

AN HFMA VALUE PROJECT REPORT

Building Value-Driving Capabilities:

Performance Improvement



hfma educational foundation
healthcare financial management association

ABOUT THE VALUE PROJECT

Of all the transformations reshaping American health care, none is more profound than the shift toward value. Quality and patient satisfaction are being factored into Medicare reimbursement, while private payers are pushing for performance and risk-based payment structures. At the same time, rising healthcare costs are creating more price sensitivity among healthcare purchasers, including government agencies, employers, and, of course, patients themselves, who are being asked to pay higher premiums, copayments, and deductibles for their care.

Hospitals have always cared about quality because they are fundamentally dedicated to patients' well-being. But today's pressures make it financially imperative to develop collaborative approaches that combine strong clinical outcomes with effective cost containment.

HFMA's Value Project aims to help guide the transition from a volume-based to a value-based healthcare payment system. With the support of 17 leading hospitals and health systems (listed on the inside back cover of this report), which serve as the project's steering committee and research sponsors, HFMA has engaged in a series of interviews with finance and administrative leaders and their clinical partners at providers who are leading the transition to value, including:

Advocate Health Care	Lee Memorial Health System
Baptist Health South Florida	The Methodist Hospital System
Baylor Health Care System	New York-Presbyterian
Bellin Health	Novant Health
BJC HealthCare	Partners HealthCare
Bon Secours Health System	Rush University Medical Center
Catholic Health East	Scottsdale Healthcare
Cleveland Clinic	Sharp HealthCare
Dignity Health	Spectrum Health
Geisinger Health System	Texas Health Resources
HCA - Hospital Corporation of America	UAB Medicine - UAB Hospital
Intermountain Healthcare	Unity Health System

HFMA has also interviewed a range of organizations representing the perspectives of patients, employers, commercial payers, and government agencies, including:

The Access Project
American College of Physician Executives
Blue Cross Blue Shield Association
Catalyst for Payment Reform
HFMA-UK
Institute for Healthcare Improvement

In addition, HFMA has conducted two industry surveys, the first on the current state of value in health care and the second on future directions for value in health care. For additional information, visit the Value Project website at hfma.org/ValueProject.

INTRODUCTION

The shift toward a value-based business model in health care will be accompanied by shifts in care delivery models—and performance improvement will drive this transformation.

To create better value, hospitals and health systems must maintain or improve the quality of patient outcomes while controlling the costs required to achieve these outcomes. These efforts will not be confined within the hospital's walls: Pressures to improve outcomes and reduce total costs across the continuum of care are increasingly focusing attention on better coordination and collaboration among primary and preventive, ambulatory, acute, and post-acute care providers—as well as with patients themselves.

Sustainable performance improvement in hospitals and health systems will require:

- A focus on process reengineering, first within the hospital and then across the continuum of care
- Identification and implementation of evidence-based best practices for clinical care
- Increased patient engagement in maintaining health, managing chronic diseases, and achieving desired care outcomes

A recurring theme of HFMA's Value Project has been the need for close collaboration between clinicians and finance and administrative professionals. Nowhere is that theme more important than in the area of performance improvement. Many organizations have gone through cost containment initiatives. A value-driving capability in performance improvement requires organizations to go the next step, working toward transformation of the care delivery system to improve the quality and cost-effectiveness of clinical care.

Needless to say, clinicians will play a significant—and often leading—role in these efforts. However, they must be supported by finance and administrative professionals' skills in the collection and analysis of data on quality, cost, and utilization and the structuring of compensation agreements and contracts to align both internal and external stakeholders with the organization's performance improvement goals. An integrated approach to performance improvement requires that clinical leaders as well as leaders in finance and administration work together to foster effective collaboration between departments, divisions, and affiliated services and providers—both inside and outside the hospital.

GETTING STARTED

A commitment to performance improvement is not a short-term affair; instead, it requires long-term dedication to continuous improvement throughout the organization. A first step is signaling the organization’s commitment to performance improvement, which requires making performance improvement part of an organization’s strategic vision.

A number of organizations dedicated to improving health care have implemented initiatives that healthcare providers can adapt as part their strategic vision. The Institute for Healthcare Improvement (IHI), for example, has defined the IHI Triple Aim, focused on the simultaneous pursuit of three aims:

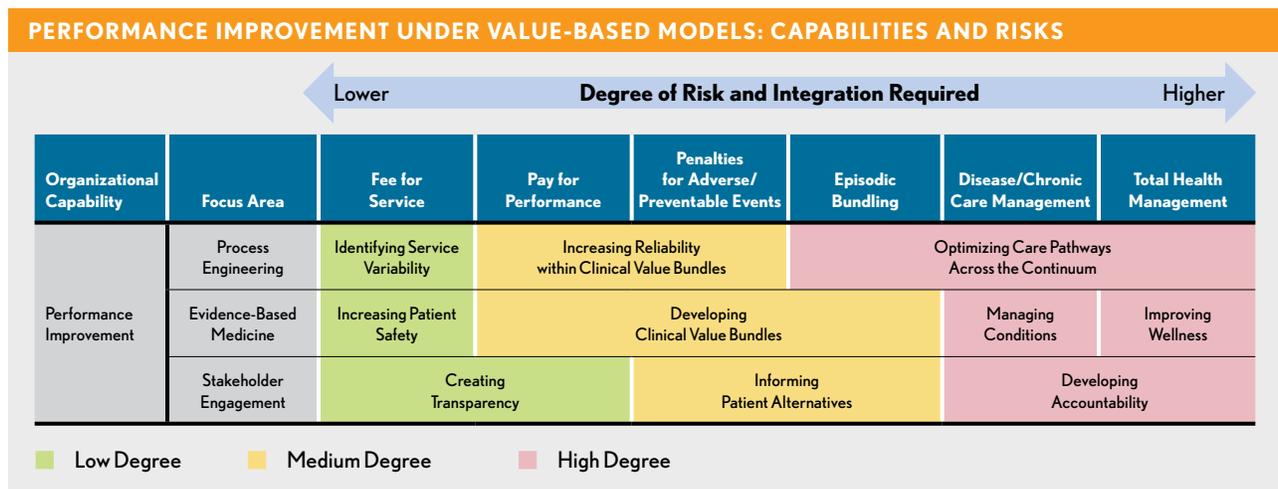
- Improving the experience of care
- Improving the health of populations
- Reducing per-capita costs of health care

Similarly, the Leapfrog Group, a coalition representing large employers, offers participation in an annual hospital survey organized around four “leaps” in computerized provider order entry (CPOE), ICU physician staffing, evidence-based hospital referral, and National Quality Forum-defined safe practices. Hospitals participating in the survey publicly report their results to Leapfrog and are able to benchmark their progress in improving the quality, safety, and efficiency of care delivery.

These and similar initiatives provide ready-made performance improvement goals for an organization.

In addition, the grid below highlights areas of importance for performance improvement as evolving payment and care delivery models ask provider organizations to assume more risk for patient outcomes or push development of more integrated care delivery networks. Within the still dominant fee-for-service environment, for example, performance improvement priorities include identifying service variability issues to reduce internal costs and increasing patient safety—a natural goal of any healthcare provider that also builds skills in avoiding adverse events and readmissions that can affect publicly reported quality scores.

As providers become more exposed to risk under pay-for-performance and episodic-bundling scenarios, process improvements across an episode of care or “clinical value bundle”—which may require hospital coordination with other providers—are gaining priority. These improvements help to reduce avoidable readmissions or other adverse conditions that may have a negative impact on payment. Under a total health management scenario involving per-member, per-month payment, performance improvement initiatives increasingly become centered on optimizing care pathways across the continuum, managing chronic conditions, and improving population health. A shift to the right on the grid also requires healthcare providers to consider new approaches to engaging patients in their care and, ultimately, cultivating a sense of accountability for health outcomes among the population being served.



Building performance improvement capabilities along this continuum positions an organization to provide better value for purchasers of care while ensuring the organization's sustainability within a more value-based payment and care delivery system. Hospitals and health systems are understandably concerned about the timing of a transition from volume-based to more value-based methods of payment: Progressing too far or too quickly with efforts that reduce utilization, for example, can negatively affect revenues. But against these concerns, hospitals and health systems should balance the following considerations.

Opportunities for growth. In areas of population growth, or where other opportunities exist to increase market share, performance improvement initiatives that reduce internal costs or more effectively manage patient flow can free up resources to invest in growing practice areas or can enable organizations to increase volume without adding additional beds or staff.

External pressures in the marketplace. In some areas of the country, such as Massachusetts, both government and private payers are already moving quickly to implement new payment methodologies that require fundamental changes to care delivery models. Hospitals and health systems that have developed their performance improvement capabilities—and have reached outside their walls to collaborate or partner with other providers—will be in a better position to adapt as similar changes take hold in their states and localities.

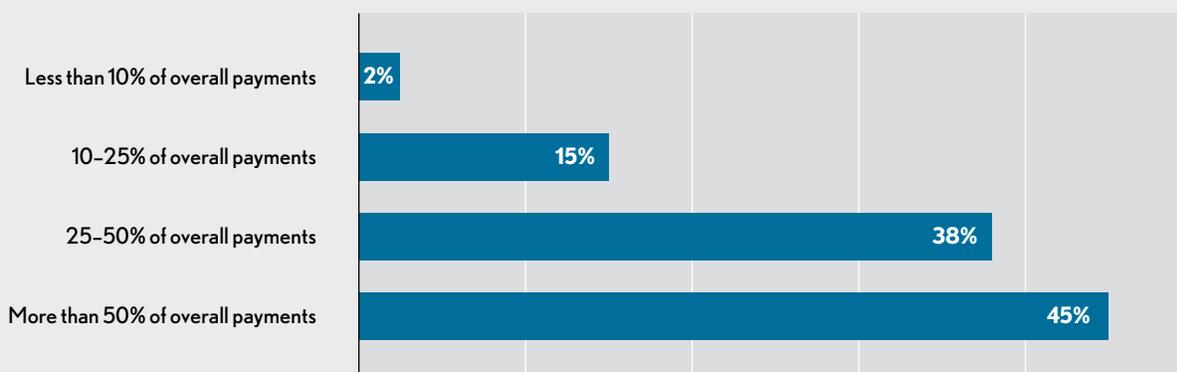
Opportunities to establish a competitive value advantage. Hospitals and health systems need not wait for change to happen to them; instead, they can be agents in driving change. The more success an organization has with performance improvement, the more confident it can be in demonstrating its value proposition to health plans and employers in its marketplace—and in securing contracts and agreements that provide better value to payers while establishing a competitive advantage over other providers.

Put bluntly, there is significant risk in taking a wait-and-see approach to performance improvement. Attendees at HFMA's 5th Annual Thought Leadership Retreat in October 2011 anticipated significant change, with more than 80 percent predicting that more than 25 percent of their overall payments will involve performance-based risk within the next 10 years.

Ten years may seem like an eternity in health care, but the ability to drive performance improvement does not come easily: One industry leader in healthcare delivery transformation, Intermountain Healthcare, has been working on performance improvement for 20 years. In a recent interview with *hfm* magazine, Intermountain's chief quality officer, Brent James, MD, offered this lesson from Intermountain's experience: "Don't wait. Even though it may not be immediately financially advantageous, you will need these skills within your organization. You'll need the cultural shifts that go with it, too" ("Brent James, MD: Using Data to Transform Healthcare Delivery," *hfm*, March 2012).

LEVEL OF PERFORMANCE-BASED RISK UNDER VALUE-BASED MODELS

Within the next 10 years, I predict provider organizations will accept performance-based risk on:



Source: HFMA Thought Leadership Retreat Survey, October 2011.

PROCESS REENGINEERING

The concept of process reengineering has become increasingly prominent in health care, as process improvement and quality management philosophies and techniques developed in manufacturing and business contexts—including Lean, Six Sigma, and the work of quality management leaders such as W. Edwards Deming and Joseph M. Juran—have been adapted by healthcare providers. Given the recognized need to improve quality, reduce costs, remove waste, and improve efficiency in health care—the very needs that spurred the development of process improvement and quality management techniques in manufacturing—a commitment to process reengineering is essential to performance improvement.

Health care is distinct from most manufacturing and business contexts, however, in that the focus of its services is individual human beings, and the outcomes at stake can be literally a matter of life or death. This has several implications for process reengineering within a healthcare setting:

- A push to minimize variations in clinical procedures must be balanced against an understanding of what variations may be clinically necessary to meet the needs of individual patients.
- Process reengineering efforts focused on clinical processes should be led by clinicians, with finance taking a supporting role in data collection and analysis with respect to the quality and efficiency outcomes of these efforts.
- An emphasis on quality improvement will often be the most effective way to engage key physicians, leaders, and staff, especially clinicians. As in other contexts where process reengineering has been applied, better and more consistent quality outcomes should in most instances lead to lower costs.

With these considerations in mind, hospitals and health systems can begin to develop a framework for process reengineering efforts designed to minimize clinical practice variations, especially those that have an adverse impact on care outcomes or costs.

A FRAMEWORK FOR PROCESS REENGINEERING

There are five strategies hospitals and health systems should consider in developing a framework for process reengineering initiatives.

Identify areas of opportunity. A strategic vision for performance improvement should be supported by a clear process for identifying areas with the greatest opportunities for quality and cost improvements. A logical starting point is areas with high volumes or high costs, or areas in which patient safety or poor quality outcomes (e.g., high rates of readmissions) are a concern. When beginning process reengineering efforts, it is also helpful to identify service lines or practice groups with clinicians open to change or eager to achieve cost savings to help grow their practice area. Early successes are more achievable when all parties are motivated to change, and these successes can then help motivate other groups within the organization.

Assemble a multidisciplinary team. Once an area for process reengineering has been identified, the focus should turn to identifying causes for significant variations in patient outcomes or physician costs. A common theme among provider interviews for the Value Project was the use of multidisciplinary investigatory teams. For example, Rush University Medical Center of Chicago uses teams comprising members of its clinical, quality, and finance staff (see the sidebar on page eight) to support physician team leaders; additional support is provided by an IT team, and oversight is provided by a senior leadership team that includes the CEO, CMO, Chief Quality Officer, and CFO. At Partners HealthCare in Boston, Mass., care redesign teams include:

- *Nursing and other clinical experts* to consult on care coordination and opportunities for expanded clinical roles
- *Administrative experts* to consult on the feasibility of design proposals, cost reduction opportunities, and financial modeling
- *IT representatives* to leverage current IT and system capabilities and plan for future improvements

ENGAGING FRONT-LINE STAFF IN PATIENT SAFETY AT NEW YORK-PRESBYTERIAN HOSPITAL

Launched in 2008, New York-Presbyterian's hospitalwide patient safety initiative is a model for disseminating information on clinical and environmental issues affecting quality and patient safety throughout the organization (e.g., communication, hand hygiene, medication reconciliation, and fire safety). It also provides a model for ensuring a two-way flow of information between leadership and frontline staff.

Every Friday, senior leaders, department heads, and key personnel at the hospital's five sites gather simultaneously to present an hour-long, structured curriculum around one or more of these clinical or environmental issues. Following the presentation, the group sends teams of two to three members

to work with staff in all areas of the hospital using "tracers"—focused interviews in which team members discuss the topics presented with the patient care directors and identify issues that need to be addressed at either a unit level or a hospital-wide level. The interviews bring hospital leaders together with frontline staff at the unit level in open discussions that encourage staff to participate in identifying factors that may contribute to incidents, interventions that prevent patient harm, and other ways to encourage a culture of patient safety. "Patient Safety Fridays" have fostered collaboration throughout the hospital on advancing the common goal of providing an environment of quality and patient safety.

- *Primary care physician liaisons* to ensure continuity of the patient experience and consideration of referring physicians' needs
- *Ad hoc subject matter experts* as needed
- *Project management experts* to facilitate and support development of project deliverables, provide overall project support, and compile best practice research and support analysis

Assess the current state of care processes, quality, and cost. Assessment of the current state should draw on both data analysis and observation of current care processes.

Key data for the current state assessment include:

- A breakdown of costs per case within the area (As demonstrated in the exhibit "Pinching the Curve" exhibit on page eight, opportunities are most significant where the cost curve is wider, shorter, and has a longer tail, which indicates a wider degree of variation per case.)
- A breakdown of costs per category (e.g., pharmaceuticals, medical/surgical supplies, labor, imaging & diagnostics, etc.) to identify the highest cost—and highest savings potential—categories within the area
- An analysis of complication rates and their associated costs
- Analyses of other quality outcomes for the service area and population mix

Team members should also adopt the practice of "walking the line," which, in a manufacturing context, means walking the shop floor to observe and engage in conversations with team members who are building a company's products. In the healthcare context, walking the line means following the path of a patient through a unit, talking with front-line caregivers about current care processes and opportunities they see for improvement. Teams also should solicit feedback from patients and their families, who may have questions or observations about their care that also identify areas for improvement. There are tools available to assist in the efforts to identify waste. For example, IHI has published a Hospital Inpatient Waste Identification Tool that relies upon a frontline staff approach (available at www.ihi.org).

Identify best practices for process redesign. Clinicians should lead research into best practices for clinical care, identifying evidence-based practices wherever possible. Beyond traditional literature reviews, providers can access resources from a variety of clinically-focused organizations dedicated to identifying and disseminating best practices in clinical care (see the sidebar on page six). Several organizations also provide resources and tools that identify best practices.

IDENTIFYING CLINICAL BEST PRACTICES

The ideal in clinical care redesign is to identify and implement processes that reflect evidence-based medicine—processes that are firmly rooted in treatments, procedures, and interventions that have been tested on relevant populations and have been demonstrated to improve the quality or efficiency of care. In reality, there are many areas of clinical practice where clearly superior evidence-based practices have yet to be defined.

At the same time, many organizations are working to identify clinical approaches that can achieve quality or efficiency gains and represent “best practices” that can help drive performance improvement. Examples include the following.

The Agency for Healthcare Research and Quality's Quality Indicators™ Toolkit for Hospitals. AHRQ's toolkit focuses on the agency's 17 patient safety indicators (PSIs) and 28 inpatient quality indicators (www.ahrq.gov/qual/qitoolkit). Currently included in the toolkit are selected best practices and improvement suggestions for eight PSIs.

The toolkit also provides tools for educating board members and staff on the clinical and financial implications of quality indicators, identifying priorities for quality improvement, implementing and sustaining improvements, and estimating the ROI from interventions implemented to improve performance on quality indicators. It is available to hospitals free of charge.

The Institute for Healthcare Improvement's Knowledge Center. The “tools” section of IHI's website (www.ihl.org) offers multiple best-practice-based resources, including guides on preventing surgical site infections, central line-associated bloodstream infections, and pressure ulcers, as well as tools on improving transitions to reduce avoidable rehospitalizations.

The Society of Hospital Medicine's Mentored Implementation Model. The Society of Hospital Medicine (SHM), the nation's medical society for hospitalists and their patients, pairs hospital teams with a mentor—a physician expert in quality improvement—to improve specific quality indicators. Under the mentor's guidance, sites assess current processes, identify resources and deficiencies, and pilot interventions tailored to the unique needs of the local hospital. Successful interventions are hardwired through system changes to sustain improvements in patient outcomes. Throughout the program, hospitals collaborate with peer sites through an SHM online community in addition to their work with their mentor.

The three signature programs of SHM's mentored implementation model to date include the following:

- Project BOOST, focusing on better outcomes for older adults through safe transitions (The aim of this project is redesign of admission and discharge processes to reduce unnecessary 30-day readmissions, length of stay, and adverse events, and to improve patient satisfaction.)
- The Glycemic Control Mentored Implementation Program, focused on optimizing the care of inpatients with hyperglycemia and diabetes and preventing hypoglycemia
- The Venous Thromboembolism (VTE) Prevention Collaborative, which provides practical assistance on blood clot reduction by designing, evaluating, implementing, and sustaining a VTE prevention program

The National Quality Forum and The Joint Commission awarded SHM the 2011 John M. Eisenberg Patient Safety and Quality Award for Innovation in Patient Safety and Quality at the national level for SHM's work on the mentored implementation program. Additional information is available at www.hospitalmedicine.org.

Clinicians also should take the lead in an examination of medical and surgical supplies, pharmaceuticals, and imaging, diagnostic, and laboratory services to identify significant variations in cost, utilization, and outcomes. The goal of this examination is to identify areas where greater standardization in all these areas can be achieved. Although finance, administrative, and IT professionals will take a secondary role in clinical care redesign, their skills in data collection and analysis, benchmarking, and costing are essential in efforts to quantify outcomes of clinical care redesign.

In addition to clinical care redesign, process reengineering should also work to redesign nonclinical processes that produce inefficiencies or waste. These efforts often will be informed by the results of “walking the line” and conversations with frontline staff, who can identify areas where unnecessary steps are required, the number of staff exceed the needs of the unit, patient transfers are delayed, or materials are wasted.

Organizations may wish to consider a two (or more)-pass approach to implementing process redesign efforts. At Rush University Medical Center, for example, the first pass might focus on improving the quality of outcomes, reducing physician practice variations, and standardizing utilization of high-cost items such as implants. A second pass might then focus on managing utilization of low-cost, high-use items; refining the care delivery model to reduce inefficiencies (for example, inefficiencies that slow down patient flow); investigating the possibility of more efficient care settings; and identifying growth opportunities for the redesigned service.

Reinforce and monitor process improvements. As an organization identifies successful process reengineering efforts, its next task is to ensure that the improved quality and cost outcomes produced through performance improvement initiatives are sustained. This requires careful monitoring of outcomes over time to ensure that new processes and protocols continue to be followed.

For example, many organizations that have fully implemented electronic health records (EHRs) will have the ability to embed adverse drug event warnings, clinical protocols, and other recommended clinical interventions within the system. In the absence of a fully functional EHR, hospitals also can adopt manual tools such as checklists based on reengineered clinical processes. In either case, protocols or checklists must be subject to physician override, but instances of such overrides should be monitored to ensure that individual physicians are generally adhering to agreed-upon process redesigns.

Sustaining cost savings through standardization of medical supplies and devices within a practice area requires ongoing collaboration with finance and the physicians and clinicians who support the area. A crossfunctional team should regularly review practice patterns to track any shifts in utilization. The team should also, as necessary, review new technologies or products that may offer improved quality outcomes and adjust cost projections and contracting strategies as needed. Similarly, labor usage should be tracked to ensure that productivity gains secured through process reengineering do not slip over time.

Extend process reengineering across the care continuum.

Most hospitals and health systems are taking a logical approach to process reengineering, beginning with a focus on inpatient care. But as changes to the payment and care delivery systems move organizations to the right of the grid shown in on page two in terms of increased integration and heightened risk, efforts at process reengineering will need to extend across the care continuum. Integration of health-care providers will also require integration of their performance improvement strategies, clinical performance improvement systems, electronic health records, and costing systems to ensure that efforts at process reengineering can be accurately measured and analyzed across the care continuum.

REENGINEERING CARE DELIVERY AT RUSH UNIVERSITY MEDICAL CENTER

Rush University Medical Center, Chicago, is located within a dynamic and competitive local market where value-based payment reform is beginning to make significant inroads. Internally, the hospital had adopted a strategic focus on quality, safety, and efficiency, and had made significant investments in electronic health records (EHRs). It also recently opened a new patient tower, which offered new opportunities for the transformation of care delivery on the medical center's campus.

Intrigued by the notion of variations and their impact on quality and cost, Rush developed a process for reengineering care delivery defined by an approach intended to accomplish the following:

- Minimize variations, unless they were driven by patient needs
- Put physician leaders of clinical programs in the lead to with an emphasis on how care is delivered to patients, not cost reductions
- Deploy the support of multidisciplinary teams comprising representatives of medical leadership, quality, and finance

The operational framework for Rush's process—described as a “Lean Care Map”—follows five steps, supported by a goal of better care coordination:

- Engage physicians in areas with clinical populations that have significant variations in cost.
- Analyze current processes, quality outcomes, direct costs, and case volumes.
- Identify evidence-based best practices.
- Apply Lean principles to reduce variations in practice and improve efficiencies.
- Hardwire new processes through IT-enabled EHR order sets, clinical decision support, and impact measurement.

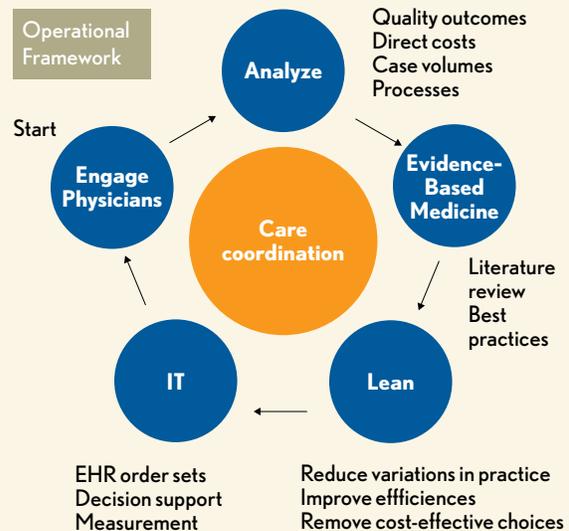
Rush emphasizes that effective care redesign often requires a two-pass process. “On the first pass, our goal is to ‘pinch the curve’ by reducing variations,” says Raj Behal, MD, Rush's associate CMO. “On the second pass, our goal is to ‘shift the curve’ by resetting to a lower cost per case.”

Since launching its clinical initiatives plan in FY10 with its bone marrow transplant and stroke programs, Rush has expanded the initiative into more than 10 clinical programs, with additional initiatives in blood utilization, imaging, targeted drugs, and observation cases that cut across program areas. The cumulative financial impact over the first two years of the initiative was about \$8 million. Quality outcomes

improved or were maintained in all clinical areas. Rush also has been able to secure efficiency gains to free up capacity: In the bowel surgery clinical area, for example, the proportion of patients discharged in less than eight days has risen from 35 percent pre-initiative to 61 percent post-initiative.

LEAN CARE MAP

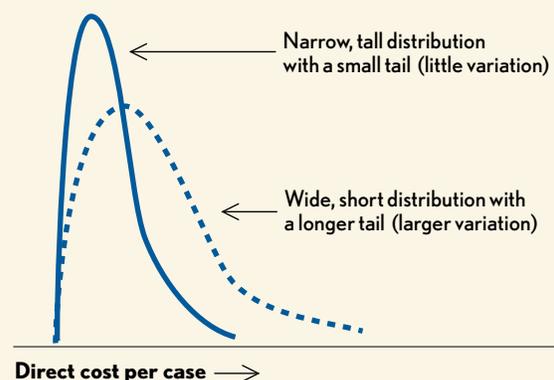
RUSH UNIVERSITY MEDICAL CENTER



Source: Rush University Medical Center.

'PINCHING THE CURVE'

REDUCING VARIATIONS IN CARE



Select clinical populations with significant **variations in costs**. The goal is to reduce variation (**pinch the curve**) and to re-set to a lower cost per case (**shift the curve** to the left)

Source: Rush University Medical Center.

PATIENT ENGAGEMENT

Significant improvements in the performance of the healthcare system, in terms of both quality and cost, also will depend on increasing the engagement of patients and their families in their care. Beginning this year, a failure to effectively engage patients may affect hospital revenues, as Medicare begins to implement payment penalties based on 30-day readmission and mortality rates for acute myocardial infarction (AMI), heart failure, and pneumonia under its hospital readmission reductions and value-based purchasing programs.

Additionally, hospital payments under Medicare’s value-based purchasing program will hinge in part on a hospital’s scores on the HCAHPS survey of patient experience. Although the HCAHPS survey addresses a range of issues related to the patient’s experience in the hospital, a number of the survey questions align closely with issues of patient engagement, including the extent to which nurses, physicians, and other care providers did the following:

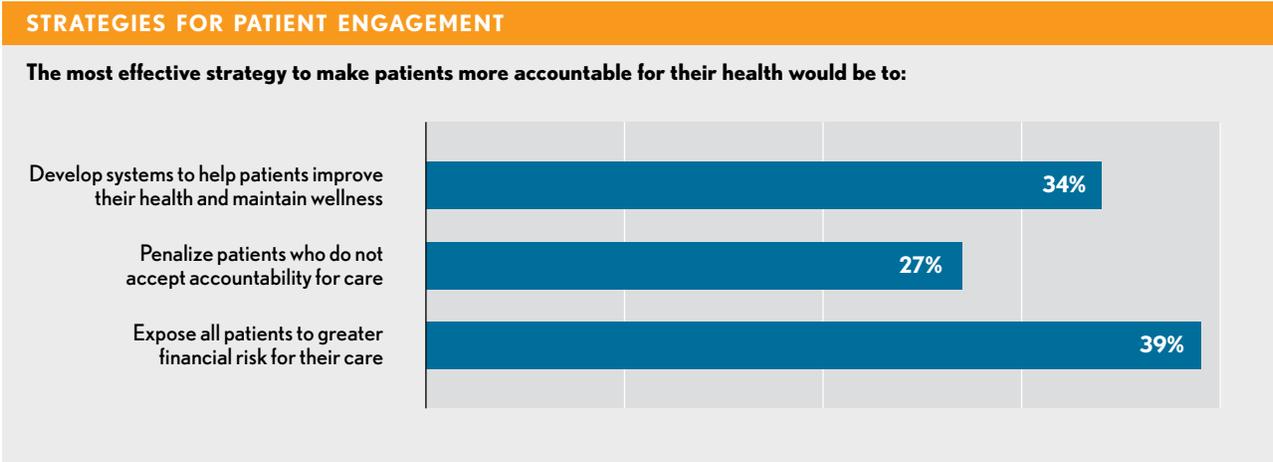
- Explained things in a way the patient could understand
- Offered clear explanations of new medications and possible side effects to the patient and his or her family, where appropriate
- Discussed a patient’s need for assistance after leaving the hospital
- Provided the patient with information in writing about symptoms or health problems to look out for post-discharge

Such actions represent basics of patient engagement. If an organization is not scoring well in one or more of these areas, it has a clear focus for improvement efforts.

The new Medicare readmission and value-based purchasing programs provide immediate motivation to improve an organization’s ability to engage its patients in the fundamentals of their inpatient and post-discharge care. But healthcare organizations should view these efforts as only a beginning. As payment structures shift to place more risk on providers, hospitals and health systems will need to strengthen and deepen their efforts at patient engagement to keep their patients well or ensure their recovery.

Healthcare organizations understandably feel some ambivalence over the issue of patient engagement, as patient behavior is something that these organizations cannot fully control. This ambivalence was evident at HFMA’s 5th Annual Thought Leadership Retreat, held in October 2011. Attendees were asked to identify from a selection of three options the most effective strategy to make patients more accountable for their health. As the exhibit below illustrates, responses were decidedly mixed.

A key takeaway from these results may be that improving patient engagement is best viewed as a collaborative effort among patients, healthcare providers, employers, and payers—an effort that will require aligned incentives to focus all stakeholders on the goal.



Source: HFMA Thought Leadership Retreat Survey, October 2011.

The reality is that today's healthcare providers are feeling much of the financial pressure to improve patient engagement. They should begin by focusing on those aspects of improved patient engagement within their control. Following are three strategies providers should consider.

Incorporate patient perspectives. One of the recommendations from the Value Project report on building a value-driving capability in people and culture was the establishment of patient and family advisory councils. Such councils ensure that healthcare organizations regularly and easily gain patient perspectives on decisions that affect the patient experience and their ability to be engaged with their care. Councils can be structured to give perspectives on the organization overall, or on specific disease conditions or patient populations for which improved patient engagement may be particularly critical or challenging.

In *Building Value-Driving Capabilities: People and Culture*, Kris White, vice president for innovation and patient affairs at Grand Rapids, Mich.-based Spectrum Health, noted that feedback or guidance on patient-directed communications is a "sweet spot" for the work of patient and family advisory councils. The effectiveness of such communications is also, of course, a key element of the HCAHPS patient experience survey and important to the ability of patients and their families to understand and follow instructions for post-discharge care. (For additional tips on the formation of patient and family advisory councils, access the report at www.hfma.org/valueproject.)

Focus on areas or patients of greatest need. The initial Medicare rules' focus on 30-day readmission and mortality rates for acute myocardial infarction (AMI, or heart attack), heart failure, and pneumonia will provide for many organizations a condition-based starting point for patient engagement efforts. Patients with these conditions will nevertheless vary in terms of their engagement with recommended care protocols to recover and avoid readmissions. Moreover, other conditions—especially chronic diseases such as diabetes or asthma—are high on the list of government and commercial payers and employers seeking to

reduce costs. Healthcare providers can anticipate pressures to increase patient engagement with management of these conditions soon, if they have not already felt them.

Disease registries—databases on all patients with a specific disease who are diagnosed and treated within a hospital or health system—are a particularly effective strategy for a condition-based focus on patient engagement. Such registries, especially when incorporated within an organization's electronic health record, can generate patient reminders of upcoming appointments or other care-management tasks and identify patients who have not followed up on recommended care.

Disease registries also can generate lists of patients most in need of additional care management, based on data indicating a pattern of failure to follow recommended care guidelines. Additionally, some healthcare organizations are experimenting earlier in the care process with tools that can help identify patients most in need of more intensive care management interventions. The University of Oregon, for example, has developed a 13-question survey known as the "Patient Activation Measure." This survey uses feedback from patients to place patients in one of four categories that predict their likelihood to understand their condition and follow recommended care guidelines (Chen, Pauline, "Getting Patients to Take Charge of Their Health," *The New York Times*' "Well Blog," Jan. 12, 2012). Providers can then effectively focus potentially resource-intensive care management interventions on patients most likely to need additional assistance.

Experiment with patient engagement techniques.

There is a wide range of strategies and tactics that a healthcare organization can deploy in an effort to improve patient engagement. For example, the Health Research & Educational Trust has published a *Health Care Leader Action Guide to Reduce Avoidable Readmissions* (January 2010) that outlines strategies for reducing readmissions at three different stages of care (during hospitalization, at discharge, and post-discharge), ranked by the level of effort (low, medium, and high) required for implementation. Higher effort typically requires higher cost; although a low-effort

REVENUE CYCLE CUSTOMER SERVICE PLAYS AN IMPORTANT ROLE IN PATIENT SATISFACTION

Patients take into account more than just the efforts of clinicians when forming an opinion of a hospital or health system: They are also strongly influenced by the level of customer service they receive from the organization's finance staff.

Patient interactions with finance professionals have a big impact on their perceptions of a healthcare organization and on their satisfaction with the services they receive. For example, many of the hospitals that earned HFMA's 2011 MAP Award for High Performance in Revenue Cycle found success by putting their focus on the patient experience within revenue cycle operations.

Savvy revenue cycle leaders at hospitals and health systems are creating their own survey tools to understand how patients feel about the nonclinical aspects of their hospital experience.

"The patient satisfaction surveys that are out there currently do not drill down to reveal where within the revenue cycle the process may have failed the patient and created a negative experience," says Suzanne Lestina, HFMA's director of revenue cycle MAP. "Creating an internal survey—or even scripting so that staff members ask patients about their experience

at the end of an interaction—allows you to get feedback from the patient in a more timely and more detailed way."

At Texas Health Presbyterian Hospital in Plano, every patient who calls the patient access intake center or the billing office receives a question: "How would you rate the level of service I provided today?" Patients are asked to rate the service on a scale of 1 to 5. Results are recorded for every call and tabulated weekly and monthly by a customer representative. Patients who give less than satisfactory scores receive a follow-up call from a manager. The reasons for low scores are discussed in department meetings, and two trainers help staff members improve not only the technical knowledge of their jobs, but also customer service.

"This effort—to survey patients at the time of preregistration and after calling the billing office—sends a message to the patients that, at the bookends of their hospital experience, we truly care about providing great service," wrote Texas Health Presbyterian in its MAP Award application. "We're not just concerned with the hospital/clinical experience, but also with the entire experience, including the revenue cycle."

strategy can usually be implemented with existing resources, a high-effort strategy may require significant investments in additional staff or new systems.

Healthcare finance professionals should play a significant role in identifying the right patient engagement strategy for an organization by assessing the financial risk an organization faces for failure to improve patient engagement in areas such as reducing readmissions or managing chronic conditions, and by projecting the cost of recommended engagement strategies. The greater the risk, the more aggressively an organization will want to pursue efforts to increase engagement. Finance skills also will be required in determining the success or failure of implemented strategies and in validating the impact of reduced readmissions, actual costs of the strategy as implemented, and other financial indicators of success or

failure (e.g., reduced average costs per patient in a bundled or per-member, per-month payment structure).

Increased patient engagement also will require the participation of other stakeholders, including employers and commercial payers. Efforts by these stakeholders to incentivize behaviors that improve wellness are already beginning. In a recent employer survey, 25 percent of respondents already penalize or reward individuals based on smoker/tobacco-use status, another 11 percent plan to do so in 2012, and 29 percent more are considering doing so in 2013 or 2014 (Towers Watson, *Health Care Changes Ahead: Survey Report*, October 2011). Interest is growing in penalties and rewards based on "biometric outcomes" such as weight or cholesterol levels. Although only 8 percent of respondents use biometric-based programs today, another 9 percent plan to do so next year and 48 percent are considering it for 2013 or 2014.

CONCLUSION

A value-driving capability in performance improvement builds upon skills already outlined in the Value Project's earlier reports on people and culture and business intelligence capabilities (both available at www.hfma.org/valueproject). Performance improvement will require a commitment from the organization's board on down—a need emphasized in the people and culture report. No performance improvement initiative begins as a guaranteed success: Some efforts will achieve their goal of improving the quality or cost-effectiveness of care, while others will fail (but often produce important lessons for future efforts). If an organization's board and senior leaders openly communicate their support for these efforts—acknowledging the inevitability of both wins and losses—they help create the culture of creativity and innovation on which performance improvement depends.

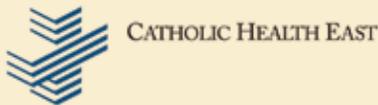
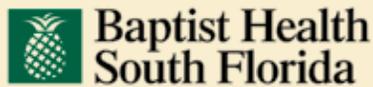
The emphasis on making data actionable, described in the Value Project's business intelligence report, is a

prerequisite to providing the information and decision support upon which performance improvement depends. This report concludes with a description of the elements of project management that should be a part of any performance improvement initiative, such as a clear definition of goals, projections of the resources needed to implement the initiative, and development of metrics against which progress toward these goals can be measured. Also critical is the definition of clear “go/no-go” points, where decisions can be made as to the viability or sustainability of a performance improvement initiative.

A basic assumption of quality management as applied to other industries has been that increased quality ultimately lowers costs. Both outcomes are essential to the long-term viability of the U.S. healthcare system, and will require constant and consistent attention to performance improvement from all healthcare providers. ■

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BUILDING VALUE-DRIVING CAPABILITIES: PERFORMANCE IMPROVEMENT

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