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How hospitals can create cost advantage where product differentiation is not present

William O. Cleverley

Cost advantage can be achieved in two ways: Identifying whether efficient levels of cost exist and benchmarking.

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How hospitals can create cost advantage where product differentiation is not present

William O. Cleverley

A challenge exists in finding accurate comparative data for bundled-payment arrangements, such as total hip replacement.

Cost advantage is necessary when a business is perceived as providing the same products or services as its competitors. In the eyes of many major healthcare payers, hospital services are not perceived as differentiated and are viewed as equally substitutable. While some payers are beginning to introduce value propositions into their payment methodology, many of these plans are merely new ways to reduce payment levels to providers.

Assuming that cost advantage in hospitals will become increasingly important, the critical question is how can hospitals achieve it? In general, two major methodologies for identifying efficient levels of cost exist. First, industry experts can help assess and design the most efficient processes for providing services. Second, benchmarking can identify standards from best practice organizations. Comparative data and benchmarking against other firms is usually the basis for both approaches.

Cost benchmarking dilemma

The cost benchmark is defined as the ratio of cost divided by output. This is a simple but very accurate picture of the desired goal, but the devil is in the details. Everyone acknowledges that cost and output must be measured in similar ways between compared organizations in the benchmark data and the firm that is comparing itself to that data.

For example, cost needs to be measured in the same way across the comparative data. This leads to a simple but troublesome comparative data issue. There is confidence that the measure of total cost is measured in a similar manner across organizations because of the use of Generally Accepted Accounting Principles (GAAP). If one firm has a total cost of $200 million and another has a total cost of $400 million, there is a great deal of assurance that the $400 million firm is twice as costly as the $200 million firm. The dilemma arises when hospitals provide cost estimates of specific services such as a total hip replacement. As organizations move from facility-level costs to costs for providing specific products or services, greater degrees of cost allocation are required, which can be subjective.

When we examine the comparability of the output metric, the reverse finding is true. It is difficult to derive a facility-wide output metric that would be regarded as comparable. For example, adjusted patient discharges or adjusted patient days are widely recognized as flawed facility-wide metrics. We have advocated using Equivalent Discharges for the last five years

Cost per output assessment

Level of comparison	Measurement of cost difficulty	Measurement of output difficulty	Recommended metrics
Facility	Strong	Challenged	Cost per equivalent discharge
Encounter	Challenged	Strong	Cost per MS-DRG or cost per ambulatory patient classification

Source: Cleverley & Associates. Used with permission.

as better measures of facility-wide performance because they are better predictors of both revenue and cost (Cleverley, W., "Time to Replace Adjusted Discharges," *hfm* magazine, May 2014, and Cleverley, W., "Understanding Why Hospital Costs are Increasing: It Depends Upon the Metrics," *hfm* magazine, December 2018).

When the output is defined in specific terms, such as a total hip replacement or a specific CT scan, it becomes easier to compare. The catch-22 is that the greater the specificity in output, the less comparable the cost. However, the output becomes more comparable (see the exhibit, page 2).

Sources of comparative data

Having identified the framework for cost benchmarking, it is important to understand the sources for cost benchmarks and their relative advantages. In general, two major sources of cost benchmarking data are available — public and proprietary. Several public sources are available from individual data firms and hospital association groups. The advantage to this type of data is that it is usually not expensive, and it is easily attainable.

It also has one other distinct advantage because it can often provide provider-specific comparisons. This is important if a firm is striving for cost advantage over a local competitive firm operating in the same market area.

The disadvantage of public data is the lack of control over data collection. The comparability of the data may be questionable either because costs were not measured and defined in the same way across all firms or there are questions regarding the similarity of the output being measured.

Proprietary databases for benchmarking costs rely on hospital specific data that is not publicly available. This data could come from organizations that collect data directly from individual hospitals and pool that data to provide reports to clients or members. Data could also be compiled by large healthcare systems and disseminated to the individual hospitals.

The advantage of proprietary data is that it provides better control of data collection to ensure both costs and outputs are measured and reported in a consistent manner across submitting entities. This can potentially make the comparison more reliable and actionable. The major disadvantage to proprietary data is that it will not be able to provide specific comparisons for hospitals that may be direct competitors. This can be problematic because ultimately the creation of a cost advantage is market specific.

Healthcare executives are charged with providing services ordered by physicians at the highest level of quality and cost efficiency.

Case illustration of effective cost benchmarking

To illustrate effective cost benchmarking, we are borrowing from a situation encountered by many U.S. hospitals. Hospital A has been contacted by one of its larger payers requesting a proposal to provide a bundled payment solution for major joint procedures. The payer has informed them that they already have a proposal from hospital A's primary competitor, hospital B. The hospital has been told that their competitor's bid incorporates expected hospital payment of $12,000, which is the current Medicare payment for MS-DRG 470 — Major Joint Replacement or Reattachment of Lower Extremity w/o MCC. Hospital A wants to assess its own current cost position for MS-DRG 470 vis a vis that of hospital B.

The first step in being able to identify specific areas for cost reduction is to recognize the ultimate objective. The product in this case is a specific encounter of care, MS-DRG 470. Management's task is to develop a production process that can generate high-quality encounters of care at efficient cost levels. While some policy advocates might say healthcare executives should be more concerned about the efficacy of what they produce (e.g., do we really need more hip replacements?), we believe those decisions are best left to physicians and policymakers. Healthcare executives are charged with providing services ordered by physicians at the highest level of quality and cost efficiency.

Cost per encounter can be expressed as the product of three key cost drivers:

> Intensity of services
> Productivity/efficiency
> Resource prices/salaries and wages

Intensity of services. Intensity of services is the mix and quantity of services that produce the encounter of care. For example, a five-day inpatient stay for pneumonia has five days of nursing care, a series of drugs, laboratory procedures and many ancillary services. There is often wide variation in the intensity of services across patients and across hospital providers. While many intensity factors are physician driven, healthcare managers can play an instrumental role in explaining the relative costs associated with alternative treatment protocols. Lowering intensity of services for a defined encounter of care can lead to reductions in total cost per encounter — again, the primary goal if we are seeking cost advantage over competitors.

Productivity or efficiency. These are the costs incurred to produce a specific procedure that is part of an overall encounter of care. For example, what staffing mix and levels are used to produce a day of nursing care in specific nursing units? While intensity and productivity are related, they are different. To make the distinction, nursing intensity would involve the number of days involved in the patient stay. Nursing productivity would measure the number of hours nurses worked to provide one day of nursing care.

Cost efficiency is usually associated with specific cost centers or departments, and we often refer to the cost per unit of service in that cost center. For example, cost per laboratory procedure is the departmental measure of efficiency in a lab. Lowering the unit costs of departmental products that

Comparison of two hospitals' MS-DRG 470 costs

Expense category	Hospital A ($)	Hospital B ($)	Variance ($)
Average LOS	2.16	1.93	0.23
Average routine LOS	2.13	1.87	0.26
Average ICU/CCU LOS	0.03	0.06	-0.03
Routine care	1,659.00	1,293.00	366.00
ICU/CCU	37.00	76.00	-39.00
Nursing total	**1,696.00**	**1,369.00**	**327.00**
Medical/surgical supplies	4,303.00	4,771.00	-468.00
Laboratory	75.00	46.00	29.00
Operating room	5,371.00	3,481.00	1,890.00
Radiology	227.00	76.00	151.00
MRI	0.00	2.00	-2.00
Pharmacy	1,308.00	575.00	733.00
Emergency department	42.00	32.00	10.00
Cardiology	12.00	23.00	-11.00
Blood	17.00	11.00	6.00
Physical/occupational therapy	540.00	374.00	166.00
Inhalation therapy	31.00	15.00	16.00
Other	17.00	11.00	6.00
Ancillary total	**$11,943.00**	**$9,417.00**	**$2,526.00**
Total cost	**$13,639.00**	**$10,786.00**	**$2,853.00**

Source: Cleverley & Associates. Used with permission.

Selective physician cost comparisons for MS-DRG 470

Physician	Average charges	Average length of stay	Average cost
A	$70,159	4.75	$19,748
B	$58,944	4.27	$16,771
C	$59,892	5.00	$15,987
D	$51,806	3.89	$14,184
E	$42,524	2.32	$11,338
F	$38,771	2.00	$10,361

Source: Cleverley & Associates. Used with permission.

comprise a patient encounter can reduce the total cost of the encounter.

Resource prices or salaries. As the price to hire staff or purchase supplies and drugs increases, the more expensive the encounter of care. For example, a hospital can minimize the length of stay associated with an inpatient encounter and it can also maintain low nurse staffing ratios, but if it pays salaries to nurses that are 25% higher than its peers, its overall costs may still be high.

Cost assessment

The preliminary cost comparison of MS-DRG 470 between hospital A and hospital B shows a total cost variance of $2,853 (see exhibit left). The data used here is from 2017 Medicare Provider Analysis and Review (MEDPAR) files and 2017 Medicare Cost Reports — both widely available at minimal cost from multiple vendors.

Two factors must be acknowledged. First, the data represent Medicare patients and not patients with commercial payers. There are few differences between Medicare costs and commercial payer costs for this MS-DRG. Second, the cost is determined by applying Medicare cost center ratios of cost to charges to revenue-center charges from the MEDPAR claims file. This is not as exact as detailed cost accounting from the hospital's internal cost accounting system, but the validity can be easily assessed against the numbers reported here. The total hospital costs could be measured against internal estimates if available.

Reviewing hospital A's initial profile suggests that there are three primary areas where its costs appear high relative to its competitor. First, nursing costs are $327 higher per case at hospital A than hospital B. Reviewing this variance tells us that $181 of the difference is related to a higher length of stay (LOS), 2.16 compared to 1.93. This value is derived by multiplying the cost per day ($1,696/2.16 or $785.19 times the LOS difference of .23 days). The remaining variance of $146 ($327 less $181) is attributed to a higher nursing cost per

patient day, $785.19 at Hospital A compared to $709.33 ($1,369/1.93).

Second, operating room costs were $1,890 higher at hospital A than at hospital B. Using departmental costs for hospital A and hospital B taken from their 2017 Medicare Cost reports and applying estimates of equivalent units of procedures provided at both hospitals, we determined that hospital A's OR cost per unit was 62% higher than hospital B's and well above U.S. averages.

This finding is corroborated by the data in the MS-DRG 470 cost comparison, which shows costs are 64% higher at hospital A than hospital B, suggesting that the cost variance is exclusively related to higher unit costs not greater intensity. Finally, pharmacy costs are $733 higher at hospital A than hospital B. While this area is harder to assess than others, we did determine that on a cost per Equivalent Discharge basis, pharmacy costs were 74% higher at hospital A than hospital B and 70% above U.S. averages.

To close the loop on this assessment, hospital A can now review specific physician costs using their internal reporting systems to assess variances and determine if treatment protocols could be modified to reduce costs without impacting patient quality. In a cost comparison for six physicians, the most easily observable fact is the first four physicians have significantly higher LOS and cost relative to physicians E and F (see second exhibit on page 4).

Further review also showed significantly higher supply costs because of implant selection and usage. Most likely, hospital A has higher costs relative to hospital B in many other areas. We found that the Cost per Equivalent Discharge was $8,998 at hospital A, which was 23% higher than the value at B. This difference is almost identical to the 26% difference in costs for MS-DRG 470.

Cost reduction actions

We believe that cost reduction will be the primary weapon for dealing with ever-tightening payments from major healthcare payers. Revenue management can be helpful, but its effects are short-term and limited. Reductions in cost result from actions taken in two primary areas.

First, the utilization of services such as nursing days, lab tests and drugs can be reduced on a per-encounter basis. Second, the cost efficiency with which nursing care and other ancillary procedures are produced can be improved. The detailed charge code analysis presented in this paper can be a powerful tool to identify specific cost-reduction opportunities, which can lead to large and sustainable improvements. //

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Joint venture removes provider, patient and payer barriers

Ed Avis

Unnecessary hospitalizations have dropped 7% at Aetna joint ventures, supported by coordinated care and direct contact with patients and their physicians.

Hospitals and insurance companies have long served the same clients, but almost always from slightly different points of view. Even when they partner in accountable care organizations (ACOs) or other managed-care structures, their financial incentives are rarely entirely aligned.

A joint venture between Aetna and Banner Health has changed that situation. The organizations have nearly equal ownership in the venture, meaning what benefits one partner benefits the other.

"You can think of joint ventures as the most highly aligned economic model," explains Brigitte Nettesheim, president, North Central Region & Joint Ventures for Aetna. "We're able to create and design value-based arrangements with incentives that are aligned with the consumer. It's not just about passing money back and forth – it's about improving the consumer experience and healthcare outcomes, including reducing the cost of care."

Banner/Aetna taps the expertise of both partners. The health plan offers HMO and PPO products on a broad network, as well as Banner's high-performance network.

Growing the relationship

Banner|Aetna, which serves commercial business clients in Arizona, emerged from a value-based care relationship between the two organizations that began in 2011. They partnered on ACO products for several years, and as they became familiar with each other, they eventually realized that a closer relationship could be beneficial. They decided to create a formal joint venture in 2016; the joint venture launched its first products in 2017.

Banner|Aetna taps the expertise of both partners. The health plan offers HMO and PPO products on a broad network, as well as Banner's high-performance network. While the plans predominantly provide access to Banner Health facilities, the joint venture also selects non-equity partners that are aligned strategically and then tactically through value-based care arrangements.

"What's important here is that we recognize that one integrated delivery system

Coordinated care reduces hospitalizations

Aetna joint ventures reduced unnecessary hospitalizations by 7% in the first four months of 2018 as compared to CY17, according to Brigitte Nettesheim, president, North Central Region & Joint Ventures for Aetna. Nettesheim says the improvement in hospitalization rates is supported by coordinated care and direct contact with patients and their physicians.

"As an example, one of our Banner|Aetna members, an 82-year-old male veteran, had a history of poorly controlled diabetes, hypertension, fluctuating blood pressure, chronic shortness of breath, weakness and fatigue," Nettesheim says. "His civilian and VA providers were not communicating with each other. He was identified by our multidisciplinary care team through multiple events that popped up in the data." Banner|Aetna is a joint venture that taps the expertise of the provider and health plan.

A care manager visited the member, reviewed his history and medications, and provided coaching. They also coordinated his care with a pharmacist and his associated physicians and went along with him to visit his primary care physician.

The member's health took a turn for the positive with the coordinated care he received.

"His diabetes medicine was decreased, which cured his low blood sugar, and the member is now keeping a strict blood pressure and sugar log," Nettesheim says. "At the end of the day, the member felt he had a strong understanding of the problems and why he is taking the medications he takes. Having a coordinated effort like that, where it feels like the entire network of providers is working on your behalf, is what we're trying to accomplish."

Another success area is the nurse-on-call program that is staffed by Banner Health nurses, says Chuck Lehn, president of Banner Health Network.

"We've had a good volume of people who are willing to call the nurse instead of going to the ED," he says. "That's a good example of getting people to the right care setting. We help people understand that if we can do something ambulatory instead of inpatient, that lowers the cost of healthcare."

may not be able to provide every service in every geography, so we partner with other, smaller health systems, as well as specific independent physician organizations," Nettesheim says.

Dividing responsibilities

The joint venture is governed by a board of directors that includes executive representatives from both organizations and is led by a small executive team comprised of a CEO, CFO, CMO and COO, plus their support staff. Most of the administrative services are provided by one of the parent organizations.

"We created a mechanism to divide up the responsibilities and the funding that goes with them," says Chuck Lehn, president of Banner Health Network. "Part of what we wanted was the ability to invest in network management and care management, and we decided that whoever would be best positioned to provide a service would do that."

"We went through all of the administrative services of healthcare and divided them," he says. "Some things were shifted to Banner and others to Aetna. We did a little of 'yours, mine, ours' to decide which party would have which responsibilities."

For example, Banner handles prior authorization, and Aetna handles new plan sales and account management. Jointly, they manage a multidisciplinary care team that includes community health case workers and some clinicians.

To keep the joint venture on track, the leadership meets regularly to discuss results.

"We have a monthly meeting and go through all the financial information and other details," Lehn says. "It's a thorough review of service results, financial results, operations, just everything that it takes to be successful. It's totally transparent, and we decide collectively what needs to be worked on."

Benefits to Banner

Lehn explains that the venture benefits Banner in a variety of ways.

First, it adds another health plan option for Banner's market.

"We wanted to engage with the communities that we serve with more affordable health insurance products and find a way for more people to have affordable coverage," he says. "That was important to us because we figured if more people have insurance, the less disparities exist. We wind up being the public safety net because we have the most emergency rooms, which is where people end up getting healthcare when they don't have other means."

Second, earning money from the premiums helps Banner maintain its finances while still transitioning patients to lower-cost care settings or preventing hospital readmissions.

The biggest challenge of the joint venture has been aligning the cultures of the two existing organizations and the new, joint organization.

"If you're a hospital and do the right thing and reduce readmissions, somebody else benefits from your work on that and you really don't," Lehn notes. "If you're more involved in the premium you can hopefully enjoy some small part of the reward for doing the right thing. If we really want to improve people's health and reduce utilization, and we're not involved in the premium, the long-term financing doesn't work for us."

That aspect has equity implications, too, Lehn notes. Because Banner is an owner, if the health plan portion of the arrangement is ever sold, or if investors are invited in, Banner stands to benefit.

Ultimately, the arrangement fosters closer relationships with patients, because it essentially removes the third-party payer.

"The financing of healthcare has always been through third parties, and this gives us a more direct relationship with the customers," Lehn says. "We felt it was valuable to have that direct line with the ultimate purchasers of healthcare services."

Creating benefits for patients

The closer connection between patient and healthcare provider also benefits patients.

"Now we can create warm transfers based on the concept of a consolidated service model," Nettesheim explains. "Members don't have to call the insurance company, who sends them to the physician's office, who sends them to the hospital billing center. It is not acceptable in our model to tell the member to hang up and call another number."

The joint venture also strives to create personalized health plans for members, Nettesheim says. Because all of the parties are connected, it's easier to keep patients on track with their plans and ensure that the financial aspects are covered.

Overcoming the cultural challenge

The biggest challenge of the joint venture has been aligning the cultures of the two existing organizations and the new, joint organization.

"Learning to work in a joint venture is different for everybody and it takes some time to do that," Lehn explains. "When we formed the joint venture, we created a business plan that said, 'This is what success would look like.' We built metrics that look at the venture from the member perspective, from each of the joint venture partners' perspectives and from the joint venture's perspective. We've tried to keep all of that in balance. But our teams work well together, and we've had some growth wins and that's kept our motivation." //

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How an urban dental center's services prevent ED visits, provide hospital referrals

An Interview with Mary Joyce Gomez by Ed Avis

St. Bernard Hospital Dental Center addresses social determinants of health by offering preventive services, regardless of a patient's ability to pay, which the community may not receive otherwise.

"One advantage of a dental department in a hospital system is that it can bring in more patients for the whole system," says Mary Joyce Gomez, DDS, medical director of the Dental Center at St. Bernard Hospital in Chicago's Englewood neighborhood on the South Side. In this interview, Gomez explains how her department serves a community in serious need of dental care, which keeps some patients out of the emergency department (ED) and provides referrals to other hospital services.

How did the St. Bernard Hospital Dental Center get started?

Gomez: The program started in 2007. We had a pediatric mobile unit that would go to into the community to give the important vaccinations to the kids. They found that many children had broken teeth, dental pain and many other dental problems. Some of them didn't even have toothbrushes. So, the hospital held some fundraisers and started the program. At that time, it was just for pediatric dental, but since then we've added adult services because the need there is great, too.

What services do you provide?

Gomez: We provide everything from basic prophylactic services to emergency dental care. One area we have become known for is treating patients with special needs, many of whom require general anesthesia. Since I joined the staff in 2017, our general anesthesia patients have soared from 72 cases a year to 400 cases a year. Special needs children and adults cannot be seen by regular dentists for a number of reasons.

For example, children or adults with cerebral palsy have myotonic contractions of their muscles, and they are not able to sit in a chair and open their mouths for a lengthy procedure in an ambulatory setting. Others have emotional or psychological limitations and cannot cope emotionally with sitting in a dental chair.

How is your program funded?

Gomez: Experience shows 99% of our patients are Medicaid patients, which covers only 40% of the expenses of running the department. We make up the difference through support from the hospital and the funders and donors of the program.

How important is dental care for a child?

Gomez: Lack of pediatric dental care trickles down from oral health to the health of the whole body, and more importantly the mind and emotions of the person. Baby teeth act as the predecessors to the permanent teeth. They guide the growth of permanent teeth and the jaw. If baby teeth have to be extracted because of infection or decay, the permanent teeth do not have that guide. This leads to orthodontic problems in the future, such as mouth occlusion. And how will mouth occlusion affect a teenager? It will affect their self-confidence, and they may get periodontal disease from crowding of the teeth. Periodontal disease, in turn, is related to diabetes and heart disease.

How does the dental clinic affect the financial health of St. Bernard Hospital?

Gomez: Before the clinic opened, people in the community would go to the ED when they had massive swelling or severe pain in their mouths. Our ED couldn't do much more than control the airway and then transfer them to a bigger hospital for drainage of major abscesses. Now, instead, patients come here to the dental clinic. We can address the pain and even save their teeth, because our approach is comprehensive. We address urgent needs first, but we always encourage patients to come back for comprehensive care, explaining that their oral health is related to their physical health.

We also take a medical history of our patients, because it affects their dental treatment. If we ask, "When was the last time you saw your physician?" and they say, "Oh, I don't know, I really don't remember," we encourage them to see a physician at our immediate care center, because we need to understand their health status before we can remove a tooth. At the clinic, dental patients get their blood work and a physical. With this strategy, we're treating the whole person and not just the teeth.

Overall, the clinic creates revenue for the physicians and the different departments of the hospital, plus we are improving patients' quality of life. I think that's the best thing. And, of course, it is keeping them from the ED, which is costly to the hospital. And we're growing our patient base overall at St. Bernard. //

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Comparative analytics: Putting data to work

James Blake, Scott R. Engel, and Erik Swanson

Almost all hospital executives responding to a recent survey said that their organizations should be doing more to leverage financial and operational data to inform strategic decisions.

Healthcare leaders have access to ever-increasing amounts of data but concerns with the accessibility and integrity of data mean that, in many organizations, data sit idle or underutilized. In a recent survey of hospital and health system finance executives, when asked to identify financial reporting challenges, 64% of respondents cited challenges in pulling data from multiple sources into a single report, and 52% cited challenges in accessing clean, consistent and trusted data.

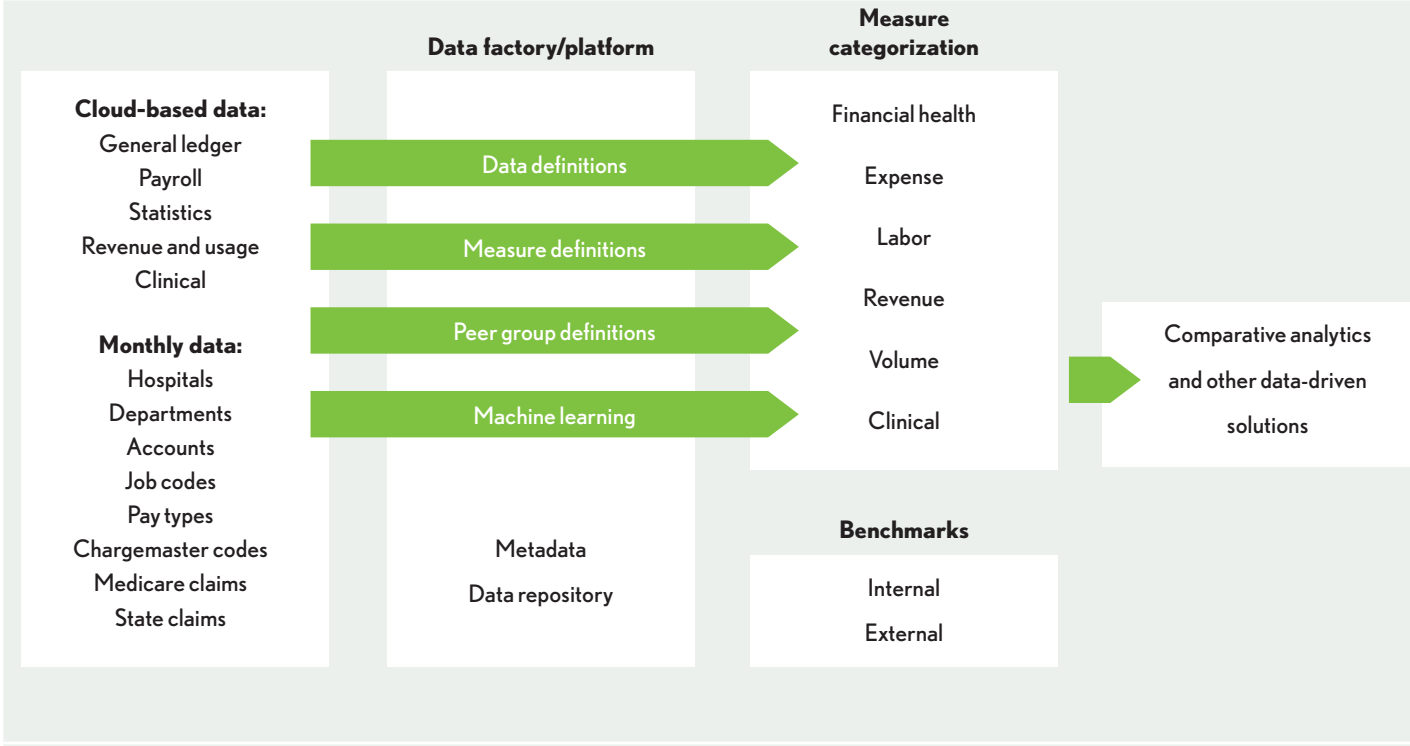
These ranked as the second and third greatest financial reporting challenges finance executives face, surpassed only by the need to create better dashboards and visuals. It is not surprising, then, that 96% of respondents said their organization should be doing more to leverage financial and operational data to inform strategic decisions (Spence, J., and Sussman, J., *2019 CFO Outlook: Performance Management Trends and Priorities in Healthcare*, Kaufman, Hall & Associates, LLC, 2019.)

The need for comparative analytics

Senior finance executives are clearly struggling, both in their efforts to get access to data and in their ability to put that data to work. A solution is needed that not only provides single-source access to clean, consistent and trusted data, but also enables analysis of these data within a framework that best supports strategic decision-making. An internal view of data alone is insufficient to determine whether strategic goals are ambitious enough for effective enterprise performance improvement within an increasingly competitive healthcare landscape. Comparative analytics provide the framework needed to ensure organizations are keeping pace with their peers.

An effective comparative analytics platform should include financial data, patient and clinical data, financial and labor benchmarks and clinical benchmarks drawn from a large group of hospitals

Structured and clean data in a comparative analytics platform



Source: Kaufman, Hall & Associates, LLC. Used with permission.

(many hundreds) that are representative of the nation's hospitals by geography, bed size and type — from large academic hospitals to small critical access hospitals. The breadth and depth of data enable platform users to identify relevant peer groups for comparative analytics across multiple performance dimensions.

Attributes of data in an effective comparative analytics platform

The value of a comparative analytics platform is derived from the breadth and depth of its data. But for that data to be helpful to the user, it must have the following four attributes.

A single source. If decision-makers come to the table with data from different sources, their ability to arrive at a conclusion will be undermined quickly by arguments over whose data are correct. To ensure that decision-making across the enterprise is based on a common source of information, a single-source data platform is essential. The platform should aggregate and integrate external and internal data across the spectrum of financial data and benchmark sources used by hospitals for planning, cost and decision support, management analytics and clinical transformation.

Structured and clean. Hospitals receive data from multiple internal and external sources and systems. To ensure both credibility and comparability, these data must be accurately classified and standardized. Data should first be structured through the application of a common taxonomy. It then should be "scrubbed" for regulatory compliance and professionally normalized and classified with data definitions, measure definitions and peer group definitions applied across expense, labor, revenue, volume, clinical and other data.

A platform that combines advanced statistical techniques with machine learning can largely automate this process, minimizing the need for time-consuming labor and the possibility of human error. The result is structured and clean data for apples-to-apples comparisons (see the exhibit, page 10).

Appropriate and accessible. Depending on an individual's role within the organization, analytic needs can range from broad and general to narrow and specific.

- C-suite executive team members require a broad view across the industry and organization and the ability to quickly discern general performance trends in key strategic dimensions.
- The CFO and finance staff need analytics on overall hospital performance compared with specific peer groups along multiple dimensions.
- Department managers require analytics on department-specific metrics and indicators driving performance so they can budget and track progress of initiatives for which they are accountable.

Data for these different user groups should be easily obtained and clearly visualized, and individuals at all levels of the organization should have the ability to drill down quickly into their reports for information related to specific targets or goals and whether goals are being met.

Timely. The value of data deteriorates over time. Executives and managers should not have to struggle with enterprise-level data that are many months to years out of date, or even more problematically, that come from various sources with different time periods. Data from both internal and external sources should be refreshed each month on a real-time basis. Real-time data change the way in which information is used and support real-time diagnosis and decision-making as executives and managers monitor the progress and impact of ongoing initiatives and performance.

The power of data put to work

A leadership team's ability to sustain high-value care delivery and long-term strategic-financial viability of the organization is increasingly dependent on how effectively its executives apply comparative analytics to inform improvement efforts related to financial performance, quality, patient experience and other performance dimensions. Clean, integrated and trusted data, provided in real time, are ready to be put to work for an organization, enabling real insights at all levels for continuous, enterprise-wide performance improvement that becomes part of an organization's culture. //

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The art of execution: Identifying and mitigating risks in healthcare provider organizations

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At one community hospital, early clinician engagement helped devise a solution to reduce emergency department debt.

When it comes to effective execution, elegant plans and high-level blueprints are not enough. Moving a healthcare provider organization from ideas to actionable solutions requires powerful change management that demonstrates leadership's commitment to seeing the initiative through and prepares the organization for successful implementation.

Moving from design to action

Putting a newly designed process, structure, policy or system into action requires a methodical and intentional approach to change management.

The most effective initiatives are exemplified by the following:

- Clarity in the goals, reasons and benefits of the change.
- Alignment with culture — understanding how the values and behaviors of an organization affect and are reflected by the initiative, including how decisions will be made, degree of team empowerment and tolerance for risk and failure.
- Focus on capabilities — the people, processes and technologies required to operationalize the change.
- A course that is flexible to navigate the challenges, risks and learnings along the journey, yet still leads toward the desired future state.
- Calibration throughout the process (via scorecards, metrics and incentive systems) to ensure that performance targets are being measured and achieved.
- Courage to raise difficult and unpopular issues that impact achievement of outcomes.
- A communication program that promotes bi-directional conversations.

An operational readiness review that identifies an initiative's key operational impacts; discovers gaps in people, processes and technology; and develops workflows, policies and training to address the gaps, is a highly effective way to manage the change process. Critical is a structured approach that engages and empowers clinical and operational work groups to test and refine designs and develop solutions to mitigate identified risks. Depending on the scope of the initiative and specific organizational needs, key operational readiness activities may include the following:

- Identifying high impact workflows.
- Defining clinical, revenue cycle, financial and operational risks associated with high-impact workflows.
- Mapping current versus future state workflows.
- Conducting demonstrations to ensure clear understanding of changes.
- Working with leadership to develop and execute risk mitigation plans.
- Identifying key performance indicators to monitor impact.

Engaging frontline managers, staff and clinicians is key to determining the "how" and "who" of making change happen on a daily basis, as well as identifying the risks and unintended consequences that could derail implementation. Carefully selected frontline users test how the new design will impact all aspects of the organization, including jobs, roles, training and education; process steps and workflows; policies and rules and information flow and system modifications.

These readiness groups identify gaps, test assumptions, surface risks, ask tough questions, define metrics and begin devising solutions for what needs to be done to operationalize the designed changes. The groups also meet regularly with key stakeholders to align operational and business priorities and ensure systemwide readiness.

Learning from examples

The examples detailed below highlight the importance of engaging frontline staff through an operational readiness program to test, refine and execute designs to ensure their real-world viability, efficacy and value:

Patient Access. A large Midwestern health system sought to improve patient access and transform its approach to primary care. Successful implementation of key recommendations, such as open access scheduling, would involve significant changes to provider schedule templates and centralized call center staff workflows. In preparation for implementation, work groups identified all new design impact points and conducted readiness assessments in each clinic focused on role and template changes.

Working with the site-based leadership team, a gap analysis was conducted and a profile for each provider was created that detailed the specific changes required to achieve the new standards. For example, care team changes were created to help clinicians and the clinic stay on schedule. Work groups also defined training requirements for the centralized call center.

Using the readiness assessment results as a guide, the new standards, templates and roles were carefully rolled out clinic by clinic. Following implementation, the organization has seen impressive results in improved access. For example, visit volumes have grown by 7%.

Web extra

View a provider profile showing recommendations for change at hfma.org/sfp/ChangeManagement


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Revenue cycle. The CFO and emergency department (ED) director of a large Southeastern community health system were concerned that ED bad debt represented 35% of overall hospital bad debt and quickly initiated a revenue cycle improvement process. Work groups comprised of revenue cycle staff and ED clinicians were charged with improving the process for copayment collection, registration, follow-up appointments and financial counseling, without disrupting patient flow or clinical care. A primary recommendation was the implementation of a discharge desk to check-out patients after their visits. Reviews with key stakeholders also identified three improvements: Changes to staffing levels to cover the required patient contact locations; a notification built into the ED bed board to facilitate bedside registration and a new process for escorting patients to the discharge desk.

Early clinician engagement was critical, particularly in gaining agreement on using floor space for a discharge desk, establishing accountability for escorting patients to the discharge desk and identifying new communication mechanisms between clinicians and registration staff to support full ED patient registrations and collections.

IT system implementation. An integrated East Coast healthcare system underwent a large-scale IT system implementation to replace acute, ambulatory and revenue cycle systems impacting more than 9,000 staff and providers. Best practice adoption was led by work groups that identified changes required in existing workflows, processes, policies, procedures and roles, as well as potential clinical, revenue cycle and operational risks associated with the new system implementation. Potential performance risks/impacts included the following:

- Accounts receivable (A/R) and discharge not billed (DNB)
- Charge capture and revenue integrity
- Patient registration and check in
- Operating room utilization and scheduling
- Utilization management/care management communication and coordination

The work groups partnered with leadership to develop and execute multi-step risk mitigation plans. The integration of clinical operations and revenue cycle staff within the work groups was an important factor in identifying and addressing how clinical changes would impact billing.

Also, critical to success was representation and participation from all three hospitals in the work groups to promote consistent workflows, processes and procedures. Work group leads were responsible for regular communication with frontline staff. Six months after implementation, the organization has seen an increase in professional billing average daily revenue of 23% and daily collections of 28%.

Web extra

View a sample risk management plan at hfma.org/sfp/RiskMitigation

Assessing and addressing implementation risks

As your organization moves from design to execution, it is critical to engage frontline users to identify and proactively address the issues that will detract from successful, sustainable implementation. Consider the Operational Readiness Assessment questions outlined below:

Clarity. Do managers, clinicians and staff at all levels understand what we are trying to do and why? Have we effectively made the case for change?

Culture. How do our organizational values and norms support the change? How are we empowering our managers, staff and clinicians to make needed decisions and changes in behavior, policies and processes?

Capabilities. How will this change impact our organizational staffing and roles; foundational workflows and processes; mandated policies and standards and integrated technology? Have we thoroughly examined these impact points and documented new roles, policies, workflows and configurations to impacted technology?

Course. Do we have a comprehensive plan that aggregates the identified impact points and assigns accountabilities and timelines, phased in an optimal manner to support the upcoming changes? Have adequate lead times and acknowledgement of dependencies been built into that plan? Can any of the remediation steps for these impact points be tested and fine-tuned prior to the planned change?

Calibration. How will we know if we are successful? How will we measure progress against our goals?

Courage. What are the difficult or controversial issues that must be addressed to reach our desired outcomes? How are we supporting our leaders and staff to take on these issues?

Conversations. Do we have adequate forums/mechanisms/opportunities in place to promote ongoing, bi-directional communication and honest feedback?

Moving forward

An effective operational readiness program that identifies and addresses the impacts, risks and unintended consequences of new designs — on roles, skill requirements, processes, policies and technology — can help leadership effectively manage change from design through execution and ensure improvements are sustainable and lead to full realization of benefits. //

This article originally appeared in HFMA's CFO Forum.

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// finance at a glance //

Care management for Medicare patients drives more than 50% of savings

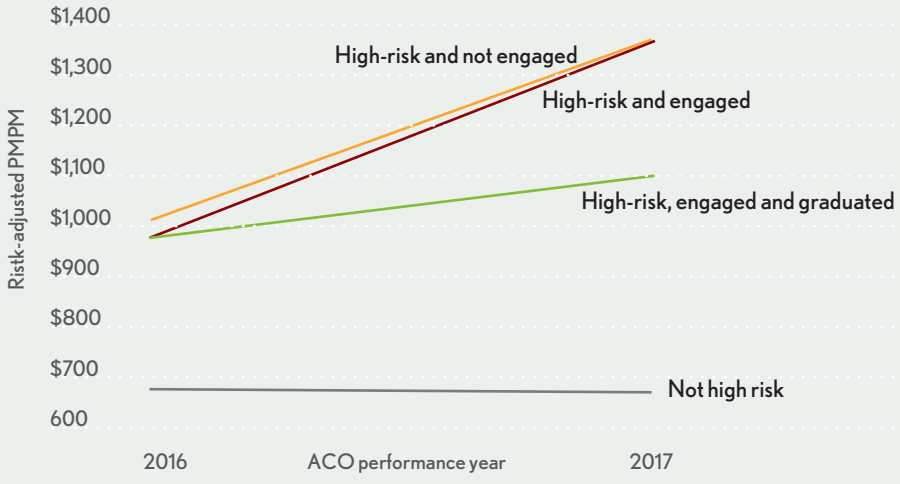
High-risk patients enrolled in Medicare who complete care-management programs have substantially better outcomes and lower spending than those who are not involved in care management, according to an Evolent Health analysis. The research found that across three full-risk accountable care organizations (ACOs) the impact of care management in 2017 was $15.1 million, more than half of the $26.6 million in shared savings for the three ACOs.

Monthly costs for patients who graduated from care management programs were 22% lower than those who did not graduate or did not engage with care management at all.

Many care management programs use engagement as an indicator of success, yet this analysis shows that focus is misplaced: When patients engaged with care management but did not graduate, their 2017 spending was nearly identical to those who never engaged in the first place. Successfully meeting individual program goals and graduating is key to reduced health care utilization. //

Care management results in lower per member per month costs

Spending for high-risk accountable care organization members who graduated from care management programs (green line) is lower than for high-risk members who did not engage in care management (red line) or who engaged but did not graduate (yellow line).



Source: Evolent Health. Used with permission.