These campuses differ according to the local population’s needs, but generally include physician offices, urgent care, lab draw stations, imaging, and maybe a freestanding emergency department.

Hurst: With the shift away from inpatient care, we have seen many health systems make increased investments in post-acute and outpatient services, such as imaging, clinical labs, and home care. Some of these investments are well-suited to being operated by the hospital or health system. However, in select markets, these types of direct investments have turned out to be too costly or counter-productive based on the market-centric
physician referral patterns, size of the organization, and newly forming networks in response to accountable care.

What advice would you offer to others looking to ensure capital planning adequately addresses the changing physician role?

Adams: Treat capital planning and procurement as important as any other operating result or metric; involve the C-suite, including the IT executive, and have finance and operations actively drive the process. It’s also important to have the right mind-set: You have to look at physician investment as a long-term strategy—even a defensive move. You can’t expect return in the same way that you would for a growth capital investment in, say, a service line.

You’ve got to be strategic about it. You have to ask, “How many primary care physicians will we need to achieve our goals in the next three to five years? What specialists will we need based on our market-driven analysis? Where will we be exposed if we don’t make that investment?”

Long: Most of the expenditures for physician practices are not in the capital arena, but in the operating subsidies and guarantees that you have to extend to purchase the practices. So you need an internal approval process that takes into account the total expenditure for the practice over a period of time. You also need to establish controls so review of a particular investment is both economic and strategic.

And, also key, don’t ignore trends on the horizon, such as reduced utilization as a result of alignment in accountable care models. If you keep building beds in a growth market, you can quickly find yourself with too many beds.

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Like everything in health care, inspiring value is complicated.

Yes, money can help bend the performance needle in a positive direction. But financial incentives are only one part of a complex equation that healthcare leaders are still trying to nail down.

Below are three things that we learned about incentives and value from this issue of Leadership.

**Detailed data inspires.** Many experts stress that one of the best ways to improve quality and reduce costs is to give staff trustworthy data that details how their performance compares to their peers.

Bruce Gould, MD, medical director, Northwest Georgia Oncology Centers, would agree. As described on pages 15-16, Gould’s practice is participating in a UnitedHealthcare pilot that shares detailed cost and quality data with oncologists. “I’ve been a practice manager for 15 years, and ... this is the first time we have received very structured feedback in terms of what it costs to take care of patients ...”

The growing availability of detailed performance data is enabling more providers to pinpoint specific improvement strategies. For example, on pages 25-26, Susan Dragoo, director of quality and innovation, INTEGRIS Health, describes the gold mine of data available from Medicare about hospital efficiency scores. “If people take the time to review these reports, then the reports will be helpful.”

**The specifics speak volumes.** On pages 36-37, we learn about two pay-for-performance initiatives involving physicians. In Geisinger’s successful approach, 20 percent of an employed physician’s salary is based on specialty-specific cost and quality targets. Well received by physicians, the approach is improving quality and efficiency.

In contrast, the New York City Health and Hospitals Corp. is facing significant barriers in rolling out its new pay-for-performance payment approach to physicians. “…the devil is in the details,” says Luis R. Marcos, MD, CEO for the Physician Affiliate Group of New York. “It’s going to take time and a lot of good communication and teamwork.”

**The mission matters.** On page 31, Donald Berwick, MD, makes a distinction between incentive systems that work for corporations and those that work for individuals. “I think we need to be very careful about identifying where pay for performance is an asset and where it actually may do some damage,” says Berwick, president emeritus and senior fellow, Institute for Healthcare Improvement. “Most doctors would rather be appealed to on the high ground about their professionalism, their missions in life, their craftsmanship, their peer relations.”

CEO Benjamin Anderson lived this lesson (page 47) when he took on the challenge of recruiting physicians for a 24-bed critical access hospital. Taking the advice of local physician faculty, Anderson successfully recruited physicians with a hospital policy that gives all staff four to eight weeks off a year to pursue international medical mission work.

These are just three lessons from the many that can be found on the following pages, told by dozens of healthcare providers who are working hard to create a higher quality, more cost-efficient healthcare system. We hope you find many other inspiring and useful take-aways.
Healthcare leaders who have the most experience with payment reform have the clearest understanding of just how difficult this work is. But they are also optimistic that new payment models can help create a sustainable system that balances higher quality with lower costs.
As payers and providers experiment with new ways of paying for healthcare services, the importance of payment reform is becoming clearer. Indeed, payment reform could slow healthcare spending by $2 trillion by 2023, according to a report by the Commonwealth Fund Commission on a High Performance Health System (see the exhibit below). That amount of savings would help some of America’s most serious fiscal challenges melt away.

“Savings could be substantial for families, businesses, and government at all levels and would more than offset the costs of repealing scheduled Medicare cuts in physician fees,” according to the Commonwealth Fund report.

Dick Salmon, MD, PhD, is encouraged by the number of forward-thinking healthcare providers and payers that are getting involved in payment reform.

“I’m optimistic that, a decade from now, the majority of physicians and hospitals will be in incentive arrangements for the majority of their patients, which reward them for achieving the Triple Aim—better quality, better affordability, better patient experience,” says Salmon, national medical executive for performance measurement and improvement at Cigna. “As a result of that, we will be making progress towards a sustainable, high-quality, affordable healthcare system.”

**TWO KEYS: COLLABORATION AND REENGINEERING**

But exactly which payment models are going to work is far from clear. Currently, there is no consensus on terminology—one person’s definition of accountable care is another’s medical home or bundled payment—let alone the mix of incentives and risks that yield the best results. What has become clear, however, is that collaboration and data sharing among payers and providers will be key on the road to new payment models.

Northwest Georgia Oncology Centers is in the third year of a payment reform pilot with the private insurer UnitedHealthcare, which requires participating physician practices to share and compare performance data. Bruce Gould, MD, medical director of the practice, says he has been shocked to see the variation in costs of different oncology practices treating patients for the same condition—and, for that matter, the costs themselves.

“I’ve been a practice manager for 15 years, and I have only learned about the costs of health care within the past year or two because of all the emphasis on payment reform,” he says. “This is the first time we have received very structured feedback in terms of what it costs to take care of patients, not only with chemotherapy, but also with hospital and radiologic services. That’s been a very eye-opening experience.”

The other solid finding from payment reform initiatives to date: The redesign of clinical care delivery to reduce costs and improve quality, as required under value-oriented payment arrangements, is not easy.

In the UnitedHealthcare pilot, for example, all the participating physicians committed to a single treatment regimen for a certain cancer situation. However, nearly half the patients received a different therapy during the first year of the program, says Lee M. Newcomer, MD, the insurer’s senior vice president-oncology. “That taught us that the operational work behind doing this, about being consistent, about trying to change a group of people who are working together usually as individuals and not as a team, is really, really hard work,” he says.

**CASE STUDY: BUNDLED PAYMENTS**

Starting in 2009, Hillcrest Medical Center in Tulsa, Okla., had a successful experience in the Centers for Medicare & Medicaid Services’ (CMS’s) Acute Care Episode (ACE) demonstration. That program sought to prove that, if hospital and physician charges for joint replacements and cardiac procedures were bundled together, providers would be encouraged to improve the coordination and quality of care, thereby reducing Medicare’s total cost for those patients.

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### HOW TO SAVE $2 TRILLION IN 10 YEARS

The Commonwealth Fund identifies payment reform as a major factor in slowing U.S. healthcare spending.*

| Payment reforms to pay for value to accelerate delivery system innovation | $1,333 billion |
| Policies to expand and encourage high-value choices by consumers | $189 billion |
| Systemwide actions to improve how healthcare markets function | $481 billion |
| **Cumulative impact on national health spending** | **$2 trillion** |

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“For providers and private payers to get done what we need to do, we have to meet in the middle where we each get part of the way to where we want to go.”

Mission accomplished. CMS saved money during the three-year demonstration, which ended in 2012, and Hillcrest improved on quality metrics for the cardiac and orthopedic procedures in the initiative (see the exhibit at right).

Based on the ACE success, Hillcrest opted to participate in Medicare’s new Bundled Payments for Care Improvement (BPCI) initiative. More than 450 organizations were chosen to participate in the BPCI, prompting CMS officials to laud the interest as “huge” and “historic.”

**Participating in BPCI.** “We feel like there’s going to be some type of bundled payment in our future,” says Nancy Harrison, director of the ACE Project for Ardent Health Services, which owns Hillcrest. “It may not be this exact same bundled payment model, but we are trying to work with this new payment approach now and work with our physicians to be ready.”

Hillcrest and four other Ardent facilities are among 192 hospitals that chose Model 2 from the four BPCI options. Model 2 is a retrospective bundled payment arrangement in which hospitals and physicians will accept a 2 percent discount from Medicare fee-for-service rates. The actual costs for hospital stays, physician services, and post-acute care will be reconciled against Medicare’s expected costs, and providers will share any savings with Medicare.

Participants can apply to participate for up to 48 episodes of care, Hillcrest was authorized to participate in 20 episodes, although Ardent expects to choose a smaller number.

In the BPCI Model 2, an episode of care includes the inpatient stay for certain medical or surgical conditions, such as a urinary tract infection or amputation, all related physician and ancillary services, and post-acute care for up to 90 days after hospital discharge. (See the Breakthrough Map on page 60 for more information about the BPCI models and bundled payment.)

“Some of the factors that we’ll look at to determine which episodes we will bundle are patient outcomes, the physician role in those episodes, opportunities for standardization, and cost savings,” Harrison says. The performance period is tentatively scheduled to begin this coming July 1. Over the next few months, Ardent will be working with physicians to create care protocols and to improve care coordination with post-acute providers.

Hillcrest is participating in BPCI under the auspices of a private company that manages transitions from hospitals to post-acute care. The private company is what CMS calls the “convening organization” for Hillcrest’s participation, and it assumes the financial risk for all post-acute services and readmissions after discharge.

**Creating value.** In the ACE demonstration, Hillcrest participated in episodes of care for several cardiac and orthopedic procedures. The hospital improved on several

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**QUALITY SCORES IMPROVED DURING MEDICARE PILOT**

Hillcrest Medical Center documented improved quality during Medicare’s Acute Care Episode (ACE) bundled payment demonstration project.

<table>
<thead>
<tr>
<th>Orthopedic Measures</th>
<th>Baseline</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylactic antibiotic received within 1 hour prior to surgical incision</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylactic antibiotic selection for surgical patients</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylactic antibiotics discontinued within 24 hours after surgery end time for hip and knee replacement procedure groups</td>
<td>87%</td>
<td>98%</td>
</tr>
<tr>
<td>Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery</td>
<td>98%</td>
<td>97%</td>
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<thead>
<tr>
<th>CABG Measures</th>
<th>Baseline</th>
<th>Year 3</th>
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</thead>
<tbody>
<tr>
<td>Prophylactic antibiotic received within 1 hour prior to surgical incision</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylactic antibiotic selection for surgical patients</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prophylactic antibiotics discontinued within 24 hours after surgery end time for 48 hours for CABG procedure groups</td>
<td>87%</td>
<td>100%</td>
</tr>
<tr>
<td>Anti-platelet medication prescribed at discharge</td>
<td>98%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hillcrest Medical Center. Used with permission.
quality measurements, including a lower readmission rate for patients in the program and shorter average lengths of stay. But the primary cost savings to the Medicare program came from reduced spending on orthopedic and cardiac implants.

Hillcrest saved, on average, 10 percent on cardiac implants in the ACE demonstration, totaling about $1 million in savings during the three-year project, because of device standardization and volume discounts from vendors. It also saved an average of 7 percent on orthopedic implants, adding up to $450,000 in savings over three years.

“It is important to note that we never force the physicians to choose a device, and we did not always choose the lowest-priced product,” Harrison says. “We accept proposals from various vendors, but we involve the physicians in the cost analysis. Through that process, we sought the best product for our patients.”

Increasing volume. During the three years of the ACE demonstration, Hillcrest saw its overall cardiac and orthopedic surgery volumes increase between 25 percent and 40 percent, depending on the procedure. At the end of the demonstration, CMS agreed to extend Hillcrest’s bundled payment program for orthopedic procedures. In the fourth year—currently in progress—orthopedic surgery volume is projected to increase at a rate of 15 percent.

Harrison does not attribute that growth entirely to the bundled payment approach, but rather to the relationship with physicians that bundled payments require. “Our physicians are very well known and have a great reputation in that market,” she says. “That probably contributes to the increased volume.”

“We have more than 60 measures now that help us understand the kind of care that cancer patients are getting, what it costs to deliver care, and where there is potential for improvement.”

COSTS DECLINE UNDER MEDICARE BUNDLED PAYMENT

Hillcrest Medical Center experienced significant decreases in some orthopedic and cardiac material costs during Medicare's Acute Care Episode bundled payment demonstration project.

<table>
<thead>
<tr>
<th>Year</th>
<th>Knee Implant</th>
<th>Knee Surgical Supplies</th>
<th>Hip Implant</th>
<th>Hip Surgical Supplies</th>
<th>Defibrillator</th>
<th>Pacemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Year</td>
<td>$4,767</td>
<td>$2,214</td>
<td>$5,283</td>
<td>$1,406</td>
<td>$26,598</td>
<td>$6,184</td>
</tr>
<tr>
<td>Year 1</td>
<td>4,353</td>
<td>1,482</td>
<td>5,094</td>
<td>1,330</td>
<td>23,785</td>
<td>5,228</td>
</tr>
<tr>
<td>Year 2</td>
<td>4,085</td>
<td>1,463</td>
<td>4,612</td>
<td>1,243</td>
<td>22,407</td>
<td>4,687</td>
</tr>
<tr>
<td>Year 3</td>
<td>4,197</td>
<td>1,727</td>
<td>5,163</td>
<td>1,514</td>
<td>21,470</td>
<td>4,475</td>
</tr>
</tbody>
</table>

Source: Hillcrest Medical Center. Used with permission.
CASE STUDY: EPISODE OF CARE

While the terms “bundled payment” and “episode of care” are sometimes used synonymously, that is not always appropriate. An ongoing pilot in five oncology practices only uses an episode of care payment strategy for physicians; there is no bundling with hospitals or other providers.

Improving cancer care value. UnitedHealthcare is one of many payers searching to improve the value of cancer care. New drugs, some of which cost $5,000 or more a month, may extend life only a few weeks; yet, current payment systems encourage their use. “Most new drug molecules are priced at $5,000 per month or more and, in many cases, the cost-effectiveness ratios far exceed commonly accepted thresholds. This trend is not sustainable,” wrote oncologist Thomas Smith, MD, and a co-author (Smith, T.J. and Hillner, B.E., “Bending the Cost Curve in Cancer Care,” New England Journal of Medicine, May 26, 2011, vol. 364, pp. 2060-2065).

UnitedHealthcare calculates the profit that the practice would have received under the buy-and-bill system, adds on a small case management fee (generally between $40 and $200, depending on the episode), and arrives at a practice-specific episode payment for each of the 19 clinical episodes. A single episode fee that covers the entire course of treatment is paid to the oncologist as soon as the patient is registered with UnitedHealthcare. Other services are paid and billed for on a fee-for-service basis.

All the oncology practices in the pilot are required to meet annually to compare results on performance measures, including patients’ survival, relapse-free survival, hospitalizations for complications, and the total cost of care for an episode.

Holding physician pay steady. Northwest Georgia Oncology’s Gould is pleased with the results of the pilot, which is now in its third year. The payment system is designed to hold oncologists’ pay steady while decreasing overall costs through standardization and improved quality of care. Gould says that Northwest Georgia Oncology Centers is doing somewhat better with UnitedHealthcare’s payment pilot than originally anticipated.

UnitedHealthcare’s Newcomer is optimistic that, when the pilot ends, the insurer will find that it decreased its
costs. In his view, the episode payment is proving itself to be worthy for situations in which care is delivered in episodic fashion: cancer care, joint replacement surgery, maybe some cardiac procedures. “It will be a tool in a big tool chest” of payment approaches in the future, he says.

Gould, meanwhile, sees the episode model as an evolutionary step on the way to something better. “I don’t see it as the final end of payment reform for cancer care,” he says. “Under this model, I could be a high utilizer of radiologic and hospital resources and still get the same episode of care payment that I’ve been getting,” Gould says. “We need to be controlling the cost not only of chemotherapy, but also hospital and radiologic utilization.”

**Changing physician practices.** Oncologists can increase their episode payments if they improve the value of the care they deliver. If patients’ survival time increases or the total cost of care decreases from one year to the next, UnitedHealthcare increases the episode payments.

Beyond that, the data-sharing requirement has great potential for improving the cost and quality of cancer care. When the five practices met to review first-year results, one of them had a much higher hospitalization rate than the other four. Practice leaders quickly pulled patient charts to look for clues and found that hospitalized patients were being readmitted before they had an outpatient visit. “They changed their processes to guarantee a clinic visit within 48 hours, and, according to the manager, they immediately started seeing a drop-off in hospitalizations,” Newcomer says.

At that same meeting, Gould was intrigued by the apparent efficacy of a treatment regimen that his practice has not historically used. “That changed my thinking about what drug regimen we should be using as a practice, not only for UnitedHealthcare patients, but for all our patients,” he says. If the second-year comparison data verifies that thinking, then oncologists at Northwest Georgia Oncology Centers will change their protocol.

**CASE STUDY: ACCOUNTABLE CARE AND SHARED SAVINGS**

Payment reform pioneer Dartmouth-Hitchcock Health in Lebanon, N.H., was one of the 10 practices in CMS’s Physician Group Practice (PGP) Demonstration, which provided the early learnings for the agency’s current accountable care organization (ACO) program. Since then, Dartmouth-Hitchcock has participated in a variety of payment reform initiatives, including medical home initiatives, bundled payments, and ACOs, sponsored by both government and private payers.

To succeed in the shared-savings PGP, the medical practice developed chronic disease registries to support population and patient management, identified high-risk patients whose risk level could be addressed through interventions, and transformed nurses to work as

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**DARTMOUTH-HITCHCOCK CLINIC’S PRIMARY GROUP PRACTICE DEMONSTRATION EXPERIENCE**

Dartmouth-Hitchcock Clinic was one of 10 participants in CMS’ Primary Group Practice Demonstration, the precursor to CMS’s current Medicare Shared Savings Program.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Measures</strong></td>
<td>Met goals for at least seven of 10 diabetes clinical quality measures</td>
<td>Met goals for at least 25 out of 27 measures for patients with diabetes, coronary artery disease, and congestive heart failure</td>
<td>Met goals for at least 28 of 32 measures for patients with diabetes, coronary artery disease, congestive heart failure, hypertension, and cancer screening</td>
<td>Met goals on at least 29 of 32 measures, including all 10 heart failure and seven coronary artery disease measures</td>
</tr>
<tr>
<td><strong>Cost Efficiency</strong></td>
<td>Did not qualify for shared savings payments</td>
<td>One of four medical groups to qualify for shared savings payments</td>
<td>One of five groups to qualify for shared savings payments</td>
<td>One of five groups to qualify for shared savings payments</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services.
patient advocates and care coordinators. The result: Dartmouth-Hitchcock achieved sufficient savings in three of the five years to earn $11 million in performance payouts from CMS. Equally importantly, it hit its quality benchmarks all five years.

Anticipating shared savings. “We said, ‘This feels good to the doctors. This is the way we want to practice anyway,’” says Barbara Walters, MD, executive medical director for Dartmouth-Hitchcock Medical Center. “So we decided to look for a commercial partner to see if this melding of population and patient point of view works in a commercial population as well.”

In 2008, Dartmouth-Hitchcock was the first organization to join Cigna’s Collaborative Accountable Care (CAC) initiative. Through this program, Cigna offers shared savings with a twist. Instead of calculating the shared savings at the end of the year, Cigna provides a care coordination payment at the beginning of the CAC arrangement that reflects a conservative estimate of the expected savings for the year ahead. If a practice hits its quality targets and reduces total medical costs by at least 2 percent relative to a comparison group, its care coordination payment increases for the next year.

Cigna currently has 58 CAC contracts with medical practices in 24 states and expects to have 100 around the country by the end of 2014.

Improving coordination. Cigna helps train the care coordinators and provides daily and monthly patient-specific reports to help them improve patient care. Duties include coordinating hospital discharges for patients at high risk of readmission, proactively working with patients likely to incur high medical costs, and patient education.

In 2010—the first year of the initiative—Dartmouth-Hitchcock posted per-patient-per-month costs that were $1.78 less than a comparison group. It also recorded an 81.1 percent compliance rate for five evidence-based standards of care, better than the previous year and better than its comparison group (Salmon, R., et al, “A Collaborative Accountable Care Model in Three Practices Showed Promising Early Results on Costs and Quality of Care,” Health Affairs, November 2012, vol. 31, no. 11, pp. 2379-2387).

Salmon, who is Cigna’s national medical executive, is encouraged by the positive trend. He considers the model to be “a first step toward population health and accountability for the Triple Aim.”

In addition to incrementally increasing value, the CAC is a payment reform model that works for insured populations that—unlike HMO members—do not have to sign up with a primary care provider who coordinates their care. The CAC model allows patients to receive care wherever they wish. In addition, it does not require providers to assume insurance risk for their patients, and it allows Cigna to collaborate with physicians to improve care delivery.

“We do that by providing claims data to the physicians and by providing training for their care coordinators and other activities,” he says. “This is a very active partnership where our goal is to help the healthcare professional be successful.”
LESSONS LEARNED
The leaders involved in payment reform shared the following lessons from their experiences to date:

Different perspectives. Providers—and CMS—tend to have a long-term view. The patients they are responsible for now are likely to be the same several years from now. Thus, it is worthwhile to work on efficiency and quality initiatives that have a long horizon.

However, for-profit private payers answer to shareholders who demand quick results. “Their world is a year budget at a time,” Walters says. “For providers and private payers to get done what we need to do, we have to meet in the middle where we each get part of the way to where we want to go.”

Challenges of distributing money. In the ACE bundled payment demonstration, Hillcrest was responsible for distributing professional payments to its physician partners, which proved to be a time-consuming, cumbersome process. In the BPCI program, Hillcrest chose a model in which CMS pays the providers. “We really wanted to be out of that so we can focus more on standardization and operationalizing the bundled payment approach,” Harrison says.

New ways to track performance. UnitedHealthcare’s pilot with oncology practices has shown the power of combining a small amount of clinical data with an insurer’s medical claims data. “We have more than 60 measures now that help us understand the kind of care that cancer patients are getting, what it costs to deliver that care, and where there is potential for improvement,” Newcomer says. “The physicians’ involvement is simply giving us a single sheet of information when the patient is enrolled. We can do the rest on our side by combining it with the claims data, handling the analytic profiling, and so on.”

Why easy can be hard. An easy way to reduce costs quickly is to prescribe medications that are on the lowest-cost tier of a patient’s formulary, and insurers get frustrated that physicians do not seem to get that. “But in day-to-day practice, I don’t know what kind of insurance my patients have when I’m seeing them, and I don’t know what tiers their drugs are on,” Walters says.

The downside of raising fee-for-service rates. Most payment reforms are still rooted in fee-for-service payments. When a provider negotiates higher fee schedules, that raises the cost of a patient’s care. “The ACO is trying to be as efficient as it can and make the total cost of care less, but built into the total cost of care is this increased amount of money that my crack contracting team negotiated,” Walters says.

“As our physicians worked to become more cost conscious and quality conscious for the ACE patients, our other patient populations benefitted at the same time.”

A related problem: new payment models often require comparing a provider’s performance with that of another group. However, if one provider has a more successful negotiating team than the other, comparing the total cost of care between the two organizations is flawed. “The commercial health plans haven’t figured out how to neutralize costs to perform actual comparisons,” Walters says.

Improvement’s ripple effect. Although the ACE demonstration involved only Medicare patients, the biggest financial benefit to Hillcrest came as a side effect of that program. “Our profitability really depends on our commercial lines of business,” Harrison says. “As our physicians worked to become more cost conscious and quality conscious for the ACE patients, our other patient populations benefitted at the same time.”

IT’S THE RELATIONSHIPS THAT MATTER
A common theme in payment reform initiatives is the imperative of good working relationships among hospital leaders, physicians, and payers.

In the ACE bundled payment program, Hillcrest found that involving physicians in decision making paid off in lowering the hospitals’ costs and improving the quality of care. Meanwhile, UnitedHealthcare found that gathering oncologists together to share and compare their performance data produces new knowledge. “If we are going to solve these cost and quality problems, we really have to collaborate. It’s a must,” Newcomer says.

Lola Butcher is a freelance writer and editor based in Missouri. Interviewed for this article (in order of appearance): Dick Salmon, MD, PhD, is national medical executive for performance measurement and improvement, Cigna, Bloomfield, Conn. Bruce Gould, MD, is medical director, Northwest Georgia Oncology Centers, Marietta, Ga. Lee Newcomer, MD, is senior vice president-oncology, UnitedHealthcare, Minnetonka, Minn. (lee_newcomer@uhc.com). Nancy Harrison is director, Acute Care Episode Project, for Ardent Health Services, Nashville, Tenn. (Nancy.Harrison@ardenthealth.com). Barbara Walters, MD, is executive medical director, Dartmouth-Hitchcock Medical Center, Lebanon, N.H.
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Physicians often wish that, in addition to medicine, they could offer other essentials to their patients—like food, utilities, and a job. This entrepreneur has created a way to make that happen.
When a family brought their three year old to Harriet Lane Clinic at Johns Hopkins Medical Center to be treated for an asthma attack, they got more than an inhaler.

By examining both the child and his home life, the pediatrician learned that the family lived in an overcrowded apartment with too little food and no utilities. In addition to medicine, the physician prescribed basic services that the family needed to maintain good health. An advocate from Health Leads—a not-for-profit organization that has a help desk at Harriet Lane—then connected the family with health insurance, financial assistance for heat and utilities, and a job training program for the child’s mother.

Similar situations played out nearly 9,000 times last year, as Health Leads served patients and their families through more than 20 pediatric and prenatal clinics, newborn nurseries, emergency departments (EDs), and community health centers in Boston, Baltimore, Chicago, and three other cities.

“Patients’ social needs have historically been viewed as peripheral,” says Rebecca Onie, Health Leads’ co-founder and CEO. “What Health Leads does is systematically make them integral, in a relatively seamless way, to the healthcare delivery that’s provided in clinical settings.”

**HOW IT WORKS**

Health Leads, which was founded in 1996 as a student-run organization, recruits, trains, and supports student volunteers from Johns Hopkins University, the University of Chicago, and other schools to serve as advocates for patients and families who need help accessing resources. “This untapped workforce of energetic, extremely capable, well-trained, and tenacious student advocates keeps Health Leads’ costs low while giving students an opportunity to gain insights they might never learn elsewhere,” says Onie.

**THE ROI**

In most communities in which Health Leads works, a health system pays part or all of the program costs because its leaders recognize the need—and the benefit. For example, research has found that pediatric patients whose families cannot pay their utility bills are 30 percent more likely to be hospitalized. So every time Health Leads connects a patient to needed resources, it may be reducing utilization.

“Despite the complexity of the patient population that we focus on, 70 percent of the patients with whom we worked last year were successfully connected to at least one resource that they needed, or they were given the information they needed to connect with the resources themselves, according to their wishes,” Onie says.

Health Leads is currently working with several of its current partners, including Children’s National Medical Center in Washington, D.C., and Chicago Family Health Center to measure the effect of its work in improving primary care utilization, decreasing ED utilization, and increasing patient satisfaction.

**AN IDEA THAT GREW ... AND GREW**

Onie was a sophomore at Harvard College when she founded Health Leads—originally called Project HEALTH—with a Boston pediatrician. She oversaw expansion to Providence and New York City before attending Harvard Law School and beginning her legal career.

Since returning to Health Leads full-time in 2006, Onie has become one of the most celebrated young executives in health care. Among other accolades, she received a MacArthur Fellowship, often called a “genius grant,” and a John F. Kennedy New Frontier Award. That probably reflects the fact that the idea she had in the mid-90s—poverty is a health determinant that must be addressed—has become clear to leaders within health care and beyond.

Indeed, Health Leads last year received nearly 600 requests to expand into additional locations. Although her organization is planning for a period of rapid growth, Onie’s first priority is to spread the idea that medical care cannot be effectively delivered in a vacuum.

“Our ultimate goal is to move to a system where basic needs are routinely addressed as a standard part of patient care—not just through Health Leads but also by catalyzing others to pursue alternative models as well, says Onie.

Rebecca Onie, JD, is CEO, Health Leads, Boston.
Come Oct. 1, 2014, hospital Medicare payments will be adjusted up or down based, in part, on how efficiently acute care facilities deliver care—both inside and outside their walls. Some may see this as a mandate to achieve more with less. But value-focused leaders consider the new efficiency score a helpful incentive.
Medicare’s Value-Based Purchasing (VBP) program steps on the accelerator, beginning Oct. 1, 2014, when it adds an efficiency score—a hospital’s spending per Medicare patient—to the formula that determines hospital pay. This marks the first time that the Centers for Medicare & Medicaid Services (CMS) has included a straight financial measure in its VBP calculation. It is also the first instance in which hospitals are directly accountable for non-acute care costs accrued by non-affiliated physicians and post-acute providers.

“We have come to a point where the folks who pay for health care are no longer looking at the hospital silo or the physician silo,” says Chad Mulvany, HFMA technical director. “They are looking at the total bottom-line dollar number.”

The new efficiency score may be inducing heartburn in many healthcare leaders, but not for Susan Dragoo, director of quality and innovation at INTEGRIS Health. “In a way, this is a measure of how well we are coordinating care, which is something that we are working very hard to improve,” she says.

Melinda Hancock, CFO at Bon Secours Virginia Health System, shares Dragoo’s enthusiasm because the efficiency score reinforces her health system’s focus on cost reduction. “We were accepted into the Medicare Shared Savings Program as of January 1, so the timing couldn’t be better,” she says. “We are trying to reduce our spend so this is beautifully aligned.”

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**CALCULATING THE SCORE**

The efficiency score introduces a new acronym—MSPB—for Medicare spending per beneficiary. The measure covers a hospital’s spending-per-Medicare-patient for eligible patient care episodes, starting three days before an inpatient hospital admission and ending 30 days after discharge.

Each hospital’s baseline MSPB, which reflects its performance for the period from May 1, 2011 to Dec. 31, 2011, is currently posted on Medicare’s Hospital Compare website. The score is determined by dividing the hospital’s MSPB by the median amount per Medicare beneficiary that CMS spends nationally.

> A score of 1 indicates that the hospital meets the average efficiency of all hospitals nationally.
> Below 1 indicates that the hospital is more efficient than the U.S. average.
> Above 1 means the hospital is more costly than the U.S. average.

**HOW WILL HOSPITALS BE EVALUATED UNDER MEDICARE’S VBP PROGRAM?**

The efficiency score will be worth 20 percent of a hospital’s value-based purchasing (VBP) score for federal FY15, which begins Oct. 1, 2014.*

![Diagram](image)

Hospitals need scores for at least two of four domains to receive a Total Performance Score.

* For hospitals with at least two domain scores, the excluded domain weights will be proportionately distributed to the remaining domains to calculate the total performance score.

Source: Centers for Medicare & Medicaid Services, Hospital Value-Based Purchasing Fiscal Year 2015 Presentation, Mar. 14, 2013.
The efficiency score will be worth 20 percent of a hospital’s VBP score for the federal FY15, which begins Oct. 1, 2014 (see the exhibit on page 24).

A hospital’s federal FY15 efficiency score will be determined by one of two calculations: Its MSPB score for the performance period of May 1, 2013, to Dec. 31, 2013, or its improvement since the baseline time period in 2011.

Hospital MSPB scores are not always predictable, say Dragoo and Hancock. For example, INTEGRIS Baptist Medical Center, a tertiary care center, had an admirable 0.99 efficiency score for the 2011 performance period, despite treating the highest acuity patients in the INTEGRIS system. “By the same token, one of our hospitals that I know to be fairly efficient was also at either 0.99 or 1.0,” Dragoo says. “I would have expected them to have a better score, so we just have to dig into those numbers and understand what’s driving that, which is a new conversation.”

**USING THE EFFICIENCY REPORTS WISELY**

“You can either improve substantially over your baseline, or you can look really good compared to every other hospital in the country—and those are the only two ways you score points in value-based purchasing,” Hancock says. “So we needed to first identify which Bon Secours hospitals were already looking good in their baselines and which ones weren’t to determine where we had work to do.”

**Pinpointing cost containment opportunities.** That was the starting point for the Bon Secours Health System, based in Marriottsville, Md. The system includes 14 acute-care hospitals along with nursing care and other facilities. “When we first saw the efficiency component show up on the Hospital Compare website, we quickly pulled all of our hospital scores and presented them to our CMOs, CNEs, CFOs, and CEOs from across the system,” says Hancock, the finance lead for Bon Secours’ systemwide clinical transformation efforts.

While that single number—say 1.01 for a hospital that is about average—seems simple, it is backed by a lot of data points. The MSPB reports available on CMS’s QualityNet.org reveal each hospital’s spending for three phases of each episode—the three days before admission, the inpatient stay, and the 30-day period after discharge—and it compares those spending levels to state and national averages.

In addition, the report breaks down spending in each phase by claim type—outpatient, skilled nursing, durable medical equipment, and others—to allow for comparison with state and national averages.

The report also identifies a hospital’s average spending per episode by major diagnostic category and compares that amount to state and national averages. Thus, leaders can see, for example, if a hospital has relatively high costs for nervous system issues or low costs for mental disorders.
LeaDeRSHIP HfMa.oRG/LeaDeRSHIP

those details make it easier to see where a hospital needs to reduce costs, INTEGRIS' Dragoo says. “Because it breaks spending down into the three phases, and it also breaks spending down by major diagnostic category, I definitely think that it gives you a place to start,” she says. “You can see how CMS derived the numbers. So if people take the time to review these reports, then the reports will be helpful.”

Pairing up finance and clinicians. At Bon Secours, Hancock tasked a team of finance leaders to analyze the hospital-specific MSPB reports for their respective markets to identify the best opportunities for improvement. Rather than trying to address all of the major diagnostic categories simultaneously, each hospital will focus on two categories to start with.

The finance leaders are meeting with CMOs and chief nurse executives at each hospital to ask why, for example, the nervous system diagnostic category is higher than the national average and what might be done to lower the cost for patients in that category.

“As you can imagine, the answer is different at every single hospital, for every single major diagnostic category. There is not a one-size-fits-all answer,” Hancock says. “This is really forcing that conversation between the clinical and financial leaders saying, ‘Here’s the data—what do we do about it?’”

When Hancock distributed the reports to hospital leaders, they were surprised to see that they were accountable for costs beyond the inpatient stay. What could they do about the costs of care provided by physicians or nursing homes that have no ties to the Bon Secours system?

“And I said: ‘That’s what Medicare is asking: What can you do about it?’” Hancock says. “Is it not in your best interest to discharge that patient in a manner that optimizes the care and reduces the spend?”

WINNING IN VBP

Swedish Health Services, in Seattle, has not yet focused much attention on the MSPB scores at the health system’s five hospitals. “But we have already begun our efficiency process improvement work, which will then roll up into CMS’s efficiency score,” says Mary Gregg, MD, vice president of quality and patient safety.

Bringing together teams. Indeed, the health system’s flagship hospital, Swedish Medical Center/First Hill, had a baseline MSPB of 0.93, showing it to be considerably less costly than the national average. In addition, for three consecutive years, Swedish/First Hill has been recognized as a Leapfrog Group top hospital because of its success in preventing medical errors, reducing mortality for high-risk procedures, and reducing hospital readmissions.
Cardiac patients are generally treated at a smaller facility in the health system—Swedish Medical Center/Cherry Hill—which has a 0.99 efficiency score. Its cardiac-related core measure scores are all extremely high, and it has one of the lowest door-to-balloon times in the country. Swedish/Cherry Hill’s baseline door-to-balloon time was 127 minutes; today it is about 50 minutes.

“The only way we have done that is by having an entire multidisciplinary team come to the table and identify how to get patients from the door to the intervention quickly,” says Gregg, a heart surgeon. The lessons learned at the Cherry Hill campus were shared with the two other Swedish facilities that treat heart patients, so that all three use the same care processes.

Leading with quality. Although many quality improvements translate into reduced costs, Swedish emphasizes patient safety and quality as institutional values in their own right. “When an institution says, ‘We’re all about finance,’ I think it is really hard to get clinicians and other staff to buy into the mission,” says Todd Strumwasser, MD, the system’s chief operations officer. “It’s important to constantly lead with quality and safety because that resonates with staff and with the medical staff. You are going to get a lot more traction on every initiative that way.”

Meanwhile, Swedish/First Hill pioneered the health system’s work to improve sepsis care, reducing its mortality rate from severe sepsis and septic shock to 18 percent, compared to a national rate of at least 50 percent. Its processes were then shared with other Swedish campuses.

“ ‘When an institution says, ‘We’re all about finance,’ I think it is really hard to get clinicians and other staff to buy into that mission. It’s important to constantly lead with quality and safety... ’”

More recently, Swedish/Cherry Hill implemented nurse-initiated telephone calls to newly discharged heart failure patients in an attempt to reduce readmissions. The national 30-day readmission rate for Medicare heart failure patients is 24.7 percent, just slightly higher than the hospital’s starting point.

“We took our 30-day readmission rate from about 23 percent down to 16 percent just by making these phone calls at 48 hours, talking to these patients about the importance of taking their medications, and guaranteeing that they would have some kind of follow up with a practitioner within a week of discharge,” Gregg says.

The transition-of-care process that connects acute care with outpatient providers is currently being tested in pilots at Swedish’s other campuses. “We are pretty confident that this will work in a group of real complicated patients who need more chronic management, but we now have to figure out how this could work with other populations,” Gregg says.

**SWEDISH’S SEPSIS MORTALITY RATES**

In 2012, Swedish had a mean sepsis mortality rate of 13%, well below the national rate of more than 50%.

![Graph showing Swedish’s Sepsis Mortality Rates](Source: Swedish Medical Center. Used with permission.)
EMPHASIZING VALUE
At INTEGRIS, a 15-hospital system in Oklahoma, Dragoo thinks the MSPB will support the health system’s use of value stream management, a continuous process improvement strategy that covers the continuum of care for a specific patient population.

“That approach is very consistent with the need to have more integration of care and better coordination of care, and the new CMS efficiency measure can help us understand our performance in that regard,” she says.

Value stream management for stroke care starts with building awareness in the community about the signs and symptoms of stroke and the importance of getting stroke patients treated as quickly as possible. “Then, of course, it goes through the physician’s office, the emergency department, the inpatient stay, rehab, and post-hospital care—looking at the entire episode of care and ways to create the ideal value for the patient,” she says.

The stroke performance improvement team at a given hospital gathers around the “mother” value stream map on a regular basis to review performance on key metrics, including core measures related to stroke care, mortality, and cost. In addition, each patient care area that has some responsibility for stroke patients has a “data wall” that shows progress on quality measures.

The team regularly “walks the value stream” to review stroke care performance in the emergency department, rehabilitation, and other areas, always looking for opportunities to further reduce waste. When opportunities are found, rapid improvement events are executed, and measurement begins again.

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EXCERPT FROM INTEGRIS’ VALUE STREAM MAP FOR STROKE CARE
INTEGRIS staff use value stream maps to identify ways to improve quality and reduce costs. This excerpt is only one section of the organization’s two-page stroke map.

Source: INTEGRIS Health. Used with permission.
INTEGRIS’ use of value stream management for stroke care has reduced the cost by $300 per inpatient admission. When healthcare costs are going up, and we are bringing that number down, I think that’s pretty exciting,” Dragoo says.

ZEROING IN ON EFFICIENCY

Like all measures in the government’s VBP initiative, CMS’s way of measuring efficiency is likely to evolve over time. The American Hospital Association (AHA) recently offered comments on a proposed efficiency measure specifically for a heart attack episode of care. Nancy Foster, AHA’s vice president for quality and patient safety policy, says many hospital executives would prefer to have cost accountability for particular diseases or conditions, rather than an entire diagnostic group or all Medicare patients.

“Hospitals oftentimes manage or change processes by first understanding where they stand relative to others in caring for, say, hip replacement patients or back surgery patients or some other condition-specific population,” she says. “So we look forward to working with CMS as they build out a cadre of measures that look at efficiency in many different ways.”

Meanwhile, Chad Mulvany, HFMA technical director, believes CMS’s approach to measuring efficiency will be flawed until all caregivers across the continuum share accountability. “Until you align the incentives for physicians and also for post-acute care providers to focus on the cost efficiency of care delivery, then I don’t think it’s an appropriate measure,” he says.

That said, the MSBP measure may help focus the attention of physicians who will soon have their own motivation to be cost conscious. The Physician Value-Based Modifier, which includes an efficiency score, will go into effect for large physician groups in 2015 and expand to all physicians two years later. “I think the hospital efficiency score is a real opportunity for hospitals to work with the physicians in the community,” Mulvany says. “I certainly would try to use that as a springboard to start the conversation.”

Of course, hospital costs account for the largest portion of the MSBP score. So the best place to start improvement efforts is at home.

“I’m a broken record on this subject, but if a hospital has not begun to use Lean, then they need to do that to understand how to eliminate waste and create ideal patient care,” INTEGRIS’ Dragoo says. “You cannot just focus on cost cutting from an old-school perspective. You must really understand what’s driving costs and how better care can result in lower costs.”

“This is really forcing that conversation between the clinical and financial leaders saying, ‘Here’s the data—what do we do about it?’”

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Having examined America’s healthcare system in his role as administrator of the Centers for Medicare & Medicaid Services, one of the nation’s foremost healthcare quality experts prescribes optimism and innovation to cure the problems at hand.
Before he turned his attention to quality improvement, Don Berwick, MD, practiced pediatrics for nearly two decades. During the years since then, he has traveled the world, exploring what works in health care and what doesn’t—and pushing everybody he meets to make patient safety and waste reduction a bigger priority. 

Despite that breadth of experience, he has not identified the best way to incentivize physicians to deliver high-value care. “I was always on salary, and part of me says that was the best incentive system I ever could have had,” he says. “I didn’t get paid more for doing something, and I didn’t get paid less for not doing something. All I had to do was think about the well-being of the patient, and I was supported to do that.”

**ORGANIZATIONAL VERSUS INDIVIDUAL INCENTIVES**

The rap on straight salary is that it does not encourage productivity, acknowledges Berwick. At the same time, the fee-for-service system is criticized for promoting overuse of services, capitated pay schemes risk underuse, and pay-for-performance systems—in Berwick’s view—work better at the corporate level than at the physician level.

The federal government’s use of penalties for hospitals that have high readmission rates and other poor outcomes have been shown to be effective incentives. “At the individual level, it’s a little more dicey because metrics at the individual physician level are very, very difficult technically,” he said. “Most doctors would rather be appealed to on the high ground about their professionalism, their missions in life, their craftsmanship, their peer relations. I think we have to be very careful about identifying where pay for performance is an asset and where it actually may do some damage.”

**NEW ROLES FOR PHYSICIANS**

Even though the best payment strategy for physicians has not yet been revealed, another element of physician practice has: Economic pressures have prompted the majority of physicians to be hired by health systems, a situation that many physicians never expected.

While some physicians may feel victimized by the changes in their profession, Berwick is optimistic about the healthcare workforce of the future. A co-founder of the Institute of Healthcare Improvement (IHI), he believes younger physicians recognize that being a good clinician is no longer sufficient for success. He points to the IHI’s Open School for Health Professions, which invites students in medicine, nursing, health administration, and related fields to learn improvement methods, patient-centered care, and patient safety.

“That enterprise right now has 130,000 students in more than 55 countries working together to learn and study and try out methods of improvement,” he says. “They are not depressed. They are not feeling like they are victims. They are taking control and saying, ‘I think I can lead improvement,’ and they can.”

**CLINICIANS TO THE RESCUE**

Indeed, he is counting on physicians and other clinicians to guide the industry to a safer and more sustainable place. Yesterday’s physicians may have defined “professionalism” as being above anything that had to do with money; today’s physicians may have defined “professionalism” as being above anything that had to do with money; today’s physicians must redefine what it means to be a professional caregiver.

“Just like hospitals are being forced more and more to think about business models that are not volume-based, so physicians have to think about their roles in the larger system—teamwork, exchange of information, and how to be a leader in cost reduction without harming patients,” Berwick says.

In fact, he believes that physicians, nurses, and other clinicians are the only individuals who can distinguish the elements of care that actually benefit patients from those that are wasteful and potentially dangerous. “They are in the best position to do that,” he says, “so the leadership opportunity is enormous.”

Donald Berwick, MD, is president emeritus and senior fellow, Institute for Healthcare Improvement, Cambridge, Mass.
SUCCESSFUL PHYSICIAN-HOSPITAL ALIGNMENT

More than ever before, physicians and hospital executives must have successful and supportive working relationships to thrive in the era of accountable healthcare delivery. In some instances, a history of distrust and misaligned incentives can make that difficult, but healthcare leaders working in good faith are finding ways to overcome those obstacles.

By Lola Butcher
Even though more than half of all physicians are now employed or contracted by hospitals, many health systems find that physician-hospital alignment remains elusive. The problem stems from both the past and the present.

For one thing, long-standing adversarial relationships between physicians and hospitals continue to haunt many communities. “Depending on whatever has occurred in the town you’re in, there is generally a lot of history on both sides—doctors walking out of meetings, administrators not following through on things they said they would do, and the list goes on and on,” says John Mehalik, MS, MD, an orthopedic surgeon in Fort Myers, Fla. “There’s typically a little bit of bad blood there.”

To complicate matters, much of the physician-employment surge of recent years was driven primarily to bargain for better rates with payers and increase hospital revenues. “A lot of it was based on really maximizing fee-for-service and putting heads in beds,” says Cliff Deveny, MD, senior vice president of physician practice management at Catholic Health Initiatives. “You saw a lot of specialists being hired to capture their ancillaries and move them to provider-based reimbursement.”

However, with the rapid move away from volume-driven health care, health systems now need physicians to share their new goal of decreasing utilization. Physicians who were once considered heroes for the revenue they brought to the hospital may now be viewed as threats to shared-savings contracts.

Thus, health system leaders must find ways to structure symbiotic relationships with physicians, whether they are employed by the system or independent, even as health systems navigate the transition from volume-based success to value-driven delivery. “What we’ve seen is that one alignment plan does not work for everybody,” Deveny says. “Alignment strategies really need to be consistent with the strategic plan of the organization and need to be consistent with its overall mission.”

Thriving with Co-management

Lee Memorial Hospital, one of four acute care hospitals operated by Lee Memorial Health System in Fort Myers, Fla., boasts that its joint replacement program ranks among the top 5 percent in the nation, according to HealthGrades. Kevin Newingham, the system’s vice president for strategic services, attributes much of that success to a three-year-old co-management agreement with 24 orthopedic surgeons from seven different practices.

In a co-management arrangement, a hospital pays a group of physicians to help manage a service line. The agreements, which typically involve a fixed management fee and incentives for quality improvement, patient satisfaction, and/or cost reduction, must be carefully set up to avoid violations of federal anti-kickback and other laws.

Laying out the structure. Among other benefits, the orthopedics co-management arrangement at Lee Memorial ended years of wrangling over implants and supplies that Lee Memorial makes available to the surgeons.

“One the co-management agreement was in place, we could sit down in an open environment and really debate the pros and cons, with the health system sharing its economic dilemma with us and us sharing our clinical dilemma with them,” says John Mehalik, MD, a partner in the Orthopedic Center of Florida and Lee Memorial’s medical director of the orthopedic service line. “The good news is that we still have an enormous choice as surgeons, but working with the health system, we were able to work directly with the vendors to get some of those costs under control.”

Improving first-case on-time starts. That has helped produce a healthy ROI for the co-management arrangement, even after Lee Memorial pays physicians for general management services and incentive bonuses for performance. In addition to saving $1.5 million on
implant costs in the past three years, co-management is responsible for reducing the readmission rate for total knee replacement patients by 25 percent, say Mehalik and Newingham. In addition, first-case on-time starts have risen to more than 90 percent and the hospital’s physician communication score on the HCAHPS patient satisfaction survey has improved.

The surgeons co-own a limited liability corporation that contracts with Lee Memorial for specific services, including medical direction, protocol development, staff education, input into strategic and operational plans, clinical oversight, and community outreach.

A leadership council comprised of four surgeons and four health system representatives oversees the co-management agreement. The agreement provides a base management fee and opportunities for surgeons who are shareholders to earn a clinical incentive fee tied to the hospital’s performance on first-case on-time starts, appropriate antibiotic administration, wrong-site surgery, patient satisfaction, and other measures. The limited liability corporation distributes its profits to surgeons who are shareholders.

Unlike some other alignment strategies, surgeon fees are not bundled with hospital fees in a co-management arrangement. Surgeons are paid on a fee-for-service basis; however, a co-management arrangement that improves hospital efficiency may also increase a surgeon’s income.

“If my turnover time is 10 minutes or 15 minutes faster in the operating room, it allows me to do one more case per day,” Mehalik says. “That improves my efficiency by 14 percent.”

**Addressing geriatric fractures.** A big win in 2012 was the launch of a geriatric fracture program, which Mehalik likens to stroke programs that have been established at many leading hospitals, ensuring high-risk patients receive immediate, evidence-based care. “As soon as a patient hits the emergency room with a certain diagnosis, there’s a protocol established,” he says. “Everybody knows what the order sets are going to be. Everybody knows what the pathway is going to be. Everybody knows what the timeline is going to look like, and everybody can work efficiently towards that.”


But building a program requires a multidisciplinary effort that includes emergency department leaders and staff, admitting physicians, and others outside the orthopedics service line. Because of their co-management role at Lee Memorial, physician leaders were able to complete the research, team-building, and protocol development in a single year, much more quickly than would have otherwise been possible.
Now that the program is in place, the surgeons’ 2013 performance metrics include the readmission rate for geriatric fracture patients.

Building a foundation. Despite his enthusiasm for the alignment model, co-management is not easy, Newingham says, because hospital staff members and independent physicians typically have entrenched ways of interacting. Building trust, new processes, and new levels of authority and responsibility requires an administrative champion, a strong physician leader, and input from operational leaders from the outset.

“It’s easy for organizations embarking on this type of a strategy to underestimate the challenge. We certainly underestimated it,” he says. “We have made a lot of progress, and it’s been very rewarding to see changes emerge, but the old adage that ‘culture eats strategy for lunch’ is certainly true.”

Mehalik recommends co-management as an alignment strategy not just for orthopedic programs but for many other areas of health care. “If we cannot get to a state where physicians and the hospital systems are working together to make sure that the care is efficient, affordable, safe, and satisfying down the road, we are not going to get the job done,” he says. “I think, really, this is the foundation on which the future of health care is going to be built.”

PAYING PHYSICIANS FOR PERFORMANCE

Reviewing two approaches. In place for nearly a decade, the pay-for-performance system has been well received by its physicians, and Geisinger has increased clinical service revenue by more than 10 percent annually since 2002. According to the Health Affairs article, “…clinicians find Geisinger’s compensation reasonable and fair because the number of physicians employed by the organization is increasing and the physician turnover rate is low.”

Additionally, health plan claims data suggest that Geisinger-employed physicians have improved quality and efficiency faster than other physicians in the health plan’s networks.

While pay for performance is a straightforward alignment approach, it is not one that is easily adopted in

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<th>Quality: Each physician typically has four or five measures that reflect Geisinger’s overall goals.</th>
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<td>Innovation: An example would be developing a new program that reduces length of stay for a certain group of patients.</td>
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<td>Legacy: Measures reflect pursuit of Geisinger’s educational and research missions. An example would be completing 100% of resident evaluations within 30 days.</td>
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<td>Growth: Measures reflect contribution to increasing the population that Geisinger serves. An example would be developing Spanish podcasts for a women’s health website.</td>
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<td>Financial: Physicians who exceed productivity benchmarks earn modest increases in compensation.</td>
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all health systems. The 11-hospital New York City Health and Hospitals Corp. (HHC), the nation’s largest public health system, recently introduced pay for performance to nearly 3,500 physicians through its physician affiliation contracts with New York University School of Medicine, the Mount Sinai School of Medicine, and the Physician Affiliate Group of New York (PAGNY).

HHC intends to reward physicians with up to $59 million in incentive payments over three years if physicians lower readmission rates, improve care coordination and preventive health services, decrease emergency department wait times, improve communication with patients, and run more efficient operating rooms. The pay-for-performance program is designed to correlate to federal and state initiatives—penalties for high readmission rates, value-based purchasing, and patient-centered medical home criteria—that will influence HHC’s financial success.

Addressing the barriers. Luis R. Marcos, MD, CEO for PAGNY, said he thinks the pay-for-performance concept will eventually work but cultural barriers will be significant. Physicians who work at HHC hospitals have never had pay tied to productivity or any other factor, and many derive professional satisfaction from their hospital’s mission.

“I personally believe it is reasonable, and human beings do respond to incentives in their behavior and in their work,” he says. “But, in this culture, ‘bonus’ is a word that people react to negatively because it is considered that physicians here take care of patients regardless of their ability to pay and ‘bonus’ is applicable to the private sector.”

Assuming the performance standards are met, the financial incentives will be awarded to the three affiliates, which will decide how to distribute the money among their members. While emergency physicians and surgeons will be able to directly influence the pay-for-performance metrics, many others will not. “If I’m a radiologist or a pediatrician working in a clinic or a pathologist,” Marcos says, “I’m going to get the money as well, but how do I connect my work with the performance indicators when my department is not even involved? I would say that about 70 percent of the physicians will not see a connection between what they do and the money they are receiving.”

He believes some physicians will be uncomfortable receiving financial incentives when other members of the care team are not eligible. “When you get some incentive money based on the performance indicators and the nurses around you don’t, sooner or later that will have to be explained,” he says.

And one more barrier to physician acceptance: The pay-for-performance incentive program replaces the cost-of-living adjustments that HHC has previously made to physician salaries. Thus, a physician’s base salary, which influences his or her retirement benefits, will not increase over time.

Despite the challenges ahead, Marcos, a physician at NYU Langone Medical Center, believes HHC is right to pursue pay for performance. “It’s the way to go, but the devil is in the details,” he says. “It’s going to take time and a lot of good communication and teamwork.”

REORGANIZING FOR SUCCESS

UnityPoint Health, a system of 29 hospitals and more than 288 physician clinics, took a broader approach when it developed its physician alignment strategy four years ago. At that time, UnityPoint (formerly Iowa Health) employed more than 900 physicians across the state, but there had been no attempt to create a cohesive group.

“We had some physicians sitting in isolated practices, some within medical groups employed directly by the hospitals, and some in medical groups that were separate corporations underneath the system or the hospitals,” says Alan Kaplan, MD, president and CEO of UnityPoint Clinic. “There were no expectations of cultural fit or performance—only of employment.”

Outlining the steps. When UnityPoint leaders decided to form an accountable care organization (ACO), its executives recognized that it could not succeed without bringing those physicians into alignment with the goals and vision of the system.

A four-component strategy was devised:

Move from hospital-centric to patient-centric and physician-driven. Physicians are now embedded in every level of governance, starting with the system’s board of directors. These physician leaders represent the patient care decision makers.

Create a physician leadership academy. In the past three years, about 75 physician leaders have graduated from the academy, which requires completion of 118 hours of on-site sessions and online courses and partnering with administrators to carry out a project that supports the health system’s strategic plan. “Those graduates have
filled all of the leadership spots in regard to the ACO, medical group leadership, and quality improvements,” Kaplan says. “We don’t pay recruitment fees for physician leaders—we just grow them inside.”

Develop a physician practice alignment approach. UnityPoint is transitioning employed physicians from what Kaplan calls “aggregated practices” into a strategically and operationally aligned medical group.

Create a clinically integrated network. The goal is for employed and independent physicians to work together on quality issues and participate in value-based contracts. This is still in the development stage.

Forming a single cohesive medical group. While the four components work together, “the employed physicians are the big story,” Kaplan says.

During a two-year process, UnityPoint created a single new medical group, transitioned physicians to a single compensation plan, and created and implemented a pay-for-performance system.

To start, dozens of disparate medical groups sent representatives to a meeting with Kaplan and a consultant—and no other UnityPoint executives. “We brought everyone in through a senate model so that the biggest group of 300 physicians did not overwhelm the little groups of 10 physicians or 50 physicians,” Kaplan says. “We sat as equals. Instead of deciding which group we were going to merge into, we used a blank piece of paper to create the medical group that we would all aspire to be part of.”

That approach was key to success because representatives at that meeting became advocates for the new medical group. “When they went back to their respective organizations and their partner said, ‘I’m not moving in with Medical Group X. I don’t even like them,’ their own partner would say, ‘This isn’t Medical Group X. This is our organization. I helped craft it,’” Kaplan says.

On Jan. 1, 2012, a total of 540 physicians merged into a new group, which is called UnityPoint Clinic, and another 300 have signed letters of intent to join in the next few years. The medical group has its own board of directors and delegates on the UnityPoint board.

Hitting quality targets. To reinforce the importance of a fresh start, UnityPoint physician leaders and system executives were invited to a two-day culture retreat where they went through a facilitated process to articulate the organization’s values. The values—patient-centric, integrity, pursuit of excellence, partnership, and community stewardship—are used intentionally to reinforce a new culture and a new way of interacting.

“If we’re in a governance meeting and we’re not quite sure where to go with an issue, it is easy to bring conversations back to the values: ‘Is this about patients first, or not?’ Then, we can move down the line,” Kaplan says. “It has been a huge help in governance, management, and leadership.”

Catholic Health Initiative’s T. Clifford Deveny, senior vice president of physician practice management (center), with James Slaggert, vice president, clinically integrated networks, and Chris Rhodes, director of communications, physician enterprise.
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Today, UnityPoint is responsible for 223,000 patients covered by four separate ACO arrangements. The alignment strategy proved itself in 2012—the first year of the system’s agreement with Wellmark, the Blue Cross and Blue Shield plan in Iowa—when UnityPoint hit all the quality targets needed for financial success.

“The only reason we were able to do that is because we had one quality department and one governance structure and line management so we can deploy a strategy,” Kaplan says. “If we were a bunch of different medical groups, we never would have gotten everyone on the same page to make that happen.”

WHAT NOT TO DO
At Catholic Health Initiatives, the second-largest faith-based system in the country, Deveny believes that appropriate physician-hospital alignment supported by transparent performance measurement can help hospitals navigate the transition from volume to value.

Speaking at an American Health Lawyers Association event, Deveny said many physician alignment initiatives are doomed from the outset. Hospital executives are not comfortable sharing power and control with physicians, do not manage physicians appropriately, and are not sure what they want from physician alignment.

“Is it all about the downstream revenue? Is it really about having a cost center and meeting the budget? Or should we be making a profit on this?” he says.

“There is still a lot of uncertainty as to what the value proposition is going forward.”

Common mistakes include using a single compensation model for all physicians—a surgeon and a palliative care physician require different pay structures—and hiring or contracting with physicians without sufficient due diligence.

Perhaps the most common mistake, he says, is the failure to delineate in writing what the health system expects from the physician and what the physician can expect in return. “The elephant in the room is really around accountability,” Deveny says. “You are joining our organization, and here’s what we expect.”

Lola Butcher is a freelance writer and editor based in Missouri. Interviewed for this article (in order of appearance): T. Clifford Deveny, MD, is senior vice president for physician practice management, Catholic Health Initiatives, Englewood, Colo. Kevin Newingham is vice president-strategic services, Lee Memorial Health System, Fort Myers, Fla. John Mehalik, MS, MD, is partner, Orthopedic Center of Florida, and medical director of the orthopedic service line, Lee Memorial Health System, Fort Myers, Fla. (jmehalik@ocfla.net). Luis Marcos, MD, is medical director for affiliations, New York University School of Medicine, and acting CEO, Physician Affiliate Group of NewYork (Luis.Marcos@nyumc.org). Alan Kaplan, MD, is president and CEO, UnityPoint Clinic, Des Moines, Iowa (kaplana@ihs.org).
REVAMPING SERVICE LINE PLANNING

Mission Hospital developed a streamlined planning approach built on enhanced data automation and standardized tools and processes.

By Laura Ramos Hegwer
For years, leaders at Asheville, N.C.-based Mission Hospital—the flagship of a 1,000-bed, five-hospital, not-for-profit system—had been developing strategic plans for their service lines that supported the health system’s goals and were grounded in extensive data. But the timing was off.

“The planning process for our core service lines was either happening simultaneous to the development of the annual budget, or it was coming after, in which case we were writing the business plans after budgets were complete,” says Kate Schmitz, MHA, vice president of service line planning and business support. “It wasn’t our intent, but it continually happened that way due to the increasing volume of strategic planning projects our team was asked to facilitate.”

In November 2011, a three-person service line planning team set out to redesign the process so that it would be in sync with the annual budget cycle—which meant starting the planning process three to six months earlier.

ASSESSING THE PROCESS
Driven by a directive from the hospital’s CEO to move the service line planning process ahead of the budget process, the team assessed what worked and what needed to change. Of the elements that were working well, three stood out:

- Dedicated planning liaisons for each core service line
- Multidisciplinary, core planning teams that included business managers
- Facilitated planning retreats that resulted in goals with quantifiable targets

The list of needed improvements to the process was more extensive:

- An annual planning calendar that puts more emphasis on pre-planning tasks
- A streamlined list of data sources focused on program development and market growth
- Ongoing data retrieval and automation to the greatest extent possible
- Standardized planning tools and processes to streamline and facilitate review by senior leadership
- An enhanced role of service line business managers in data collection and analysis

DEVELOPING A NEW PLANNING CALENDAR
A critical step in the redesign process was creating a calendar that ensured the CEO’s charge was achievable each and every fiscal year. Because Mission’s fiscal year runs from October to September, the hospital’s planning cycle was reconfigured into four quarters, each with specific tasks and objectives. The exhibit, on page 13, shows the key steps in each phase.

As part of the redesign, the team allowed more time for pre-planning tasks so the business plans could be completed in time for inclusion in the annual capital and operating budgets.

STREAMLINING DATA, STANDARDIZING TEMPLATES
In addition to creating the calendar, one of the most critical aspects of the redesign was determining which data provided the greatest strategic value in the pre-planning phase, according to Cathi Durham, MBA, MHA, director, business development and strategy. “We asked ourselves, does this data have strategic importance? Does it help support the decision-making process? If not, we pulled it out.”

Specifically, the planning team—which includes Schmitz, Durham, and a senior planning analyst—was able to eliminate scores of data elements related to operational, quality, and productivity measures that were being regularly reported and intensely monitored in other venues. While critically important, the reporting of such measures in the strategic plan ended up being static and didn’t offer much insight into the strategic direction of the service line. “The plans needed to focus on enhancing and growing services that are financially viable and demanded by the community, not on answering every single question about the service line,” Durham says.

The planning team also trimmed the breadth and depth of market data they analyzed and shared with the service line planning teams. “We were doing a deep dive on every market and service, and it was taking days to manipulate ... Now, with less time spent in the data weeds, we have more time during the pre-planning phase to actually think and draw initial conclusions ...”
time during the pre-planning phase to actually think and draw initial conclusions to share with service line leadership,” Schmitz adds.

A sharper focus has also helped make planning meetings with the service lines more meaningful, she adds. Before the redesign, Schmitz and her colleagues spent most of their meeting time presenting data. “Now we are able to spend more time in the qualitative aspects of the service strategy and facilitating discussions about where we need to be, how will we get there, and how we are going to measure it,” Schmitz says.

In addition to streamlining the data, standardized templates for the plans and pro formas were developed, which further enabled the development of multiple plans simultaneously. Not only did standardization reduce the amount of time required to develop the core data elements and analyses, it also facilitated reporting and communication of the plans, Schmitz says. “Prior to the redesign, senior leadership reviewed multiple plans in multiple formats and at different time intervals. Now they receive a recognizable product that they can more quickly review and find the answers to their questions,” she says.

**AUTOMATING DATA COLLECTION**

With a small team of planners and a growing list of services to support, the planning team realized that it needed to adopt and employ tools to automate as much of the data formatting and reporting as possible. Now the team uses a commercially available data visualization tool to automate its quarterly market share reporting. “We have created templates for each service line and are able to develop highly detailed reports by service area and sub-service lines within two weeks versus two months,” Durham says. “This allows the team to provide more regular reporting of market presence and trends, and as a result, service line leaders have a much deeper understanding of their service line’s market position.”

**BALANCING VISION WITH REALITY**

According to Schmitz, the core service line planning teams at Mission Hospital were designed to balance strategic visioning with operational and financial reality. The teams include the service line vice president, the service line director, a business manager, physician leaders, and select stakeholders. The teams are coordinated and facilitated by the designated planning liaison.

Mission Hospital has a group of business managers who report to Schmitz and are assigned to specific service lines to work directly with the service line leadership teams on financial and statistical data needs. They collaborate routinely with the decision support team...
and the budget team in the finance department on complex data extracts, pro forma development, annual budgeting, and a host of other ad hoc data needs and analyses. “These individuals are the key component to ensuring that the strategic planning process has a significant tie to the service line annual budget and to tracking and monitoring the impact of strategic initiatives,” Schmitz says.

ADAPTING MISSION HOSPITAL’S APPROACH

Schmitz and Durham say the redesign has led to a more results-oriented strategic planning process at the service line level. They offer these suggestions to other organizations looking to revamp their planning approach:

**Automate and simplify data collection whenever possible.** Mission Hospital developed a resource library to facilitate access to the most recent data and analyses. The resource library is a simple, Excel-based tool with hyperlinks to the most recent data and formatted charts and graphs. Having quick access to data sources helps planning members save time and preserves the “source of truth” for each data element, thereby avoiding conflict arising from multiple data sources, Durham says.

**Develop a dashboard to keep the momentum going.** Service line leaders at Mission Hospital use a dashboard to help implement their strategic plans and track their progress (see the exhibit above). They can also pull metrics from the dashboards to use in their status updates.

Finally, Schmitz recommends viewing the planning process as a continual cycle. The process should focus just as much on implementation and tracking as it does on plan development, she says.

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Cathi Durham, MHA, is director, business development and strategy, Mission Hospital, Asheville, N.C. (cathi.durham@msj.org).
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When this first-time CEO joined a failing health system in rural Kansas, he knew he would have to recruit physicians, re-establish patient confidence, and replenish the organization’s finances. He didn’t know that he would have to go to Zimbabwe to get started.
Benjamin Anderson was a physician-recruiter in Dallas when he set his career goal: Become a rural hospital CEO by the time he was 40. He got his chance in late 2008 when he was called to interview at Ashland Health Center, which includes a 24-bed critical access hospital, a long-term care unit, and a rural health clinic.

As Anderson recalls: “The board chairman said, ‘Ben, these facilities are 55 years old, our finances are upside down, we have no doctor and no CEO, and we’ve had neither for more than six months. Our morale is low, our turnover is high, and if we don’t turn this thing around quickly, we’re going to lose this facility. If that happens, we’ll lose our schools because we won’t have the jobs to support our schools. And if that happens, we’ll lose our community.’”

Anderson took the job.

THE RECRUITING MISSION
Shortly after assuming the helm at Ashland Health Center, Anderson arranged a meeting with two physician faculty members from the Wichita-based Via Christi Family Medicine Residency to get advice about the hospital’s most pressing need: How to recruit physicians to a town of 900 residents that is an hour’s drive to the closest Walmart.

They told Anderson to look for physicians who are committed to international medical missions. Physicians who are willing to practice medicine in a mud hut in Africa don’t put a lot of value on having a nearby Nordstrom’s or fancy restaurants; they are motivated by the opportunity to serve. To recruit mission-driven physicians, Ashland Health Center needed to offer a good quality of life in rural America and significant time off—up to eight weeks a year—that clinicians could use to work in a developing country.

The two faculty physicians then challenged Anderson to prove that he was committed to mission-focused health care by going to Africa himself. “Just flipantly, I said, ‘All right. I’ll go,’” Anderson says. “I didn’t really have any idea what I was signing up for.”

A LIFE-CHANGING TRIP
Ten months later, he flew to Zimbabwe to build screens that keep cobras and mosquitoes out of missionary housing. The trip changed his life and the life of Ashland Health Center.

“Coming back, I decided this was really the direction that our organization needed to go, not just for physicians, but for all of our staff,” he says. “If all of our staff could have an opportunity like this, it would transform the culture in our organization.”

Two years ago, Ashland’s board approved a policy that allows every employee to take between four and eight weeks off work each year for mission trips or any other purpose. Since then, a maintenance worker, certified nurse assistant, and other staff members have gone on mission trips.

And the health center now has two physicians, both of whom have worked as medical missionaries in developing countries.

BOTTOM-LINE RESULTS
With the two new physicians, a physician assistant, and a nurse practitioner (in addition to the physician assistant who did solo duty before the new staff arrived), Ashland’s service volumes are up in every category. In 2012, the health clinic treated 27 percent more patients than the year before.

When Anderson arrived on the job in January 2009, the organization had about two weeks of operating capital in the bank. Today, that number is $1.6 million, or about 80 days of operating capital.

“We are regaining some of the trust that had been lost and starting to attract a patient base from outside the community,” Anderson says.
By identifying employee and executive behaviors that drive results and designing incentive plans that have teeth, organizations are accomplishing lofty goals.

Setting clear goals and rewarding leaders and employees for meeting targets are common factors in the incentive plans developed by North Mississippi Health Services (NMHS) and North Shore-LIJ Health System.

NMHS, a two-time recipient of the Malcolm Baldrige National Quality Award, encourages employees to adopt specific behaviors that directly impact the health system’s objectives. North Shore-LIJ uses a scorecard approach to unify a mammoth health system around common goals. In 2010, the health system won the National Quality Forum’s National Quality Healthcare Award.
How are you ensuring that NMHS employees and executives are focused on health system goals?

Brown: We created a clear and aligned connection between NMHS’s critical success factors—people, service, quality, finance, and growth—and employee behavior. To accomplish that, we identified “high-impact behaviors,” which are specific actions our employees take to positively contribute to our goals.

For example, a high-impact behavior for inpatient satisfaction is hourly rounding. Unit staff coordinate their schedules to ensure that someone checks on patients on a regular basis. This reassures patients and family members that we are checking on them both clinically and from a service perspective.

In the emergency department, a survey revealed that the top drivers of patient satisfaction are wait times and the patient’s perception of the quality of physician care. Our emergency department staff is keenly aware of reducing the amount of time people spend in the ED, but that isn’t always possible. When long wait times are unavoidable, staff can minimize patient frustration by executing the high-impact behaviors that we’ve identified. These include setting expectations on arrival, updating patients on a regular basis about how long they can expect to be in the emergency department, and letting patients know what the next step in the care process will be.

To underscore the importance of patient satisfaction, hospital staff members have the authority to spend up to $50 to fix a patient complaint. For example, if long wait times meant that patients missed lunch or incurred extra travel charges for a return trip, staff members can offer to buy them a meal or reimburse expenses.

What approach is North Shore-LIJ taking?

Cabral: At North Shore-LIJ, we first ensured that the health system’s goals were meaningful and reflected areas that would lead to success. We talked with senior leaders and found that the goals they were focusing on were different than those that the health system was measuring. We suspected that same misalignment of goals among our staff employees.

To repair the disconnect, we created a clear method for communicating goals across the organization. We have about 46,000 employees and 350 physician and ambulatory groups that came together as a result of a merger about a decade ago. To communicate goals across such a large organization, we report monthly results of our three measures—quality, patient satisfaction, and financial performance—on a scorecard on our intranet and on bulletin boards throughout our facilities. We compare how we are performing internally, and we also benchmark our performance against national numbers.

Finally, we developed a short-term incentive program for our leadership. The reward had to be significant enough, and it had to be a component of pay rather than an addition to annual salary. There is nothing subjective about the measurement tool. You either hit your target or you don’t. That is powerful.
Can you share more details about North Shore-LIJ’s leadership incentive program?

Cabral: North Shore-LIJ implemented a short-term incentive program for top-level executives because we wanted them to work alongside our frontline staff on our top goals: quality, patient satisfaction, and financial performance (see the exhibit below). The executives have the same targets as our housekeepers, nurses, and laundry workers. Some of the specific metrics we’re tracking include the likelihood that patients will recommend our health system, performance on Medicare quality indicators, and reducing length of stay.

To strengthen the power of the executive short-term incentive program, we designed it as a component of pay. That gets everyone’s attention. The target incentive is 20 percent of base salary. We pay some portion of that percentage depending on how well the health system meets its goals at threshold, target, or stretch levels for each of the components. Then the payout is calculated depending on the percentile by which the goal is met.

A few executives questioned how they could be measured on patient satisfaction when they don’t interact with patients every day. We offered specific examples to make the correlation. For example, a chief legal officer contributes to the patient satisfaction target by identifying potential hotspots that could result in patient lawsuits.

To encourage collaboration between executives in different facilities within our system, 40 percent of the bonus is reliant on how the entire health system performs,

### NORTH SHORE-LIJ’S ANNUAL INCENTIVE PLAN CALCULATION

<table>
<thead>
<tr>
<th>Your Name and Title Here</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Salary</td>
</tr>
<tr>
<td>Target Bonus</td>
</tr>
<tr>
<td>Target Total Cash Compens.</td>
</tr>
<tr>
<td>Actual Bonus as of Sept. 17, 2007</td>
</tr>
<tr>
<td>Actual Total Cash Compens. as of Sept. 17, 2007</td>
</tr>
<tr>
<td>Above (Below) Target</td>
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</table>

<table>
<thead>
<tr>
<th>System</th>
<th>(100% Weight)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Weight</td>
</tr>
<tr>
<td>Patient Experience</td>
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</tr>
<tr>
<td>Quality</td>
<td>25%</td>
</tr>
<tr>
<td>Quality/Financial Perf.</td>
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</tr>
<tr>
<td>Financial Performance</td>
<td>25%</td>
</tr>
<tr>
<td>System Results</td>
<td></td>
</tr>
</tbody>
</table>

Link between performance and bonus payout:

<table>
<thead>
<tr>
<th>Performance</th>
<th>Payout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threshold</td>
<td>50%</td>
</tr>
<tr>
<td>Target</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum</td>
<td>150%</td>
</tr>
</tbody>
</table>

Source: North Shore-LIJ Health System. Data for illustrative purposes only. Used with permission.
and 60 percent is based on how well the executive’s business unit performs.

We expect our leaders to seek guidance from other higher-performing facilities to find solutions to their units’ weaknesses. For example, if one hospital is in the 90th percentile in patient satisfaction scores, and another is in the 30th percentile, the executive from the lower performing facility must reach out to the executive who drives higher scores. If not, that lack of initiative will impact the incentive pay.

At the request of our executives at each facility, we developed a targeted incentive plan for their subordinate leaders equal to 10 percent of their base pay. The incentive is a component of their salary, and this next level of leaders is measured on the same components (patient satisfaction, quality, and financial performance) as the executives, creating alignment.

To ensure subordinate leaders are focused on the results of their individual facilities, 70 percent of their incentive is based on the business results of their particular unit, while 30 percent is based on the performance of the entire health system.

**Does NMHS also have a financial incentive plan?**

**Brown:** We are the only health system in Mississippi to have a team incentive plan for all full- and part-time employees, including our senior leaders (see the exhibit below). That broad coverage of all employees is a major factor in our organization’s success.

Each facility is measured on patient satisfaction and cost-per-unit of service. Employees can earn an annual bonus from 0 percent to 5 percent of their annual salaries depending on the level they achieve on each goal.

For the patient satisfaction goal, the payout ranges from 1.5 percent at the 75th percentile, 2 percent at the 80th percentile, and 2.5 percent at the 90th percentile. The cost-per-unit of service payout ranges from 1.5 percent at 3 percent over target cost, 2 percent at target cost, and 2.5 percent at 5 percent under target cost.

That’s a potential 5 percent bonus for teams meeting the highest levels of patient satisfaction with efficient operations. Employees receive monthly feedback on their progress. Quality of care is also considered. It is measured based on patient satisfaction survey results.

In addition to providing financial rewards to employees, the team incentive plan is a great way to communicate organizational goals. I look at it as a communication strategy as much as a compensation strategy.

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**NORTH MISSISSIPPI HEALTH SERVICES’ TEAM INCENTIVE PLAN**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Level 1 Goal</th>
<th>Level 1 Award*</th>
<th>Level 2 Goal</th>
<th>Level 2 Award*</th>
<th>Level 3 Goal</th>
<th>Level 3 Award*</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patient satisfaction</td>
<td>75th</td>
<td>1.5%</td>
<td>80th</td>
<td>2.0%</td>
<td>90th</td>
<td>2.5%</td>
</tr>
<tr>
<td>Cost-per-unit of service (CPUS)</td>
<td>103% CPUS goal</td>
<td>1.5%</td>
<td>100% CPUS goal</td>
<td>2.0%</td>
<td>95% CPUS goal</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total award opportunity</td>
<td></td>
<td>3.0%</td>
<td></td>
<td>4.0%</td>
<td></td>
<td>5.0%</td>
</tr>
</tbody>
</table>

*Actual awards are percentages of gross salaries for the measurement period. Levels are independent of each other.

Source: North Mississippi Health Services. Used with permission.
Have you documented any improvements or successes related to the goals associated with your reward programs?

Brown: In 2005, we improved our alignment by measuring our incentive performance targets against our critical success factors: people, service, quality, finance, and growth. Since that time, our patient satisfaction score increased 10 percentage points, and our healthcare quality scores increased 8 percentage points.

We also maintain an AA bond rating, demonstrating our strong financial performance. The icing on the cake was when NMHS won the Malcolm Baldrige National Quality Award, once in 2006 for our 650-bed flagship medical center and again in 2012 for the entire health system.

Cabral: Inpatient satisfaction rose by 3.3 percent between 2006 and 2010, and satisfaction among patients who visit our emergency departments rose 8.3 percent in that same time period.

We also saw positive results on the Medicare measures: AMI [heart attack], HF [heart failure], PNE [pneumonia], and SCIP [surgical care improvement project]. Between 2006 and 2008, AMI improved by 11.6 percent, HF by 9.3 percent, PNE by 3.2 percent, and SCIP by 8.2 percent.

In addition, our ICU central-line associated infections fell by 70 percent, ICU ventilator-associated occurrences of pneumonia fell by 50 percent, surgical site infections fell by 24 percent, and MRSA infections fell by 23 percent. Length of stay fell from 5.26 days in 2007 to 4.85 days in 2010.

Harnessing the Giving Incentive

Service to others is an untapped workplace motivator and may surpass pay and promotions as factors in improving productivity, according to Adam Grant, PhD, an expert on organizational psychology and a professor at the Wharton School. When workers recognize the connection between their work and the people they are helping, they do their jobs better, Grant writes in his new book Give and Take (The Viking Press).

For example, an Israeli study found that attaching patients’ photos to their CT scans increased radiologists’ diagnostic accuracy by 46 percent. In addition, 80 percent of the radiologists’ key diagnostic findings were discovered only when they saw the patients’ photos.

As Grant explains in his book, most people are either “takers,” “matchers,” or “givers.” In the workplace, takers try to get as much from others as possible while matchers trade favors evenly. In contrast, givers are willing to go the extra mile for others without expecting any specific return. They see their work as a way to serve others, whether that is patients, customers, or their fellow workers.

Making the connection between work and mission has an added benefit: It counteracts worker burnout, which is a common challenge for givers. Successful givers use two strategies to limit burnout. The first is seeking help from others when they become overwhelmed. The second is recognizing the positive impact of their work on others.

For example, Grant shares the story of a university call center where workers tasked with soliciting alumni donations experienced burnout and reduced productivity. The givers were the lowest performers because their failures to bring in donations deprived them of their highest motivation—helping others. However, their results turned around when they received letters and spoke on the phone with students who received scholarships funded by the donations. Money collected rose from $412 to $2,000 per shift. Although all of the call center workers improved their productivity, those classified as givers demonstrated the highest gains in effort and revenue.
Are there any nonfinancial rewards that you tie to organizational goals?

Brown: Our Ideas for Excellence program rewards employees for submitting ideas that would improve one or more of our critical factors or is a Lean or innovative idea. In 2012, we received more than 12,000 ideas, and we implemented one-third of them. For example, at one facility, an administrative employee noticed that daily reports printed on costly four-part computer paper weren’t being used. Her recommendation to stop printing the reports was approved, and the facility saved $12,000 per year on paper costs.

Another nonfinancial incentive program initiative, Stars Online, invites employees to nominate co-workers for acts of kindness or exemplary service. Last year, 5,350 employees were recognized as Stars.

Points earned for ideas accepted by Ideas for Excellence and for being recognized through Stars Online can be used to purchase items from an online gift catalog.

Cabral: Before any organization implements a nonfinancial incentive program, it should ensure that employees are receiving competitive compensation and benefits. Employees who are paid well aren’t distracted by salary issues, and they can focus on the goals set forth in your nonfinancial reward programs.

Our nonfinancial rewards include recognizing employees for exemplary performance and length of service with a personal letter of appreciation and a choice of gifts from a catalog. The value of the gifts increases based on employees’ tenure with the health system.

In addition, our Annual President’s Award Program recognizes team members across the system for extraordinary performance in three areas: exceptional patient experience, innovation, and teamwork. The award presentation is one of the most widely anticipated employee events at North Shore-LIJ.

What challenges or lessons learned can you share? How did you overcome those obstacles?

Brown: Employees need to realize that the incentives are not awarded automatically each year: They must be earned. Our emphasis on identifying behaviors that drive results is helping employees become self-motivated to achieve organizational goals.

Also, we realized that you have to consider everyone who contributes to your organization when you develop an incentive program. For example, our non-employed physicians weren’t participating in our Ideas for Excellence program and Stars Online because they didn’t have access to the electronic nomination form.

Once we expanded access, participation from those groups increased.

Cabral: When we implemented the short-term incentive program to drive patient satisfaction scores, we saw scores improve within the first six months. However, once we took our eye off the ball, and we stopped the incentive program, the numbers went right back to where they were. Why? We didn’t design the program to sustain the change and the momentum. That is why many incentive programs fail. My advice is to develop incentive and reward programs with a long-term strategy.
TRENDS IN HEALTHCARE EXECUTIVE PERFORMANCE INCENTIVES

Annual incentive plans that reward executives for achieving year-end goals are almost universal across hospitals and health systems, according to data from Integrated Healthcare Strategies. Some large health systems also have long-term performance incentive programs that encourage leaders to achieve targets over a multi-year period.

Although financial performance is still the top criteria against which healthcare executives are measured, a large majority of health systems and hospitals also track patient satisfaction and clinical quality, according to Sullivan, Cotter & Associates, Inc.

### TYPICAL ANNUAL EXECUTIVE INCENTIVES, 2012-2013

For annual goals, many healthcare executives receive incentives as a percentage of salary. These incentives are awarded in addition to salary.

<table>
<thead>
<tr>
<th>Position</th>
<th>Annual Target Award</th>
<th>Maximum Annual Award</th>
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</thead>
<tbody>
<tr>
<td>System CEOs</td>
<td>30% – 40%</td>
<td>35% – 60%</td>
</tr>
<tr>
<td>Other system executives</td>
<td>20% – 30%</td>
<td>30% – 45%</td>
</tr>
<tr>
<td>Hospital CEOs</td>
<td>20% – 30%</td>
<td>30% – 45%</td>
</tr>
<tr>
<td>Other hospital executives</td>
<td>15% – 20%</td>
<td>20% – 30%</td>
</tr>
</tbody>
</table>


### TYPICAL LONG-TERM EXECUTIVE INCENTIVES, 2012-2013

For achieving goals across several years, many healthcare executives receive incentives as a percentage of salary in the following ranges. These incentives are awarded in addition to salary.

<table>
<thead>
<tr>
<th>Position</th>
<th>Multi-Year Target Award</th>
<th>Maximum Multi-Year Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>System CEO</td>
<td>15% – 30%</td>
<td>25% – 60%</td>
</tr>
<tr>
<td>Other senior executives</td>
<td>10% – 20%</td>
<td>15% – 30%</td>
</tr>
</tbody>
</table>


### TYPES OF PERFORMANCE METRICS TIED TO HEALTHCARE EXECUTIVE INCENTIVES

In 2012, healthcare executives in health systems were awarded annual incentives based on the following criteria.

Incentives can produce improvements—or lower quality, if leaders are not vigilant.

James L. Reinertsen, MD, is CEO, The Reinertsen Group (jim@reinertsengroup.com).

Healthcare organizations are under great pressure to reduce costs while maintaining or improving quality and safety. It’s true that not all costs are within the direct control of providers (for example, the obesity epidemic, high malpractice costs, pockets of poor social support that spawn exceptionally high utilizers, and the mind-boggling administrative costs of our private multi-payer insurance model).

However, some cost drivers are under our control. At the top of that list is overuse, driven mainly by the over-supply of procedural and specialty services, which in turn is driven by a payment model that rewards physicians for high volumes of lucrative procedures and tests.

Also high on the list is misuse, driven by potentially avoidable complications of care, which occur because our organizational cultures, systems, and environments do not foster or reward high levels of safety and reliability.

We know the old incentive system doesn’t work. But will our new set of incentives be any better? Will value-based purchasing (VBP) rewards for high scores on quality measures, penalties for healthcare-acquired conditions, bundled payments for procedures and chronic diseases, and accountability for cost and quality for populations in accountable care organizations (ACOs) change the cost trajectory while maintaining or improving quality and safety?

DEMING ON INCENTIVES
As we watch this complicated experiment unfold, and as we urge our physicians and staff to achieve better scores on dozens of measures, leaders should keep in mind W. Edward Deming’s view of incentives. He held that there are three ways to achieve a better number:

> Improve the system (i.e., make things better)
> Sub-optimize the system (i.e., achieve the number at the expense of something else, perhaps more important, but unmeasured)
> Cheat

Deming warned that the stronger the incentive to achieve a number, the higher the likelihood of sub-optimization and cheating, rather than true improvement.

Examples of Deming’s concern are playing out now. Many organizations are expending enormous resources to achieve top decile performance on VBP measures, when the gap between current performance (95 percent, say) and top decile (usually 100 percent) is clinically insignificant and driven almost entirely by documentation and coding.

Could those resources be better spent improving something else that is unmeasured, but very important? Probably. Will hospitals that were stung by penalties for readmissions put pressure on their medical staffs to put patients in observation beds rather than readmit them? I’ve already seen that scenario playing out. What about the race to get meaningful use rewards for electronic health records that we aren’t really ready to deploy, and the potential for making safety worse instead of better (Institute of Medicine, Health IT and Patient Safety: Building Safer Systems for Better Care, 2012)? And who doesn’t think that aggressive coding won’t drive some bundled payment budgets and some risk-adjusted population costs, on which ACO shared savings will be based?

A CENTRAL TASK
The volume-driven incentive system encouraged overuse and tolerated, if not rewarded, misuse. While the new value-driven incentives are designed to address those problems, leaders must be aware of the potential for any incentive system to drive sub-optimization and cheating, rather than true improvement. A central leadership task is to translate these new incentives to physicians and staff in ways that ensure that when you get a better number, you are producing a better system. ▲
FIVE IT TACTICS OF AN ACO

Beth Israel Deaconess has taken five steps to prepare for population health management.

At Beth Israel Deaconess, we created a model office workflow to ensure data is recorded by individuals with the same roles during the same processes using the same value sets. For example, every physician records blood pressure and medication names in the same place in the same format so that the data can be easily aggregated for quality, safety, and efficiency analysis.

Health information exchange. Data needs to be shared among caregivers for care coordination and panel management. Approaches can include viewing data in remote locations, pushing summaries between providers, or pulling summaries from multiple sites of care.

We have created novel approaches to secure data sharing, and we participate in many federal and state health information exchange pilots. Summaries are now sent electronically for all transitions of care among providers, hospitals, and payers.

Business intelligence/analytics. Once data is collected and shared, it needs to be analyzed—retrospectively to identify gaps in care and prospectively to ensure patients receive the right care at the right time.

Beth Israel Deaconess worked with the Massachusetts eHealth Collaborative to create a community-wide quality data center. This is used for all accountable care, meaningful use, and risk-contract quality reporting. We also piloted popHealth, which is sponsored by the Office of the National Coordinator for Health IT. An open-source, automated quality measurement system, popHealth allows providers to aggregate data from EHRs to generate clinical quality reports.

Universal availability of PHRs. By providing a platform for information exchange between patients and clinicians, personal health records (PHRs) help engage patients and families in their care, ensure the communication of care plans, and achieve seamless handoffs.

We have offered comprehensive PHRs to all of our patients since 1999. Patients can view their records, including their labs and medications. Patients can also schedule appointments, refill medications, and send secure messages to their providers. It works just as well on iPhones as it does on iPads and desktops.

Decision support services. Care management requires alerts, reminders, pathways, and guidelines. Ideally, all members of the care team will receive decision support inside their electronic record based on enterprise rule sets.

At Beth Israel Deaconess, we’ve used the concept of decision support service providers to turn data into knowledge and wisdom inside our EHRs and web applications. If all providers access the same evidence, we can standardize care throughout all our locations, reducing cost and improving quality.

THE BIGGEST CHALLENGE
Of these five tactics, the biggest challenge is defining the care management rules. In other words, what conditions, wellness measures, home care interventions, best practices, and evidence should be incorporated into the point of care and analytic systems?

Beth Israel Deaconess has hired a new senior vice president of care management to help answer these questions. He started in early May. It’s a good start.
Data Analytics: A Medical Necessity and Financial Imperative

Faced with health reform, a tough economy, and the shift to fee for value, hospitals need to optimize their investments in clinical and financial systems. MedeAnalytics’ Clinical Performance Intelligence solution does just that, by providing multidisciplinary insight into the drivers of cost and quality, improving the bottom line through:

**Provider Performance Management** to reduce practice variability by enabling providers (physicians and nurses) and clinical leaders to identify and understand the root causes of variations in care.

**Quality Management** to meet or exceed quality measures by providing insight into clinical performance and financial impact.

**Service Line Management** to make data-driven strategic business decisions by analyzing service line profitability and evaluating population needs.

**Essentials to meet today’s challenges**

To learn about MedeAnalytics’ Clinical Performance Intelligence, visit [www.medeanalytics.com/cpi](http://www.medeanalytics.com/cpi) or call 510-379-3300.
On the road to achieving value, there is not just one route that will get you there.

reinforced the phrase, “When you’ve seen one hospital, you have seen one hospital.”

For example, the CFO at Chicago’s Ingalls Health System described how his 563-bed community hospital aims to succeed as an independent entity in today’s merger-friendly marketplace. While leaders at Ingalls understand the importance of scale, they also believe there is a place for independent providers, assuming they demonstrate innovation, flexibility, and adaptability.

To this end, Ingalls has joined several collaborative partnerships. In addition to taking part in a buying cooperative to save on supplies, Ingalls is working closely with four other nearby hospitals to reduce readmissions. The effort, which is part of the federal Community-Based Care Transitions Program, has already resulted in significant reductions in readmissions in the community.

In contrast, Florida’s Boca Raton Regional Hospital has been increasing in scale and reputation—as well as brick and mortar—by providing state-of-the-art specialty care to its affluent patient population. The 400-bed hospital almost didn’t survive the Great Recession. In 2008, Boca Raton incurred a $120 million loss. Consultants were even brought in to prepare the hospital for sale.

However, Boca Raton achieved a dramatic 18-month turnaround by focusing intensely on improving productivity, reducing costs, and improving quality. As a result, the hospital has attracted major philanthropic support from the community, enabling additional investments in clinical programs.

ACHIEVING REVENUE CYCLE PERFORMANCE
During the process of finalizing the selections for HFMA’s 2013 MAP Award for High Performance—which recognizes healthcare organizations that achieve excellence or demonstrate substantial improvement in revenue cycle performance—we saw a similar theme. Yet again, although the information provided by each award applicant is the same, the submissions we received reinforced the fact that there are many different ways for an organization to become a high performer.

All of the MAP winners demonstrated excellence against benchmark metrics, such as net days in accounts receivable and patient satisfaction. However, the approaches that these organizations used to improve their benchmark scores were very different based on the organization’s culture. Some approaches were structured and process oriented, many used formal performance improvement tools such as Lean and Six Sigma, while others were less formal. Still others tied their employee and executive compensation and rewards systems into every day goals that were established for the revenue cycle teams. Some approaches were driven by the executive team, and still others were driven by management and motivated teams of staff members.

The take-away: All these MAP applicants are committed to excellence—and are excited and eager to achieve—no matter the organization’s management approach or style.

CHOOSING YOUR PATH
Flexible and adaptable, committed and incented ... it’s all about developing a perspective to deliver on the promise of value. There are many paths to delivering this promise in all facets of healthcare organizations. What path have you chosen?
look who’s on the map

Healthcare leaders pushing to improve performance turn to HFMA’s MAP – the comprehensive source for industry-standard metrics, data, and strategies on the revenue cycle. We’re building a community dedicated to advancing best practices and sharing the lessons. Join us.

GET ON THE MAP. hfma.org/map
BETTING ON BUNDED PAYMENT

Many are wagering that bundled payments will encourage providers to reduce costs and improve quality. These fixed payments cover the cost of all services given to a patient (for example, physician + hospital + labs) during a medical or surgical event over a specific period of time.

THE GOALS VERSUS THE EVIDENCE

LOWER COSTS, MORE COORDINATED CARE
Successful bundled payment interventions have reduced spending by about 10% relative to fee-for-service payment, according to AHRQ. However, the agency calls the current overall evidence for bundled payment “weak.”

Medicare’s Bundled Payment for Care initiative encourages coordination across traditional silos

- Model 1: Acute care only
- Model 2: Acute care through 30, 60, or 90 days post-acute care
- Model 3: Post-acute care triggered by a hospital stay
- Model 4: Acute care, including physician services and any 30-day readmissions

Source: HFMA based on information from Medicare’s Bundled Payments for Care Improvement website, accessed April 2013.

IMPROVED QUALITY
Bundled payment has had inconsistent and generally small effects on quality, says AHRQ. Some are trying to change that. The PROMETHEUS Payment® model includes a financial reward for meeting quality targets.

Of all bundled payments reported

- 83% without quality incentives
- 17% with quality incentives

Source: Catalyst for Payment Reform, National Business Coalition on Health, and NORC at the University of Chicago, April 2013. Data from eValue8 data collection.

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Agency for Healthcare Research and Quality (AHRQ), Bundled Payment: Effects on Health Care Spending and Quality: Closing the Quality Gap, August 2012.
A TIMELINE OF BUNDLED PAYMENT

KEY U.S. EVENTS

1984
The Texas Heart Institute reduces costs, without negatively affecting quality, using a single global fee for cardiovascular surgery.\(^b\)

2007
PROMETHEUS launches four commercial pilots, which include chronic care bundles.\(^f\)

2009
Medicare’s ACE demonstration improves cardiac and orthopedic margins.\(^a\)

2010
Lowe’s arranges a cardiac surgery bundled price with the Cleveland Clinic for its employees.\(^g\)

1991
The first major federal bundled payment pilot—Medicare’s Participating Heart Bypass Center Demonstration Project—cuts spending by -10%.\(^c\)

2005
Geisinger’s CABG ProvenCare\(^SM\) bundle reduces readmissions by 15.5%.\(^d\)

2013
450+ providers join Medicare’s Bundled Payments for Care Improvement initiative.\(^h\)

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\(^b\) Congressional Budget Office, *Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment*, January 2012.
\(^e\) That Was Then, This is Now: The Progression of PROMETHEUS Payment, Healthcare Incentives Improvement Institute, 2009-2010.
\(^f\) Cleveland Clinic and Lowe’s Arrange Bundled Price for Heart Surgery, HFMA’s Payment & Reimbursement Forum, February 2011.
\(^g\) Centers for Medicare & Medicaid Services, *CMS Announces New Initiative to Improve Care and Reduce Costs for Medicare*, January 31, 2013.
A RISKY AFFAIR

PROVIDERS TAKE ON MORE RISK

Bundled payment and other value-based payment models are changing the risk structure.

Bundled payment shifts cost and quality risks to providers

<table>
<thead>
<tr>
<th>Providers</th>
<th>lowest financial risk</th>
<th>highest financial risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payers</td>
<td>highest financial risk</td>
<td>lowest financial risk</td>
</tr>
<tr>
<td>Consumers</td>
<td>risk of overtreatment</td>
<td>risk of undertreatment</td>
</tr>
<tr>
<td>Employers</td>
<td>risk of high costs from inefficiency</td>
<td>risk of high costs from undertreatment</td>
</tr>
</tbody>
</table>

Fee for service = traditional method of paying providers for each service performed; per diem = a set payment for specific services for an inpatient day, regardless of true cost; capitation = specified dollar amount per covered person, usually stated in a monthly amount.

Source: HFMA, Healthcare Payment Reform: From Principles to Action.

3 RISK STRATEGIES FOR PROVIDERS

PICK THE RIGHT BUNDLE

Bundles should have “enough variation to provide opportunities for cost reduction, but not so much variation as to pose excessive risk to the organization,” advises the AHA.

Before picking a bundle, providers should have utmost confidence in the benchmark data, understand what is driving the variation, and determine whether they can reasonably reduce the variation.

Medicare costs vary more for back surgery than colectomies across U.S. hospitals*

<table>
<thead>
<tr>
<th></th>
<th>lowest cost hospitals</th>
<th>highest cost hospitals</th>
<th>% difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>back surgery</td>
<td>$23,249</td>
<td>$31,009</td>
<td>33.4%</td>
</tr>
<tr>
<td>colectomy</td>
<td>$25,372</td>
<td>$27,922</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

*Analysis of complete national Medicare claims data from January 2005 to November 2007, adjusted for illness severity, regional wages, etc.


Source: American Hospital Association, Moving Towards Bundled Payment, 2013.
PINPOINT OPPORTUNITIES FOR COST REDUCTIONS
Reducing discretionary care and avoidable complications (e.g., unnecessary specialist consultations, preventable readmissions, adverse drug events) will generate higher margins in bundled payment arrangements. So, too, will refining post-acute pathways.

Some post-acute pathways for heart failure patients are more expensive than others*

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>hospital to community to hospital</td>
<td>$19,244</td>
</tr>
<tr>
<td>hospital to skilled nursing facility</td>
<td>$17,497</td>
</tr>
<tr>
<td>hospital to skilled nursing facility to community</td>
<td>$16,058</td>
</tr>
<tr>
<td>hospital to hospice</td>
<td>$11,002</td>
</tr>
<tr>
<td>hospital to community to home health to community</td>
<td>$10,760</td>
</tr>
<tr>
<td>hospital to home health to community</td>
<td>$10,550</td>
</tr>
<tr>
<td>hospital to community</td>
<td>$8,853</td>
</tr>
</tbody>
</table>

*Average Medicare payments for 30-day fixed-length episodes for heart failure and shock, 2007-2009.

Source: Data from Dobson & DaVanzo, Medicare Payment Bundling: Insights into Claims Data and Policy Implications, 2012.

PRICE THE BUNDLE
Providers should price their bundles after assessing historical costs and competitive prices and adjusting for various risk scenarios.

In PROMETHEUS case rates, a margin for potentially avoidable conditions and profit is allowed.

PROMETHEUS evidence-informed case rates

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowance for potentially avoidable costs</td>
<td>Based on a negotiated percentage of current potentially avoidable costs</td>
</tr>
<tr>
<td>Margin</td>
<td>Currently based at 0-10% of typical</td>
</tr>
<tr>
<td>Severity-adjustment allowance</td>
<td>Caused by known patient health status; arrived at through a step-wise multi-variable regression model</td>
</tr>
<tr>
<td>Evidence-informed base of covered services (adjusted for local practice patterns)</td>
<td>Core/typical services that are recommended by best practice or evidence, adjusted for “normal” variation reflecting practice patterns</td>
</tr>
</tbody>
</table>

Source: HFMA, Transitioning to Value: PROMETHEUS Payment Pilot Lessons, June 2011. The total evidence-informed case rate = type of services x frequency x price per service.

For more on bundled payment and other value-based payment approaches, visit hfma.org/leadership, Summer 2013 issue.
Healthcare leaders reveal how they and their teams stay inspired when the going gets tough.

**RECOGNIZING THE PATIENT BURDEN**

I am motivated by the reality that, despite all of the difficult decisions we providers have to make, we are not the ones facing the biggest hurdles. The financial burden that health care can place on the average family is staggering and, to be blunt, unacceptable. There may not be a perfect answer out there, but it is our responsibility to keep the load that our patients must bear as light as possible. There are many reasons to be optimistic about the future of care in our community, and every day we strive to take another step in that direction. Our patients deserve nothing less.

*Thomas E. Wilhelmsen, Jr., is president and CEO, Southern New Hampshire Health System, Nashua, N.H.

**PERSISTING WITH A PLAN**

I find nothing more motivating than the opportunity to create, whether discovering a solution or creating a business that provides value to our customers. The challenge of meeting a goal, along with plenty of encouragement and recognition (even in the form of a simple “thanks”) keeps our teams focused. In addition, mapping out a plan helps the team visualize the end result and strive for a common goal. As obstacles block progress, the best response is to refocus on the ultimate goals: outstanding patient experience and compassionate care. However, in the end, sheer persistence and stubbornness keep me and the team going.

*Karna Colberg-Swenson is director of continuous improvement, Mercy Medical Center, Cedar Rapids, Iowa.

**ENGAGING IN THE GREATER GOOD**

I am drawn to initiatives that connect me with something bigger than my individual practice—those that are likely to benefit both patients and the future of our organization. Most healthcare leaders also identify with a desire for excellence driven by an internal motivation to continuously improve. That involves total immersion or engagement: A leader is much more likely to overcome challenges when fully engaged. Finally, the most basic incentive may be that of autonomy. We are most satisfied when we maximize control, whether it is over our individual clinical practice or our group strategic planning and philosophy.

*Cory Wilson, MD, is an emergency medicine physician, Wheaton Franciscan Healthcare, Milwaukee, Wis.

**ACCOMPLISHING THE IMPOSSIBLE**

I am motivated by the mission of health care—caring for patients—and most of the people and organizations I work with have this same “true north.” The more challenging issue is staying incentivized in the face of the Gordian Knot that is health care today. I think the key to success is to communicate. People need to know that you value them and their input, and they need to know that, in the face of a huge project, you have made progress and realized a step forward. For me, it is the very challenge of doing what seems nearly impossible—fostering collaborations among competitors and undertaking multi-year, multi-organization projects—that is inspiring.

*Susan Stuard is executive director, Taconic Health Information Network and Community (THINC), Fishkill, N.Y.*
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